STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345050	A. BUILDING _____ B. WING _____	C 03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACOB'S CREEK NURSING AND REHABILITATION CENTER	1721 BALD HILL LOOP MADISON, NC 27025

(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 000	INITIAL COMMENTS The survey team entered the facility on 3/9/18 to conduct a complaint survey. The survey team identified immediate jeopardy at F600 J and exited the facility on 3/10/18. The survey team obtained additional information on 3/11/18 via telephone. Due to inclement weather of snow and ice, the survey team could not go back to the facility on 3/12/18 and 3/13/18. The survey team returned to the facility on 3/14/18 to conduct a partial extended survey. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity J	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		4/6/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/05/2018

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F 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident representative interviews the facility failed to notify the resident representatives and physicians in a timely manner of a previous occurrence of abuse resulting in a lack of intervention for the prevention of another occurrence for 2 of 5 resident's reviewed for notification of physical abuse/resident to resident altercations (Resident #1 and Resident #2).	F 580	Jacob's Creek acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	

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F 580	Continued From page 2 Findings included: 1. Record review revealed Resident #2 was admitted to the facility on 3/8/16 with diagnoses of dementia, anxiety disorder, cerebrovascular accident, and depression. The quarterly minimum data set (MDS) assessment dated 12/27/17 revealed Resident #2 was severely cognitively impaired requiring extensive assistance with bed mobility, range of motion impairment of lower extremities, and dependent for locomotion on the nursing unit. Record review of a 24 hour report dated 3/2/18 for second shift (3:00 PM to 11:00 PM) completed by Nurse #2 indicated a nursing report was received from Nurse #3 on first shift (7:00 AM to 3:00 PM) that Resident #2 and Resident #1 were in an altercation. Nurse #2 was interviewed on 3/9/18 at 4:40 PM. Nurse #2 indicated she received report from Nurse #3 on 3/2/18 at the change of shift that there was an altercation between Resident #2 and Resident #1. Nurse #2 indicated she did not know what happened in the altercation or when it occurred. Nurse #2 indicated she went to assess Resident #2 at the beginning of her 3:00 PM to 11:00 PM shift on 3/2/18. Nurse #2 indicated she observed a fresh bruise on the bridge of the nose and a small red bruise above the nose on Resident #2. Nurse #2 indicted she did not document this bruise because it did not happen on her shift. Nurse #2 indicated she made the assumption all the required documentation regarding the altercation and the assessment had been already completed on the 1rst shift (7:00 AM to 3:00 PM) on 3/2/18.	F 580	Jacob's Creek response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Jacob's Creek reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F580 Notify of Changes (Injury/Decline/Room, etc.) The plan of correcting the specific deficiency The position of Jacob's Creek Nursing and Rehabilitation Center regarding the process that lead to this deficiency; the facility did not notify the resident representatives and physicians in a timely manner of a previous occurrence of abuse resulting in a lack of intervention for the prevention of another occurrence for 2 of 5 resident's reviewed for notification of physical abuse/resident to resident altercations (Resident #1 and Resident #2). Facility did not ensure that Resident #1's and Resident #2's resident representatives and physicians were notified on 3/2/2018. Jacob's Creek Nursing and Rehabilitation Center's plan for correcting the deficiency is to ensure that the facility notifies the resident representatives and physicians in a timely manner of changes	

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F 580	Continued From page 3 Nurse #3 was interviewed on 3/9/18 at 3:52 PM. Nurse #3 confirmed she did give report to Nurse #2 at the end of her 7:00 AM to 3:00 PM shift on 3/2/18 regarding an altercation that had occurred between Resident #2 and Resident #1. Nurse #3 stated the altercation occurred between 9:00 AM and 10:00 AM. Nurse #3 indicated when she assessed Resident #2 there was no bruising or redness but it looked like Resident #1 hit Resident #2 in the nose. Nurse #3 stated, "I did not write a note at that time but thought I would later write a note after I finished my medication pass. I did report it off to the oncoming nurse at the end of the shift to [Nurse #2]." Nurse #3 indicated she did not notify anybody of the altercation between Resident #2 and Resident #1 other than Nurse #2 on 3/1/18. Nurse #3 indicated she did not fill out a progress note or an incident report on 3/2/18. Nurse #3 indicated she could not recall the exact day the altercation between Resident #2 and Resident #1 happened, she thought it was on a Wednesday. An incident report for Resident #2 dated 2/28/18 had a nursing description of the incident that stated, "Male resident observed in hallway arguing with this resident. Male resident heard yelling "get out of my room." This resident yelled back "someone shoot him." Male resident hit this resident in the face/nose with his hand. Male resident reports this resident was in his room. However, both residents were observed in the hallway outside of resident's room at time of altercation." The documentation in the incident report dated 10/28/17 indicated the physician was notified of the incident on 3/5/18 at 1:47 PM and the responsible party was notified on 3/5/18 at 1:47 PM.	F 580	(Injury/Decline/Room, etc.) to include occurrences of abuse. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 3/10/2018, MDS-RN (Minimum Data Set-Registered Nurse) reviewed 100% progress notes from 3/2/2018 through 3/10/2018 to identify any changes (Injury/Decline/Room, etc.) to include occurrences of abuse to ensure notification of resident representatives and physicians in a timely manner. On 3/10/2018, Administrator reviewed 100% incident reports from 2/28/2018 through 3/10/2018 to ensure notification of resident representatives and physicians in a timely manner. The audits resulted in no negative findings. On 3/10/2018, DON (Director of Nursing) initiated education on all nursing staff members on expectations of documentation to include notification of resident representatives and physicians in a timely manner of changes (Injury/Decline/Room, etc.) to include occurrences of abuse. All nursing staff members were educated prior to working their next assigned shift by 3/15/2018. Any newly hired nursing staff members will be educated on expectations of documentation to include notification of resident representatives and physicians in a timely manner of changes (Injury/Decline/Room, etc.) to include	

