

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/31/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>HEARTLAND LIVING &amp; REHAB AT THE MOSES H CONE MEM H</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1131 NORTH CHURCH STREET</b> <b>GREENSBORO, NC 27401</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225 SS=D	<p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4)</p> <p>483.12(a) The facility must-</p> <p>(3) Not employ or otherwise engage individuals who-</p> <p>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;</p> <p>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or</p> <p>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.</p> <p>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.</p> <p>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in</p>	F 225		9/28/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/20/2017

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to 1. report an allegation of misappropriation of a resident ' s personal property to the state agency, Healthcare Personnel Investigations and law enforcement and 2. do a thorough investigation of the allegation for one of three sampled residents for misappropriation of personal property. Resident #4.</p> <p>The findings included: Resident #4 was admitted to the facility on 7/21/17. Review of the Minimum Data Set (MDS)</p>	F 225	<p>F 225</p> <ul style="list-style-type: none"> <li>•The process, root cause, that lead to the deficient practice, was one individual failing to follow the established policy, Abuse Prevention Program, which was updated on 3.27.17, regarding allegations of abuse.</li> </ul> <p>The facility Abuse Prevention Program requires that all allegations of abuse, neglect, exploitation and misappropriation of property be handled appropriately: the resident should be protected, the incident</p>		

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F 225	Continued From page 2 an Admission, dated 7/28/17 indicated Resident #4 had no short or long term memory problems and his cognition was intact. The MDS indicated he had no behaviors or moods exhibited. Review of the facility ' s investigation included interviews with Resident #4, aide #1 and charge nurse #1. Review of a typed, unsigned interview dated 8/17/17 of charge nurse #1 indicated Resident #1 reported to medication aide #1, that aide #1 had stolen his liquid Morphine from his bag located in his room. Charge nurse #1 talked to Resident #4 about his allegation. Resident #4 told charge nurse #1, aide #1 had come into his room while he was in the restroom, got into his bookbag, took his Morphine and added water to the bottle. "He said ' now it ' s no good and I think I ' m going to call the police. Take finger prints and send it to the lab. ' A family member was visiting and told him not to call the police. The incident was reported by charge nurse #1, to the Director of Nursing, who was out of the facility at that time. The charge nurse #1, sent aide #1, to get a drug screen. The investigation included a hand written, signed and dated account of the allegation, by aide #1. The statement indicated Resident #4 had accused aide #1 of "drinking his Morphine and watering it down, which is completely false." The investigation included a typed interview of Resident #4 dated 8/17/17 and signed by the Director of Nursing (DON). This interview revealed the DON arrived at the facility around 6:00 PM on 8/17/17. She discussed with Resident #4 about the accusation he had made regarding the Morphine. The resident "stated" I don ' t want to talk about anything concerning Morphine. He said, I was just making it up. No one did anything to my Morphine and don ' t want anyone else to ask me about my Morphine. (The statements made by Resident #4 were not in	F 225	should be reported to the healthcare personnel registry within 24 hours (2 hours for abuse and / or bodily injury) and then again at 5 days, and to local agencies including police as indicated. The physician and responsible party must be notified, the allegation should be thoroughly investigated, and interventions should be put into place as needed. In the situation cited, a staff member failed to report the allegation of misappropriation of property to the personnel healthcare registry and to the police, and failed to conduct a thorough investigation.  •Plan of correction and procedure for implementing: -The employee involved in the situation cited was replaced with a new Director of Nursing who was trained on our policy regarding allegations of abuse, including misappropriation of property, and in how to conduct an investigation. -Allegations of abuse, neglect, exploitation and misappropriation of property will be called to the DON and Administrator when the allegation is made and these two people will ensure the allegation is reported to state and local agencies per the Abuse Prevention Program and federal regulations. -The DON or the Administrator will direct all investigations in allegations of abuse. -The Administrator will review all investigations related to allegations of abuse, including related documents / interviews etc, to ensure completeness and to ensure compliance with our Abuse Prevention Program and federal		