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F 580	Continued From page 4 Review of the medical record of Resident #2 did not reveal any documentation regarding an altercation between Resident #1 and Resident #2 on 3/2/18 or 2/28/18. Record review of the nursing notes for Resident #2 dated 3/3/18 stated, "Resident was sitting at the entrance into the dining room when another resident was propelling self into the dining room. CNA (certified nursing assistant) observed other resident hitting this resident in the face with a fist. Residents were separated. Administer was contacted at 1901 (7:01 PM). RR (Resident Representative) [Name] was contact at 1910 (7:10 PM) who made a visit to the facility and verbalized understanding. Deputy and detective was contact and made report." Nurse aide (NA) #7 was interviewed on 3/10/18 at 12:20 PM. NA #7 indicated he was working at the nurses station on 3/3/18 when he heard Resident #2 and Resident #1 arguing. NA #7 indicated he immediately went to the residents. NA #7 indicated he observed that Resident #2 was in a reclining chair in a corner with Resident #1 facing her in his wheel chair. NA #7 indicated Resident #1 had Resident #2 "pinned against the wall." NA #7 indicated he observed Resident #1 repeatedly hitting Resident #2 with his fist in the her face. NA #7 indicted he immediately separated Resident #1 and Resident #2. The physician for Resident #2 was interviewed on 3/12/18 at 10:32 AM. He indicated he did not recall being notified of an altercation for which Resident #2 was involved in the week prior to 3/3/18. He stated he did not recall being notified on 3/5/18 of any altercations between Resident #2 and Resident #1.	F 580	occurrences of abuse in orientation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The ADON (Assistant Director of Nursing), MDS-RN and Restorative Nurse will utilize audit tool to ensure continued compliance with notification of resident representatives and physicians in a timely manner of changes (Injury/Decline/Room, etc.) to include occurrences of abuse. These audit tools will be completed daily 5 times a week for 4 weeks, weekly for 4 weeks, monthly for 4 months. The title of the person responsible for implementing the acceptable plan of correction The Administrator is responsible for the implementation of the acceptable plan of correction.	

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The resident representative of Resident #2 was interviewed on 3/9/18 at 11:40 AM. He stated a nursing supervisor called him on 3/3/18 to notify him of an altercation during which Resident #2 was struck by Resident #1. He stated he was informed by the nursing supervisor that this had happened before. He stated he had no knowledge of a previous incident. The resident representative indicated he was then concerned about the continued safety of Resident #2 at the facility.

The facility DON was interviewed on 3/9/18 at 4:00 PM. She stated her expectations for reporting, notification of family, and documentation of altercations between residents was given to the nurses during orientation to the facility. She said the nurses were expected to notify either the DON or the Administrator, the resident's family and the physician of any resident altercations.

The facility Administrator was interviewed on 3/10/18 at 8:36 AM. She stated her expectations were for any changes in condition, to include behaviors and altercations, the family and the physician were to be notified. The Administrator stated that if she had been notified of a previous physical altercation, prior to 3/3/18, between Resident #2 and Resident #1, she would have put Resident #1 on one to one monitoring sooner possibly preventing an incident from happening on 3/3/18.

2. Resident #1 was admitted on 9/9/09 with diagnoses of schizophrenia, dementia, and Alzheimer's disease. The quarterly MDS dated 1/11/18 revealed Resident #1 was moderately

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F 580	Continued From page 6	F 580		

cognitively impaired with physical behaviors 1 to 3 days of the assessment period.

Record review of a 24 hour report dated 3/2/18 for second (3:00 PM to 11:00 PM) completed by Nurse #2 indicated a nursing report was received from Nurse #3 on first shift (7:00 AM to 3:00 PM) that Resident #2 and Resident #1 were in an altercation.

Nurse #2 was interviewed on 3/9/18 at 4:40 PM. Nurse #2 indicated she received report from Nurse #3 on 3/2/18 at the change of shift that there was an altercation between Resident #2 and Resident #1. Nurse #2 indicated she did not know what happened in the altercation or when it occurred. Nurse #2 indicated she went to assess Resident #2 at the beginning of her 3:00 PM to 11:00 PM shift on 3/2/18. Nurse #2 indicated she observed a fresh bruise on the bridge of the nose and a small red bruise above the nose on Resident #2. Nurse #2 indicted she did not document this bruise because it did not happen on her shift. Nurse #2 indicated she made the assumption all the required documentation regarding the altercation and the assessment had been already completed on the 1rst shift (7:00 AM to 3:00 PM) on 3/2/18.

Nurse #3 was interviewed on 3/9/18 at 3:52 PM. Nurse #3 confirmed she did give report to Nurse #2 at the end of her 7:00 AM to 3:00 PM shift on 3/2/18 regarding an altercation that had occurred between Resident #2 and Resident #1. Nurse #3 stated the altercation occurred between 9:00 AM and 10:00 AM. Nurse #3 indicated when she assessed Resident #2 there was no bruising or redness but it looked like Resident #1 hit Resident #2 in the nose. Nurse #3 stated, "I did

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F 580	Continued From page 7	F 580		

not write a note at that time but thought I would later write a note after I finished my medication pass. I did report it off to the oncoming nurse at the end of the shift to [Nurse #2]." Nurse #3 indicated she did not notify anybody of the altercation between Resident #2 and Resident #1 other than Nurse #2 on 3/1/18. Nurse #3 indicated she did not fill out a progress note or an incident report on 3/2/18. Nurse #3 indicated she could not recall the exact day the altercation between Resident #2 and Resident #1 happened, she thought it was on a Wednesday.

An incident report for Resident #1 dated 2/28/18 had a witness statement from Nurse #3, "Resident was in the hallway and verbally arguing with another resident. [Resident #1]. Nurse heard them arguing, he said, "Get out of my room." She yelled, someone shoot him. Then nurse saw [Resident #1] hit [Resident #2] in the nose with fist. Nurse ran over to separate them. Separated them. Nurse told [Resident #1] that you do not hit anyone. Nurse asked what was wrong that he hit her. He said she was in my room. Clearly, she was not. They both were in the hallway, near his doorway. No injuries noted." The documentation on the 2/28/18 incident report indicated the physician was notified on 3/5/18 and the responsible party was notified on 3/5/18.

Review of the medical record of Resident #1 did not reveal any documentation regarding an altercation between Resident #1 and Resident #2 on 3/2/18 or 2/28/18.

Record review of the nursing notes for Resident #1 dated 3/3/18 stated, "Resident was propelling self into dining room where other was sitting outside of dining room area. CNA (Certified

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Nursing Assistant) observed resident to be punching resident in the face with a fist. Residents [were] separated. Administer was contacted. [Resident Representative] case worker was contacted. 1 on 1 put in place. Deputy and detective where contacted to come to facility. Room change to 200 hall."

Nurse aide (NA) #7 was interviewed on 3/10/18 at 12:20 PM. NA #7 indicated he was working at the nurses station on 3/3/18 when he heard Resident #2 and Resident #1 arguing. NA #7 indicated he immediately went to the residents. NA #7 indicated he observed that Resident #2 was in a reclining chair in a corner with Resident #1 facing her in his wheel chair. NA #7 indicated Resident #1 had Resident #2 "pinned against the wall." NA #7 indicated he observed Resident #1 repeatedly hitting Resident #2 with his fist in the her face. NA #7 indicted he immediately separated Resident #1 and Resident #2.

The physician for Resident #1 was interviewed on 3/12/18 at 10:32 AM. He indicated he did not recall being notified of an altercation for which Resident #1 was involved in the week prior to 3/3/18. He stated he did not recall being notified on 3/5/18 of any altercations between Resident #2 and Resident #1.

The resident representative for Resident #1 was interviewed on 3/12/18 at 10:40 AM. The resident representative confirmed she was notified on 3/5/18 of a previous altercation between Resident #2 and Resident #1 that happened prior to 3/3/18. The resident representative did not know the date of the previous altercation between the two residents.

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F 580	Continued From page 9 The facility Administrator was interviewed on 3/10/18 at 8:36 AM. She stated her expectations were that for any changes in condition, to include behaviors and altercations, the family and the physician were to be notified. The Administrator stated that if she had been notified of a previous physical altercation, prior to 3/3/18, between Resident #2 and Resident #1, she would have put Resident #1 on one to one monitoring sooner possibly preventing an incident from happening on 3/3/18.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to protect a cognitively impaired resident (Resident #2) from physical abuse inflicted by a cognitively impaired resident (Resident #1) for 1 of 4 sampled residents reviewed for physical abuse. Resident #2 experienced pain, bruising, and swelling to the	F 600	Jacob's Creek acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents.	4/6/18

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F 600	Continued From page 10 right cheek and eye as a result of being hit by Resident #1. Jeopardy began on 3/3/18 when Resident #1 hit Resident #2 in the face, which resulted in Resident #2 being physically injured requiring pain medication and an assessment at an emergency room after the trauma. Immediate jeopardy was removed on 3/11/18 when the facility provided an acceptable credible allegation of removal. The facility will remain out of compliance at a scope and severity level position D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced. Findings included: Resident #2 was admitted to the facility on 3/8/16 with diagnoses of dementia, anxiety disorder, cerebrovascular accident, and depression. The quarterly minimum data set (MDS) assessment dated 12/27/17 revealed Resident #2 was severely cognitively impaired requiring extensive assistance with bed mobility, range of motion impairment of lower extremities, and dependent for locomotion on the nursing unit. Resident #1 was admitted on 9/9/09 with diagnoses of schizophrenia, dementia, and Alzheimer's disease. The quarterly MDS dated 1/11/18 revealed Resident #1 was moderately cognitively impaired with physical behaviors 1 to 3 days of the assessment period. The documentation in the care plan last updated on 3/3/18 for Resident #1 revealed a focus area for the problematic manner in which the resident	F 600	The Plan of Correction is submitted as a written allegation of compliance. Jacob's Creek response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Jacob's Creek reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F600 Free from Abuse and Neglect The plan of correcting the specific deficiency The position of Jacob's Creek Nursing and Rehabilitation Center regarding the process that lead to this deficiency; the facility failed to protect a cognitively impaired resident (Resident #2) from physical abuse inflicted by a cognitively impaired resident (Resident #1) for 1 of 4 sampled residents reviewed for physical abuse. Facility did not ensure that they protected a cognitively impaired resident (Resident #2) from physical abuse inflicted by a cognitively impaired resident (Resident #1) on 3/2/2018. Jacob's Creek Nursing and Rehabilitation Center's plan for correcting the deficiency is to ensure that the facility protects cognitively impaired residents from physical abuse inflicted by cognitively	

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JACOB'S CREEK NURSING AND REHABILITATION CENTER	1721 BALD HILL LOOP MADISON, NC 27025

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had ineffective coping skills, aggression, combativeness related to cursing, hitting grabbing staff, and verbal/physical aggression toward other residents at times. The care plan was updated on 2/5/18 for one on one monitoring of Resident #1 until his behavior subsided and then 15 minute visual checks to monitor his behavior/needs. The care plan had been updated on 3/3/18 with the intervention of one on one monitoring of the resident.

Nursing notes and Medication Administration records (MAR) dated 2/23/18 to 3/6/18 revealed Resident #1 was being monitored every 15 minutes for aggressive behavior. An interview with the Quality Improvement (QI) Nurse on 3/10/18 at 10:44 AM revealed Resident #1 had been on 15 minute visual checks since 2/5/18 as an intervention added to the care plan after Resident #1 had a previous physical altercation with another resident in the facility. The QI nurse confirmed the facility nurses were performing 15 minute visual checks on 2/28/18 and 3/2/18.

The incident report for Resident #1 dated 2/28/18 had a witness statement from Nurse #3, "Resident was in the hallway and verbally arguing with another resident. [Resident #1]. Nurse heard them arguing, he said, "Get out of my room." She yelled, someone shoot him. Then nurse saw [Resident #1] hit [Resident #2] in the nose with fist. Nurse ran over to separate them. Separated them. Nurse told [Resident #1] that you do not hit anyone. Nurse asked what was wrong that he hit her. He said she was in my room. Clearly, she was not. They both were in the hallway, near his doorway. No injuries noted." The documentation on the incident report of the immediate action taken stated, "Both residents were immediately

impaired residents to include Resident #1 and Resident #2.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 3/8/18, the administrator facilitated a quality improvement meeting with DON, ADON, Social Worker, QI (Quality Improvement) Nurse, Infection Control Nurse, Restorative Nurse, RN Supervisor and Staff Facilitator to discuss: 1) what was being done to protect Resident #1, 2) how to keep Resident #2 from having altercations with other residents, 3) the root cause of the resident to resident altercation, 4) education of nurses.