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F 225	Continued From page 3 quotation marks when typed.) The interview did not indicate why Resident #4 lied about the accusation. Interview with charge nurse #1 on 8/30/17 at 3:50 PM revealed Resident #4 wanted to talk to her on 8/17/17. When she entered his room, his sister was in the room, and they were speaking in Arabic, and seemed upset. The charge nurse #1 asked them to slow down and tell her what was wrong. Resident #4 told her aide #1 had come into his room, while he was in the bathroom, got into his backpack type bag and took his Morphine. The resident told her he knew she took it, her mouth was blue like his medicine, and he had observed her in his room, going into his bag. She called the Director of Nursing and informed her of the accusation. She was told to send aide #1 to be drug tested. She gave aide #1 the paper work to give to the lab and the aide left the floor. Charge nurse #1 explained the aide returned, and said she had a family emergency and was going home. Charge nurse #1 did not know if the accused aide (#1) had the drug test performed. Interview with Resident #4 was conducted by phone on 8/31/17 at 11:55 AM. Resident #4 explained he was in the bathroom on 8/17/17 when someone came into his room. He asked, who is it?, and it was the aide (aide #1). He asked what was she doing, and was told she had to get papers from him for the nurse. She left, and again he heard someone come into his room. He had the door open slightly and could see who it was that came into his room. Again, it was aide #1, and she said she had to get more papers for the nurse. Resident #4 explained when he came out of the bathroom, he checked his bag. He had a bottle of Morphine in a box, that was in the bag. The box was in the bag, but the Morphine was	F 225	requirements. -Nursing, dietary, therapy, activities, and housekeeping staff will be inserviced on the existing Abuse Prevention Program policy which requires all allegations of abuse, including misappropriation of property be reported and investigated thoroughly. -Heartland leadership staff will be inserviced on how to conduct a thorough investigation, and how/ when to report an allegation of abuse.  •Monitoring -Ten residents per week for 4 weeks will be interviewed to ensure that incidents of abuse, including misappropriation of property, were reported to staff. -The process used and the paperwork associated with all investigations into allegations of abuse will be reviewed by a team composed of at least the Administrator, DON, and Director of Operations monthly for 4 months, looking for opportunities to improve the process. -The resident interviews, and the reviews of the individual investigations into allegations of abuse, will be submitted to the Quality Management with QAPI Team monthly for 4 months. The Quality Management with QAPI Team will modify this plan if compliance with the facility Abuse Prevention Program and the federal regulations is not maintained.  •Person responsible for implementing the plan of correction is the Executive Director.		

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F 225	Continued From page 4 gone. Resident #4 explained he had been to the cancer center and the doctor had given him prescriptions he needed when he went home. He had filled his Morphine before coming back to the facility. He had asked an aide to tell her to come to his room. Aide #1 came to his room, and he told her "you took my medicine, the Morphine bottle." He further explained aide #1 said "no" and he told her that he "Saw her, he would tell everyone you took it." Aide #1 told Resident #4 she would look for it. He continued explaining, aide #1 left his room and returned about 10 minutes later with the bottle of Morphine. The bottle was full to the top and he knew there was not that much in the bottle before it was removed from his room. Resident #4 asked aide #1 "what did you do to my medicine? What did you put in it." His sister came in and he told her what happened. He then told the nurse and he told his therapist. Resident #4 said he saw her tongue and it was blue, like his medicine. He explained he was sure now, (the aide took his Morphine) her tongue was blue. He asked her about her blue tongue and she explained it was from candy. Resident #4 asked her to show what was in her pockets and she had no candy in her pockets. When asked if anyone in the administration had talked to him about the missing Morphine, he stated "No" he only talked to the nurse and the "lady in therapy." When he went out to the cancer center on 8/17/17 he told the nurse that gave him (intravenous) fluids and the doctor about the Morphine incident. He gave the bottle of Morphine to the doctor. The doctor looked at the bottle and wrote him another script for the medication. Resident #4 explained he was afraid to take the medicine, as it had something added to it and he did not know what it might have been. He needed his medicine because of his cancer.	F 225			