On 3/8/18, Social Worker #1 and Social Worker #2 initiated interviews with all alert and oriented residents. The social workers asked three (3) questions: 1) Do you feel safe at Jacob's Creek? 2) Has anyone, including residents, made you feel unsafe or threatened you? 3) If someone, including another resident, were to make you feel unsafe or threatened you do you know who to report it to? On 3/9/18 Social Worker #1 and Social Worker #2 completed the interviews. The interviews resulted in no negative findings.

On 3/10/18, at approximately 1:30pm, the administrator instructed the DON to continue Resident #2 on 1:1 supervision, 24 hours per day, until the interdisciplinary (IDT) behavior team determines 1:1

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redirected. Female resident (Resident #2) was assisted to dining room, away from this resident's (Resident #1) room. Stop sign in place in resident's (Resident #1) doorway to help deter residents from approaching resident's room. 15 minute visual checks continue in place to help monitor needs/behaviors. Resident is currently followed in house for psych services. Medications reviewed. Recent medication changes implemented by Psych during visit on 2/26/18. MD notified. RR (resident representative) notified."

The incident report for Resident #2 dated 2/28/18 had a nursing description written by Nurse #3 that stated, "Male resident observed in hallway arguing with this resident. Male resident heard yelling "get out of my room" This resident yelled back "someone shoot him." Male resident hit this resident in the face/nose with his hand. Male resident reports this resident was in his room. However, both residents were observed in the hallway outside of resident's room at time of altercation."

Record review revealed there was no documentation in the progress notes for Resident #1 or Resident #2 for the events described on the 2/28/18 incident report. Documentation on the MAR indicated 15 minute checks were being implemented by the nursing staff on 2/28/18.

An interview with Nurse #3 on 3/10/18 at 3:52 PM revealed she filled out an incident report on Monday 3/5/18 for events that occurred on 2/28/18. Nurse #3 confirmed she separated Resident #1 and #2 and continued with the 15 minute checks on 2/28/18.

supervision is no longer necessary. The IDT (Interdisciplinary Team) behavior team will review and discuss high risk behavior residents, to include Resident #1 and Resident #2. The IDT behavior team will meet weekly for six (6) months to determine maintaining of applicable interventions such as the need for continued 1:1 supervision, 24 hour per day.

On 3/10/18, at approximately 2:30pm, clinical teams of the ADON and CNA (Certified Nursing Assistant) #2, QI nurse and Restorative nurse, and the RN supervisor and CNA #3 completed a 100% skin assessments on non-alert and oriented residents. The skin assessment findings were given to the DON for root cause analysis, completed 3/12/18. The outcome of the skin assessments was no findings that required submission to the Health Care Registry. All areas identified during the skin assessment (bruises, skin tears) had determinable causes.

On 3/10/18, the MDS-RN completed a 100% audit of the nurse progress notes from 2/23/18 through 3/10/18. The audit identified one (1) event that the administrator submitted to the Health Care Registry as a 24 hour report on 3/10/18.

On 3/10/18 the administrator completed a 100% audit of the risk management incident/accident reports from 2/23/18 through 3/10/18 to identify any incidents/accidents that would require any

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F 600	Continued From page 13 An interview was conducted with the facility Administrator on 3/10/18 at 8:36 AM. The Administrator revealed she was not aware of the 2/28/18 incident, where Resident #1 struck Resident #2, until she was notified by Nurse #6 on 3/3/18. The Administrator confirmed Resident #1 was put on one to one monitoring and was moved to another hallway on 3/3/18 to protect Resident #2 and the other residents. The Administrator stated that if she had been notified of a previous physical altercation, prior to 3/3/18, between Resident #2 and Resident #1, she would have put Resident #1 on one to one monitoring sooner possibly preventing an incident from happening on 3/3/18. An interview with the Director of Nursing (DON) on 3/10/18 at 9:55 AM revealed the QI Nurse started interviews with the staff and obtaining statements on 3/6/18 regarding the altercation between Resident #1 and Resident #2. The DON revealed nobody had seen or heard the events described by Nurse #3 in the incident report dated 2/28/18. An interview with the QI nurse on 3/10/18 at 10:44 AM revealed she reviewed and revised the incident report dated 2/28/18 on Wednesday, 3/7/18. The QI nurse revealed the Administrator and the Director of Nursing signed off on the incident report dated 2/28/17 on Thursday, 3/8/18. Record review of a 24 hour report dated 3/2/18 for second shift (3:00 PM to 11:00 PM) completed by Nurse #2 indicated a nursing report was received from Nurse #3 on first shift (7:00 AM to 3:00 PM) that Resident #2 and Resident #1 were in an altercation.	F 600	follow-up related to resident abuse. The audit revealed eight (8) incidents that the facility implemented appropriate interventions such as room changes, medication adjustments, and clinical interventions. On 3/10/18 the RVP (Regional Vice President) completed an education with the administrator and DON regarding the responsibility of the administrator and DON to complete 24 hour and 5 day reports to the Health Care Registry. On 3/10/18 the RVP educated the administrator and DON regarding the use of the Allegations of Resident to Resident Abuse checklist. The training included a directive for the administrator to educate all the department heads (QI nurse, MDS nurse, administrator's assistant, administrative assistant, social workers, medical records, accounts payable, accounts receivable, activities assistant, and housekeeping supervisor) on the use of the Allegations of Resident to Resident Abuse checklist. On 3/10/18 the administrator initiated an education for all department heads regarding the prevention and administrative oversight of abuse/resident to resident altercation. All department heads were educated prior to their next scheduled day to work by 3/12/18. Any newly hired department heads on the prevention and administrative oversight of abuse/resident to resident abuse altercation in orientation.	

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F 600	Continued From page 14 Nurse #2 was interviewed on 3/9/18 at 4:40 PM. Nurse #2 indicated she received report from Nurse #3 on 3/2/18 at the change of shift that there was an altercation between Resident #2 and Resident #1. Nurse #2 indicated she did not know what happened in the altercation or when it occurred. Nurse #2 indicated she went to assess Resident #2 at the beginning of her 3:00 PM to 11:00 PM shift on 3/2/18. Nurse #2 indicated she observed a fresh bruise on the bridge of the nose and a small red bruise above the nose on Resident #2. Nurse #2 indicted she did not document this bruise because it did not happen on her shift. Nurse #2 indicated she made the assumption all the required documentation regarding the altercation and the assessment had been already completed on the first shift (7:00 AM to 3:00 PM) on 3/2/18. Nurse #2 indicated that the monitoring of Resident #1 every 15 minutes continued on 3/2/18 and was documented on the MAR. Nurse #3 was interviewed on 3/9/18 at 3:52 PM. Nurse #3 confirmed she did give report to Nurse #2 at the end of her 7:00 AM to 3:00 PM shift on 3/2/18 regarding an altercation that had occurred between Resident #2 and Resident #1. Nurse #3 stated the altercation occurred between 9:00 AM and 10:00 AM. Nurse #3 indicated when she assessed Resident #2 there was no bruising or redness but it looked like Resident #1 hit Resident #2 in the nose. Nurse #3 stated, "I did not write a note at that time but thought I would later write a note after I finished my medication pass. I did report it off to the oncoming nurse at the end of the shift to [Nurse #2]." Nurse #3 indicated she did not notify anybody of the altercation between Resident #2 and Resident #1	F 600	On 3/10/18 the DON, ADON, QI nurse, and Infection Control Nurse began educating all nursing staff members on documentation expectations with regards to resident to resident altercations and documentation. All nursing staff members were educated prior to working their next scheduled shift by 3/15/18. Any newly hired nursing staff members will be educated on documentation expectations in orientation. On 3/11/18, the administrator, DON, ADON, QI nurse, MDS-RN, RN charge nurse, social worker, therapy manager, weekend manager on duty, and/or corporate consultant educated all staff members on how to supervise and monitor residents at high risk for abuse/resident to resident altercation. All staff members were educated prior to working their next scheduled shift by 3/15/18. Any newly hired staff members will be educated on documentation expectations in orientation. On 3/11/18, the Administrator, DON, ADON, QI nurse, MDS-RN, Activity Director and Social Worker began a weekly IDT behavior team meeting to identify and review residents through the following criteria: 1) admission paperwork, 2) progress note review, 3) incident report review, 4) social work note review, 5) 24 hour report sheet review, 6) other pertinent medical information. The facility will implement interventions to reduce the risk of abuse incidents and to provide	

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F 600	Continued From page 15 other than Nurse #2 on 3/1/18. Nurse #3 indicated she did not fill out a progress note or an incident report on 3/2/18. Nurse #3 indicated she could not recall the exact day the altercation between Resident #2 and Resident #1 happened, she thought it was on a Wednesday. Nurse #3 indicated the monitoring of Resident #1 every 15 minutes continued and new interventions were not implemented on 3/2/18. Review of the medical records of Resident #2 and Resident #1 did not reveal any documentation regarding an altercation between Resident #1 and Resident #2 on 3/2/18. Record review of the nursing notes for Resident #2 dated 3/3/18 stated, "Resident was sitting at the entrance into the dining room when another resident was propelling self into the dining room. CNA (certified nursing assistant) observed other resident (Resident #1) hitting this resident (Resident #2) in the face with a fist. Residents were separated. Administer was contacted at 1901 (7:01 PM). RR (Resident Representative) [Name] was contact at 1910 (7:10 PM) who made a visit to the facility and verbalized understanding. Deputy and detective was contact and made report." Nurse aide (NA) #7 was interviewed on 3/10/18 at 12:20 PM. NA #7 indicated he was working at the nurses station on 3/3/18 when he heard Resident #2 and Resident #1 arguing. NA #7 indicated he immediately went to the residents. NA #7 indicated he observed that Resident #2 was in a reclining chair in a corner with Resident #1 facing her in his wheel chair. NA #7 indicated Resident #1 had Resident #2 "pinned against the wall." NA #7 indicated he observed Resident #1 repeatedly	F 600	focused supervision of high risk behavioral residents. On 3/11/18, the administrator, DON, ADON, QI nurse, social worker, and/or staff facilitator began educating newly hired staff during orientation regarding high risk behavior residents, what to watch for, what to do, when to report, who to report to, and what to document. On 3/11/18, the Activities Director began developing activities based on recommendations from the IDT behavior team beginning in the 3/11/18 meeting. The Activities Director began asking families for ideas to occupy high risk residents (ideas such as: previous likes, previous occupation skills, hobbies, etc.) based on recommendations from the IDT meeting. The activity department will be required to carry out the care planned activities for high risk behavior residents. High risk behavior resident activities may be facilitated by facility staff, volunteers, or family members. On 3/11/18, the Administrator, DON, ADON, QI nurse, MDS-RN and admissions director began reviewing all newly admitted residents upon admission and re-admission for high risk behaviors. The MDS-RN will generate a 48 hour care plan which includes high risk behaviors. On 3/11/18, the RVP completed training with the Administrator and DON regarding: 1) complete root cause analysis of resident behaviors, 2) ensuring	

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hitting Resident #2 with his fist in her face. NA #7 indicted he immediately separated Resident #1 and Resident #2 and one to one monitoring of Resident #1 was put in place.

The nursing supervisor (Nurse #6) was interviewed on 3/10/18 at 11:30 AM. Nurse #6 indicated on 3/3/18 NA #7 reported to her Resident #1 hit Resident #2 in the face. Nurse #6 stated she immediately made sure the residents were separated and Resident #1 was put on one to one monitoring. Nurse #6 indicated she spoke with Nurse #2 who told her that this was the second time that week Resident #1 had hit Resident #2. Nurse #6 indicated she called the facility administrator to notify her of the event. Nurse #6 indicated she then called the responsible party for Resident #2 and mentioned to the responsible party that she "knew it had happened before." Nurse #6 stated the responsible party was not aware of the previous altercation between Resident #2 and Resident #1. Nurse #6 indicated she got off the phone after telling the responsible party for Resident #2 that she would obtain more information and call him back. Nurse #6 indicated she looked in the progress notes of the medical records of Resident #2 and Resident #1 and did not see any documentation of previous altercations between the residents. Nurse #6 indicated she spoke with Nurse #2 who confirmed she received report on 3/2/18 from Nurse #3 that Resident #2 and Resident #1 were in an altercation. Nurse #6 indicated she asked Nurse #2 to call Nurse #3 to confirm an altercation happened between Resident #2 and Resident #1 prior to 3/3/18. Nurse #6 indicated Nurse #2 sent a text message to Nurse #3 who confirmed an altercation had happened between Resident #2 and Resident #1.

that appropriate interventions are developed timely, 3) interventions are reviewed regularly for appropriateness, and 4) interventions are sustained through the IDT and QI review processes of repeated review and updated care planning.