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F 225	<p>Continued From page 5</p> <p>Resident #4 concluded the interview that he did not want the aide (aide #1) to get into trouble, he wanted to know why she took it and what she did to it. Resident #4 was asked if he had lied about the Morphine and he said "No." He was asked if he tried to get another script on purpose, and he said "No."</p> <p>A message was left for the nurse at the cancer center physician ' s office. A return call was not made by the nurse.</p> <p>Interview with the Director of Nursing on 8/31/17 at 12:00 PM revealed she had received a phone call from the lab that did the drug screen on aide #1. She did not remember who she talked to, and she did not have anything written from the lab regarding the drug test. The DON indicated she had been told by "someone" at the lab the test was negative for the drug. Aide #1 was off work until she received the phone call. She thought the call came in on the following Monday.</p> <p>An interview was conducted with speech therapist #1 on 8/31/17 at 3:00 PM revealed Resident #4 had informed her his Morphine bottle had been missing after aide #1 had come into his room. Resident #4 was in the bathroom, and saw aide #1 come into his room and went through his bag. She explained Resident #4 told her to leave and he checked his bag after she left and the Morphine bottle was gone. Resident #4 was not out in the hallway yelling or screaming. He had asked to speak to aide #1. Resident #4 told her the aide ' s tongue (aide #1) was blue. Speech therapist #1 explained she had not been interviewed by nursing management. She had reported the incident to her supervisor.</p> <p>Interview conducted with aide #2 on 8/31/17 at 9:30 AM revealed she was working on 8/17/17 and had taken Resident #4 his breakfast tray.</p>	F 225			

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F 225	<p>Continued From page 6</p> <p>Interview revealed she had not been interviewed about what had happened on 8/17/17 with the Morphine by nursing administration.</p> <p>Interview conducted with medication aide #1, on 8/31/17 at 9:50 AM revealed Resident #4 had asked her to send aide #1 to his room to talk with him. Interview revealed she had not been interviewed by nursing administration about what had happened on 8/17/17 with the Morphine.</p> <p>Interview conducted with aide #3 on 8/31/17 at 10:00 AM revealed she had not been interviewed about what had happened on 8/17/17 with the Morphine by nursing administration.</p> <p>Interview with aide #1 on 8/31/17 at 3:00 PM revealed she denied being in Resident #4 ' s room on morning of 8/17/17. She explained she did go to his room for papers the nurse wanted. The resident handed them to her at the door. She explained she took the form for the drug test to (name of the hospital) health center. The procedure included, she gave the form to the health center staff, a specimen cup was given to her and she went to a bathroom on a hallway, obtained the urine specimen and gave the specimen to the health center staff. She left the nursing home on 8/17/17 because they "gave her the day off."</p> <p>During an interview with the Nurse Manager of the (name of the hospital) Employee Health Center on 8/31/17 at approximately 3:30 PM, when asked about the process of obtaining a urine drug screen from an active employee sent from the facility, she stated that the employee will present a paper of authorization to the front desk receptionist, along with a photo ID to verify identity and will be asked to wait in the lobby until a nurse calls them back. If no authorization paper is presented, they would then call the employee to verify what test needed to be done.</p>	F 225			

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F 225	Continued From page 7 The Employee Health Center would also require a signed consent of authorization for the test. She also stated that the employee is told not to leave the lobby once checked in for any reason. Staff at the Employee Health Center wait at least 10 minutes prior to bringing the person back to decrease the chance of tampering with the sample, and if the urine is found to be cold and not warm they may suspect that the person used an outside specimen. She stated that the chain of custody was very important in the process, so once the employee is brought into the clinic the nurse verifies the photo ID again and then instructs them on the process. The employee must wash their hands, the nurse opens the cup and then would ask them to go into the restroom and obtain a sample without turning water on or flushing the toilet. When the nurse manager was asked about results and how these were communicated to the facility, she stated that new hires will show immediate results. However, if it is a drug screen for an existing employee, a more thorough test is sent to the lab. If these results are positive for any reason an outside agency will assign someone to call and speak to the employee about current prescription medications and will follow up with physician ' s offices to verify the medication and dose in the employee ' s system. Once this process is complete and results are obtained the results would be called into the DON or Administrator. When the information was passed, a note will be added to the employee ' s chart documenting the date, time, and who the results were given to. The RN Manager and the Receptionist were both asked if aide #1 had completed this process on 8/17/17 and their records revealed that the employee had not been to the clinic since 2014. Interview with the Administrator on 8/31/17 at	F 225			



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F 225	Continued From page 8 4:00 PM revealed she was informed the aide had been drug tested, Resident #1 was "drug seeking" and said he lied about what had happened and agencies had not been notified since it did not happen. During the interview, the Administrator was asked what she would expect from supervisors when allegations of misappropriation were made against an employee. The Administrator explained the accused staff member would be suspended pending the outcome of the investigation, an investigation would be conducted. Agencies would be notified if the allegations were proved and law enforcement would be notified if the theft occurred. The facility ' s policy and procedure was reviewed with the Administrator and she agreed the supervisory staff should have sent a 24 hour report to the state agency and called law enforcement. The Administrator explained she had been off during the occurrence of the allegations and investigation and thought it had been "handled" when she returned. Further interview with the Administrator revealed the DON had called the Employee Health Center on 8/31/17 and was informed aide #1 had not shown for the drug screen. The Employee Health Center had no record of aide #1 coming in for the test.	F 225			
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3)  483.12 (b) The facility must develop and implement written policies and procedures that:  (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of	F 226		9/28/17	

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F 226	Continued From page 9 resident property,  (2) Establish policies and procedures to investigate any such allegations, and  (3) Include training as required at paragraph §483.95,  483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-  (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.  (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property  (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to follow their policy and procedure for an allegation of misappropriation of a resident's property for one of three sampled residents. The facility failed to report the allegation to the Health Care Personnel Investigation within 24 hours and at 5 working days, failed to report the allegation to law enforcement and failed to do a thorough investigation. (Resident #4). The findings included: Review of the facility's "Abuse Prevention	F 226	F 226  •The process, root cause, that lead to the deficient practice, was one individual failing to follow the established policy, Abuse Prevention Program, which was updated on 3.27.17, regarding allegations of abuse.  The facility Abuse Prevention Program requires that all allegations of abuse, neglect, exploitation and misappropriation of property be handled appropriately: the		

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F 226	Continued From page 10 Program" dated 2006, included in the definitions of abuse "g. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent." This policy indicated an investigation would be conducted and would include, but not limited to the following: "a.) Any documentation available that describes the events and/or the events leading up to the incident. This may include but not limited to: (1) Completed Grievance or Incident/Accident Report; (2) (2) Documented witness interviews with persons (e.g staff, other residents, family, visitors) involved or who provided care to the resident, and anyone having knowledge of the event ... (3) All allegations that do not involve abuse and do not result in serious bodily injury must be reported to the State agency/HCPDR within 24 hours. (4) Resident interview if possible. Interview should be conducted by at least two different qualified staff persons at different times for consistency and details; (5) (5) Descriptions of events leading up to and/or immediately following the event ... (7) The Executive Director .... Will submit a written report to HCPDR and any other agencies listed above, as appropriate within five working days of the event. This report will include a summary of the investigation, conclusion and any corrective action taken. (c) The ED (Executive Director) or appropriate designee, will compile all completed information and type a summary report of findings within 5 business days of the event occurrence; ... (f) Ensure that all alleged violations involving	F 226	resident should be protected, the incident should be reported to the healthcare personnel registry within 24 hours (2 hours for abuse and / or bodily injury) and then again at 5 days, and to local agencies including police as indicated. The physician and responsible party must be notified, the allegation should be thoroughly investigated, and interventions should be put into place as needed. In the situation cited, a staff member failed to report the allegation of misappropriation of property to the personnel healthcare registry and to the police, and failed to conduct a thorough investigation.  •Plan of correction and procedure for implementing: -The employee involved in the situation cited was replaced with a new Director of Nursing who was trained on our policy regarding allegations of abuse, including misappropriation of property, and in how to conduct an investigation. -Allegations of abuse, neglect, exploitation and misappropriation of property will be called to the DON and Administrator when the allegation is made and these two people will ensure the allegation is reported to state and local agencies per the Abuse Prevention Program and federal regulations. -The DON or the Administrator will direct all investigations in allegations of abuse. -The Administrator will review all investigations related to allegations of abuse, including related documents / interviews etc, to ensure completeness and to ensure compliance with our Abuse		