On 3/11/18, the RVP completed training with the IDT behavior team regarding: 1) why the team is meeting, 2) what information the team should look at, 3) how to look at root cause, 4) how to make recommendations, 5) being proactive and creative, 6) appropriate and sustainable interventions, 7) teaching staff- looking at all departments as trainers, 8) looking at resident identification, 9) the “5 Whys” of root cause analysis.

On 3/11/18, the RVP completed training with the administrative nurse team titled “Immediate Interventions” which covered: 1) immediately remove the abused resident, 2) provide constant supervision for the abuser, 3) provide immediate medical intervention, 4) provide immediate redirection techniques as developed by the IDT behavior team, 5) plan of corrections, what broke, why, audit, training, monitoring.

On 3/11/18, the DON, ADON, QI Nurse, MDS-RN, Infection Control Nurse, and Staff Facilitator, began training all staff on how to provide immediate interventions for resident to resident altercations such as: 1) immediate protection of residents, separate the residents, 2) supervision of

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F 600	Continued From page 17 Nurse #3 stated she called the responsible party back and confirmed for him that a previous altercation had happened. Nurse #6 indicated she assessed the injuries of Resident #2. Nurse #6 indicated she observed a bruise on the bridge of the nose and a red spot "some other place on her face" that appeared to be from a previous incident. Nurse #6 indicated Resident #2 had fresh swelling and bruising to the right side of her face. The facility Administrator on 3/10/18 at 12:30 PM provided a screen shot of text messages between Nurse #2 and Nurse #3 on 3/3/18. A text message from Nurse #3 confirmed an altercation had happened between Resident #1 and Resident #2 prior to 3/3/18 on a Wednesday. The text messages indicated Nurse #2 was informing Nurse #3 she needed to back date documentation of skin assessments and incident reports as well as notify administrative staff and resident representatives regarding the 2/28/18 altercation. Nurse #2 confirmed in an interview on 3/10/18 at 4:40 PM that Nurse #6 asked her to call Nurse #3 on 3/3/18. Nurse #2 indicated she did speak with Nurse #3 on 3/3/18 and told her she needed to do an incident report for the altercation she observed between Resident #2 and Resident #1. Nurse #2 revealed she did not know when the altercation between the residents Nurse #3 observed occurred. Nurse #2 confirmed that one on one monitoring of Resident #1 began on 3/3/18 after Resident #1 hit Resident #2 for the second time that week. The facility Administrator was interviewed on 3/10/18 at 8:36 AM. She indicated Nurse #6	F 600	aggressive resident to protect others, 3) notify supervisor/nurse, and 4) follow supervisor/nurse's direction. All staff were educated prior to working their next scheduled shift by 3/15/18. Any newly hired staff members will be educated on immediate interventions in orientation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The ADON, MDS-RN and Restorative Nurse will utilize audit tool to ensure continued compliance with protection of cognitively impaired residents from physical abuse inflicted by cognitively impaired residents. These audit tools will be completed daily 5 times a week for 4 weeks, weekly for 4 weeks, monthly for 4 months. The title of the person responsible for implementing the acceptable plan of correction The Administrator is responsible for the implementation of the acceptable plan of correction.	

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called her on 3/3/18 at 5:59 PM and informed her Resident #1 hit Resident #2 in the face. The facility Administrator stated she told Nurse #6 to put Resident #1 on one to one observation, call the police, call the resident representatives, and to look for another room for Resident #1. The Administrator indicated that Nurse #6 notified her Resident #1 had a previous altercation with Resident #2 earlier in the week. The Administrator called the resident representative for Resident #1 to notify her of the events of 3/3/18. The Administrator stated she then went to the facility and spoke with Nurse #2 and NA #7. The Administrator stated she was informed by Nurse #6 that the she told the resident representative of Resident #2 that an altercation had occurred between Resident #2 and Resident #1 on Wednesday, 2/28/18. The Administrator stated the sheriff's office and residents' physicians were notified of the events. The Administrator stated Resident #1 continued on 3/3/18 24 hour on one to one monitoring by the nursing staff. The Administrator revealed she was not aware of the 2/28/18 incident, where Resident #1 struck Resident #2, until she was notified by Nurse #6 on 3/3/18. Interventions to protect Resident #2 from Resident #1 were initiated on 3/3/18.

The Administrator stated on Sunday, 3/4/18 Resident #2 was sent to the hospital for an assessment of injuries. Review of the hospital record for Resident #2 dated 3/4/18 revealed the resident was assessed in the emergency room because of pain after trauma. The hospital record revealed no fractures, only soft tissue swelling of the right cheek.

A nursing note dated 3/4/18 indicated Resident #2

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had injuries from the altercation on 3/3/18 that included bruising to the right cheek and eye, a mark on the chin and above the lip. The resident complained of pain at a 5 out of 10 and was given as needed pain medication which was resolved 30 minutes later.

A nursing note dated 3/5/18 indicated Resident #2 still had bruising on her face, right cheek, lip and nose. The resident complained of pain and was given as needed pain medication documented as effective.

An observation and interview of Resident #2 on 3/9/18 at 12:09 PM revealed she had a red and green bruise under her right eye. She stated she did not know how the bruise happened and it only hurt when she touched it.

An observation of Resident #1 was made on 3/9/18 at 10:26 AM. The resident was observed to be lying in bed with a staff member (NA # 8) sitting outside of his door in the hallway in a chair. NA #8 was interviewed at the time of the observation and indicated someone was outside of the door of Resident #1 24 hours a day to monitor the resident. NA#8 indicated something had happened last weekend and a rule was created for the monitoring of Resident #1. NA #8 stated Resident #1 was allowed to come out of his room but she would have to follow him if he chose to do so.

An interview was conducted with the Director of Nursing (DON) on 3/10/18 at 9:55 AM. The DON revealed the altercation between Resident #1 and Resident #2 documented on the 24 hour report sheet dated 3/2/18 had not been investigated prior to the complaint survey. The DON also

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revealed the other residents on the hallway where Resident #1 resided had not been assessed for injuries after 3/2/18.