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F 226	Continued From page 11 abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property are reported immediately ... 5. Additional agencies ....may be notified ...especially if criminal actions had occurred ...." Resident #4 was admitted to the facility on 7/21/17 with diagnoses of cancer of the throat. Review of the Minimum Data Set (MDS) an Admission, dated 7/28/17 indicated Resident #4 had no short or long term memory problems and his cognition was intact. The MDS indicated he had no behaviors or moods exhibited. Resident #4 required limited assistance from staff for activities of daily living. The pain assessment revealed Resident #1 had a pain level of 6, on a scale of 0 to 10. His pain interfered with activities of daily living and sleep Interview with Resident #4 was conducted by phone on 8/31/17 at 11:55 AM. Resident #4 explained the incident occurred when he was in the bathroom on 8/17/17. Resident #4 explained someone came into his room. He asked, who is it?, and it was the aide (aide #1). He asked what was she doing, and was told she had to get papers from him for the nurse. She left, and again he heard someone come into his room. He had the door open slightly and could see who it was that came into his room. Again, it was aide #1, and she said she had to get more papers for the nurse. Resident #4 explained when he came out of the bathroom, he checked his bag. He had a bottle of Morphine in a box, that was in the bag. The box was in the bag, but the Morphine was gone. Resident #4 explained he had been to the cancer center and the doctor had given him prescriptions he needed when he went home. He had filled his Morphine before coming back to the facility.	F 226	Prevention Program and federal requirements. -Nursing, dietary, therapy, activities, and housekeeping staff will be inserviced on the existing Abuse Prevention Program policy which requires all allegations of abuse, including misappropriation of property be reported and investigated thoroughly. -Heartland leadership staff will be inserviced on how to conduct a thorough investigation, and how/ when to report an allegation of abuse.  •Monitoring -Ten residents per week for 4 weeks will be interviewed to ensure that incidents of abuse, including misappropriation of property, were reported to staff. -The process used and the paperwork associated with all investigations into allegations of abuse will be reviewed by a team composed of at least the Administrator, DON, and Director of Operations monthly for 4 months, looking for opportunities to improve the process. -The resident interviews, and the reviews of the individual investigations into allegations of abuse, will be submitted to the Quality Management with QAPI Team monthly for 4 months. The Quality Management with QAPI Team will modify this plan if compliance with the facility Abuse Prevention Program and the federal regulations is not maintained.  •Person responsible for implementing the plan of correction is the Executive Director.		

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F 226	<p>Continued From page 12</p> <p>Continuing with the interview with Resident #4, he had asked an aide to tell aide #1 to come to his room. Aide #1 came to his room, and he told her "you took my medicine, the Morphine bottle." He further explained aide #1 said "no" and he told her that he "Saw her, he would tell everyone you took it." Aide #1 told Resident #4 she would look for it. He continued explaining, aide #1 left his room and returned about 10 minutes later with the bottle of Morphine. The bottle was full to the top and he knew there was not that much in the bottle before it was removed from his room. Resident #4 asked aide #1 "what did you do to my medicine? What did you put in it." His sister came in and he told her what happened. He then told the nurse and he told his therapist. Resident #4 said he saw her tongue and it was blue, like his medicine. He explained he was sure now, (the aide took his Morphine) her tongue was blue. He asked her about her blue tongue and she explained it was from candy. Resident #4 asked her to show what was in her pockets and she had no candy in her pockets.</p> <p>Further interview with Resident #4 by phone revealed he had not been interviewed by any administrative staff about the incident. When asked if anyone in the administration had talked to him about the missing Morphine, he stated "No" he only talked to the nurse and the "lady in therapy." When he went out to the cancer center on 8/17/17 he told the nurse that gave him (intravenous) fluids and the doctor about the Morphine incident. He gave the bottle of Morphine to the doctor. The doctor looked at the bottle and wrote him another script for the medication. Resident #4 explained he was afraid to take the medicine, as it had something added to it and he did not know what it might have been. He needed his medicine because of his cancer.</p>	F 226			

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F 226	Continued From page 13 Resident #4 concluded the interview that he did not want the aide (aide #1) to get into trouble, he wanted to know why she took it and what she did to it. Resident #4 was asked if he had lied about the Morphine and he said "No." Review of the facility's investigation included interviews with Resident #4, aide #1 and charge nurse #1. Review of a typed, unsigned interview dated 8/17/17 of charge nurse #1 indicated Resident #1 reported to medication aide #1, that aide #1 had stolen his liquid Morphine from his bag located in his room. Charge nurse #1 talked to Resident #4 about his allegation. Resident #4 told charge nurse #1, aide #1 had come into his room while he was in the restroom, got into his bookbag, took his Morphine and added water to the bottle. "He said 'now it's no good and I think I'm going to call the police. Take finger prints and send it to the lab.' His sister was visiting and told him not to call the police. The incident was reported by charge nurse #1, to the Director of Nursing, who was out of the facility at that time. The charge nurse #1, sent aide #1, to get a drug screen. The investigation included a hand written, signed and dated account of the allegation, by aide #1. The statement indicated Resident #4 had accused aide #1 of "drinking his Morphine and watering it down, which is completely false." The investigation included a typed interview of Resident #4 dated 8/17/17 and signed by the Director of Nursing (DON). This interview revealed the DON arrived at the facility around 6:00 PM on 8/17/17. She discussed with Resident #4 about the accusation he had made regarding the Morphine. The resident "stated" I don't want to talk about anything concerning Morphine. He said, I was just making it up. No one did anything to my Morphine and don't want anyone else to ask me about my Morphine. (The	F 226			

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F 226	<p>Continued From page 14</p> <p>statements made by Resident #4 were not in quotation marks when typed.) The interview did not indicate why Resident #4 lied about the accusation.</p> <p>Interview with the Director of Nursing on 8/31/17 at 12:00 PM revealed she had received a phone call from the lab that did the drug screen on aide #1. She did not remember who she talked to, and she did not have anything written from the lab regarding the drug test. The DON indicated she had been told by "someone" at the lab the test was negative for the drug. Aide #1 was off work until she received the phone call. She thought the call came in on the following Monday.</p> <p>An interview was conducted with speech therapist #1 on 8/31/17 at 3:00 PM revealed Resident #4 had informed her his Morphine bottle had been missing after aide #1 had come into his room. Resident #4 was in the bathroom, and saw aide #1 come into his room and she went through his bag. She explained Resident #4 told her to leave and he checked his bag after she left and the Morphine bottle was gone. He had asked to speak to aide #1. Resident #4 told her the aide's tongue (aide #1) was blue. Speech therapist #1 explained she had not been interviewed by nursing management. She had reported the incident to her supervisor. Interview conducted with aide #2 on 8/31/17 at 9:30 AM revealed she was working on 8/17/17 and had taken Resident #4 his breakfast tray. Interview revealed she had not been interviewed about what had happened on 8/17/17 with the Morphine by nursing administration.</p> <p>Interview conducted with medication aide #1, on 8/31/17 at 9:50 AM revealed Resident #4 had asked her to send aide #1 to his room to talk with him. Interview revealed she had not been interviewed by nursing administration about what</p>	F 226			