The facility DON was interviewed on 3/9/18 at 4:00 PM. She stated her expectations for reporting, notification of family, and documentation of altercations between residents was given to the nurses during orientation to the facility. The DON said it was her expectation the nurses immediately take the safety of the residents into account. She said the nurses were then expected to notify either the DON or the Administrator, the resident's family and the physicians of any resident altercations. The DON said the nurses were expected to document the altercation and initiate incident reports so that the multidisciplinary team could identify what interventions or actions were necessary.

On 3/10/18 at 12:40 PM the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation of compliance on 3/11/18 at 7:36 PM. The allegation of compliance indicated:

Credible Allegation of Compliance:

Jacob's Creek Nursing and Rehabilitation Center was placed into Immediate Jeopardy on March 10, 2018, for abuse. The process that lead to the deficiency was determined to be ineffective communication.

Prior to the incident on 3/3/18, Resident #1 exhibited behaviors of physical abuse towards other residents in several incidents. The facility assessed each incident independently, including potential causes, to prevent the resident behavior

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without looking cumulatively at previous behaviors. The facility attempted to escalate interventions based on the previous interventions' ineffectiveness.

As of 3/11/18, the facility created a process designed for a systematic, predictable examination into: 1) root causes for resident behaviors, 2) the tracking of resident behaviors, 3) creation of applicable and sustainable interventions for resident behaviors, and 4) effective training of facility staff regarding interventions to decrease the potential of resident behaviors.

On 3/2/18, there was no episode where Resident #1 hit another resident, including Resident #2.

What is the facility's plan for correcting the specific deficiency?

On 2/5/18, 15 minute checks began as an intervention for Resident #1's behaviors regarding a resident-to-resident altercation with another resident. Resident #1 was immediately removed and redirected with 15 minute checks instituted. On 3/2/18 at 5:30pm, Nurse #2 documented in Resident #1's electronic health record "Resident continues on 15 minute checks with no new behaviors at this time."

Resident #1 was maintained on a 15 minute check schedule. The 3/3/18 incident occurred between the 15 minute check time-frame. At the time of the incident on 3/3/18, where Resident #2 was struck by Resident #1, CNA #7 was documenting at the nurse station in direct line of site with Resident #1 and Resident #2. Nurse #6 was in the immediate vicinity passing

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medications. Root cause analysis why the 15 minute check was not effective in preventing Resident #2 from abuse: staff missed the opportunity to redirect Resident #1 away from Resident #2 prior to the incident.

On 3/3/18 at approximately 5:58 pm, Certified Nursing Assistant (CNA) #7 observed Resident #1 hitting Resident #2 in the face. CNA #7 immediately intervened, separating Resident #2 from Resident #1. CNA #7 called down the hall for Nurse #6 who immediately came to assist Resident #2. CNA #7 stayed with Resident #1.

On 3/3/18 at approximately 6:00pm, Nurse #6 assessed Resident #2 with bruises to her face. The assessment revealed areas on Resident #2's face, around the right eye, that were red. Also, there were two small abrasions, one above the upper lip and one below the lower lip, approximately the size of a pencil eraser, not bleeding. Nurse #6 asked Resident #2 if she was okay and if she was hurting. Resident #2 responded with a smile. Resident #2 had no tears and had a relaxed look on her face.

On 3/3/18 at approximately 6:03pm, Nurse #6 verified CNA #7 remained with Resident #1, receiving 1:1 direct supervision. Nurse #6 assessed Resident #1's hands. Resident #1 had no visible injury to his left or right hand.

On 3/3/18 approximately 6:05pm, Nurse #6 notified the administrator of the resident to resident physical altercation. The administrator instructed Nurse #6 to notify law enforcement.

On 3/3/18 at approximately 6:10pm, Nurse #6 notified law enforcement. A sheriff's deputy

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arrived at the facility, looked at Resident #2, and interviewed Resident #1 twice. The sheriff's deputy instructed Resident #1 that he is not allowed to hit other residents. The law enforcement officers assessed the situation and determined no other actions were required, they left satisfied with the facility interventions that were in place for Resident #1 and Resident #2.
On 3/3/18 at approximately 6:13pm, Nurse #6 notified Resident #2's resident representative (RR) of the resident to resident physical altercation and Resident #2's facial discolorations. Resident #2's RR stated he would come to the facility.

On 3/3/18 at 6:50pm, Resident #2's RR arrived at the facility and visited with Resident #2. The RR declined Nurse #6's suggestion to send Resident #2 to the hospital for evaluation and declined an offer to have in-house x-ray done.

On 3/3/18, Nurse #6 notified the on-call medical doctor. No new orders were received.

On 3/4/18, Nurse #6 obtained consent from Resident #2's RR to send Resident #2 to the hospital for evaluation. The hospital completed a CT scan and x-rays on Resident #2. The hospital called Nurse #6 and reported Resident #2's test results had no negative findings.

On 3/5/18, the administrator called Nurse #3 to the office for an interview. The administrator had received a telephone call from Resident #2's RR requesting a meeting. The purpose of the interview with Nurse #3 was to gather information and ask Nurse #3 if there was a resident to resident altercation involving Resident #2 that the administrator was not aware of. Nurse #3

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reported that she "did not know". After prompting by the administrator, Nurse #3 revealed that she knew who Resident #1 and Resident #2 were. Nurse #3 also revealed Nurse #3 had reported to Nurse #2 the altercation occurred between Resident #1 and Resident #2 at the beginning of the shift on 2/28/18. The administrator asked Nurse #3 to re-enact what happened during the altercation on 2/28/18. Nurse #3 demonstrated how Resident #1 "bopped" Resident #2 on the nose with a fist, in a downward motion. The administrator asked Nurse #3 "what did you do to keep (Resident #2) and everyone else safe?" Nurse #3 replied that they didn't have any more issues the rest of the day, Resident #1 stayed in his room, and Nurse #3 kept Resident #2 with Nurse #3. The administrator told Nurse #3 that notifications were not made, there was no documentation, and there was no incident report. Nurse #3 stated it happened early in the shift, the nurse got busy, and the nurse "forgot." The administrator initiated re-education of all registered nurses (RNs) and licensed practical nurses (LPNs), including Nurse #3:

"You must in all changes in condition, to include behaviors and altercations, notify the family & the MD and put interventions in place. You must ensure that the safety of the residents is immediate and head to toe assessments MUST be documented. In the event of altercation, you MUST notify the DON &/or the administrator for directions on how to proceed. Failure to do so may result in disciplinary action."