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F 226	<p>Continued From page 15</p> <p>had happened on 8/17/17 with the Morphine. Interview conducted with aide #3 on 8/31/17 at 10:00 AM revealed she had not been interviewed about what had happened on 8/17/17 with the Morphine by nursing administration. Interview with aide #1 on 8/31/17 at 3:00 PM revealed she denied being in Resident #4's room on morning of 8/17/17. She explained she did go to his room for papers the nurse wanted. The resident handed them to her at the door. She explained she took the form for the drug test to (name of the hospital) health center. The procedure included, she gave the form to the health center staff, a specimen cup was given to her and she went to a bathroom on a hallway, obtained the urine specimen and gave the specimen to the health center staff. She left the nursing home on 8/17/17 because they "gave her the day off."</p> <p>Interview with the Nurse Manager of the (name of the hospital) Employee Health Center on 8/31/17 at approximately 3:30 PM, revealed they had no record of aide #1 coming in for the drug screen. The RN Manager and the Receptionist were both asked if aide #1 had completed this process on 8/17/17 and their records revealed that the employee had not been to the clinic since 2014. Interview with the Administrator on 8/31/17 at 4:00 PM revealed she was informed the aide had been drug tested, Resident #4 was "drug seeking" and said he lied about what had happened and agencies had not been notified since it did not happen. During the interview, the Administrator was asked what she would expect from supervisors when allegations of misappropriation were made against an employee. The Administrator explained the accused staff member would be suspended</p>	F 226			



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F 226	Continued From page 16 pending the outcome of the investigation, an investigation would be conducted. Agencies would be notified if the allegations were proved and law enforcement would be notified if the theft occurred. The facility's policy and procedure was reviewed with the Administrator and she agreed the supervisory staff should have sent a 24 hour report to the state agency and called law enforcement. The Administrator explained she had been off during the occurrence of the allegations and investigation and thought it had been "handled" when she returned. Further interview with the Administrator revealed aide #1 had not had the drug screen done. The DON had called the Employee Health Center and requested the drug screen report. The DON was informed the aide had not come in for the test.	F 226			
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii)  (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to follow the care plan for resident transfer which resulted in a fall for one of three residents. Resident #2  The findings included:	F 282	F 282 •The process, root cause, that lead to the deficient practice, was human error: Facility practice requires that staff follow established care plans when providing care. In the situation cited, a staff member failed to reference and follow an	9/28/17	

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F 282	<p>Continued From page 17</p> <p>Resident #2 was admitted to the facility on 4/28/17 with diagnosis of seizures. The Minimum Data Set (MDS) dated 7/3/17 indicated she short and long term memory problems, required extensive assistance of two staff for bed mobility and transfers.</p> <p>The care plan dated 4/28/17 (admission care plan) indicated the resident had a potential for falls, was non ambulatory and must be transferred with a lift.</p> <p>Review of an incident report revealed Resident #2 had an assisted fall on 8/17/17. The resident sustained no injuries. The fall occurred during a transfer.</p> <p>Interview with aide #1 on 8/31/17 at 3:00 PM revealed she was taking care of Resident #2 on 8/17/17. She usually transferred Resident #2 by herself and had no problems. Aide #1 explained someone from therapy had told her the resident could transfer by stand and pivot. The aide explained she should provide care according to the information provided by the aides. During the transfer, Resident #2 had problems with her knees and they buckled. She sat the resident on her knee, and lowered her to the floor.</p> <p>Interview with MDS nurse on 8/31/17 at 3:15 PM revealed the care plan was current, with the initial problem dated 4/28/17 for use of a lift for transfers. She had not received any updates from therapy to change how the resident was transferred.</p>	F 282	<p>established care plan before transferring a resident, and as a result used the wrong method.</p> <ul style="list-style-type: none"> <li>•Plan of correction and procedure for implementing: <ul style="list-style-type: none"> <li>-The employee involved in the situation cited was suspended pending investigation and then terminated.</li> <li>-A training document will be developed, emphasizing the need for staff to reference and follow the established care plan, (written version and / or the Kiosk information), prior to providing care for a resident.</li> <li>-Nursing staff will be inserviced on the training document.</li> </ul> </li> <li>•Monitoring <ul style="list-style-type: none"> <li>o Random audits of 10 nurses and CNAs (5 of each) will conducted weekly, reviewing how each person provides care, and comparing it to the established care plan. The care that is monitored will include but not be limited to resident transfers.</li> <li>o The results of the audits will be reviewed monthly for 3 months by the Quality Management Team with QAPI team to ensure compliance is in effect. The Quality Management Team with QAPI team will modify the plan of correction if compliance is not present</li> </ul> </li> <li>•Person responsible for implementing the plan of correction is the Executive Director.</li> </ul>		