On 3/8-9/18, Social Worker #1 and Social Worker #2 initiated interviews with all alert and oriented residents. The social workers asked three (3) questions: 1) Do you feel safe at Jacob's Creek?

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2) Has anyone, including residents, made you feel unsafe or threatened you? 3) If someone, including another resident, were to make you feel unsafe or threatened you do you know who to report it to? The interviews resulted in no negative findings.

On 3/8/18, the administrator facilitated a quality improvement (QI) meeting to discuss: 1) what was being done to protect Resident #2, 2) how to keep Resident #1 from having altercations with other residents, 3) the root cause of the resident to resident altercation, 4) education of nurses.

On 3/10/18 at approximately 1:30pm, the administrator instructed the director of nursing (DON) to continue Resident #1 on 1:1 supervision, 24 hours per day, until the interdisciplinary (IDT) behavior team determines 1:1 supervision is no longer necessary. The IDT behavior team will review and discuss high risk behavior residents, to include Resident #1 and Resident #2. The IDT behavior team will meet weekly for six (6) months to determine maintaining of applicable interventions such as the need for continued 1:1 supervision, 24 hour per day.

On 3/10/18 at approximately 2:30pm, clinical teams of the assistant director of nursing (ADON) and CNA #2, quality improvement (QI) nurse and restorative nurse, and the RN supervisor and CNA #3 completed a 100% skin assessment on non-alert and oriented residents. The skin assessment findings were given to the DON for root cause analysis, completed 3/12/18. The outcome of the skin assessment was no findings that required submission to the Health Care Registry. All areas identified during the skin

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assessment (bruises, skin tears) had determinable causes.

On 3/10/18, the MDS-RN completed a 100% audit of the nurse progress notes from 2/23/18 through 3/10/18, 6pm. The audit identified one (1) event that the administrator submitted to the Health Care Registry as a 24 hour report.

On 3/10/18 at approximately 5:30pm, the administrator completed a 100% audit of the risk management incident/accident reports from 2/23/18 through 3/10/18 to identify any incidents/accidents that would require any follow-up related to resident abuse. The audit revealed eight (8) incidents that the facility implemented appropriate interventions such as room changes, medication adjustments, and clinical interventions.

What procedure was implemented for correction of the specific deficiency cited?
On 3/10/18 at approximately 5:00pm, the regional vice president (RVP) completed an education with the administrator and DON regarding the responsibility of the administrator and DON to complete 24 hour and 5 day reports to the Health Care Registry.

On 3/10/18 at approximately 5:30pm, the RVP educated the administrator and DON regarding the use of the Allegations of Resident to Resident Abuse checklist. The training included a directive for the administrator to educate all the department heads (QI nurse, MDS nurse, administrator's assistant, administrative assistant, social workers, medical records, accounts payable, accounts receivable, activities assistant, and housekeeping supervisor) on the use of the

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Allegations of Resident to Resident Abuse checklist.

ALLEGATIONS OF RESIDENT TO RESIDENT ABUSE

Allegations of Resident to Resident physical, verbal, or sexual abuse will be reported timely. The Administrator should be informed timely after incident occurs or as soon as the allegation is reported.

The Administrator will direct the investigation.
The investigation will begin timely.
The Administrator will notify:
o Regional V.P.
o Other Corporate staff as appropriate or directed by Regional V.P.
o Take immediate steps to protect the residents:
o Remove/separate residents
o Monitor location of each resident until more information is obtained regarding the incident
o Complete Resident Q.I. Reporting form (in electronic health records system - Risk Management portal or as needed, BN-9038)
o Interview the "accused" resident and the "injured" resident as indicated.
o If the resident is unable to write their own statement, summarize the events. During the interview process, ask the resident "how did it make you feel"'?
o Obtain written witness statements
o Interviewable residents (review MDS coding)
o Employees that observed the incident
o Employees in the identified area
o Complete a physical assessment; document findings in the nurse notes
o Notify physician

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F 600	Continued From page 28 o Notify family o After discussion with Regional V.P., notify State agency, Adult Protective Services, or Ombudsman as indicated, except in Kentucky - notify State agency and Adult Protective Services immediately. o Allegations of sexual abuse may indicate a "rape kit" to be completed at the hospital (per physician directive). Refer to Allegation of Sexual Abuse, Abuse, Neglect and Misappropriation of Resident Property for further information (Administrative Policies Manual). Facility Guidelines (Version Date: 11/2013) o Corrective measures will be discussed with Regional V.P. Examples: Review and revision of MDS and care plan Discharge from facility Transfer to another unit Thirty (30) minutes or hourly Q.I. observation audits New medications or revision of drug regimen Review/analysis of history/pattern of allegations Retraining of staff (2.1. Committee Review) Consultant referral 1:1 monitoring o Points to Remember: o It is important that all allegations are taken seriously and investigated timely Establish investigative file in your office Encourage all staff to report any concerns related to resident to resident abuse o Departments should communicate concerns Corrective measures must be initiated o Notify Regional V.P. and other corporate consultants as directed Facility Guidelines (Version Date: 11/2013) On 3/10/18, at approximately 6:00pm, the	F 600		

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administrator initiated an education for all department heads regarding the prevention and administrative oversight of abuse/resident to resident altercation.

On 3/10/18 at approximately 6:30pm, the DON, ADON, QI nurse, and infection control nurse began educating 100% of RNs, LPNs, nursing assistants, and geriatric care assistants (GCAs) on documentation expectations:

Expectations: Documentation, I expect:
o24 hour report sheets - date, sign, shift, notes on incidents, accidents, resident to resident altercation, abuse, neglect.
oIncident reports - completed before leaving shift, MD notification, RR notification, and document interventions put into place.
oNotification - in addition to notifying MD & RR, nursing staff is required to notify their supervisor.
oI expect anyone witnessing resident abuse, including resident to resident abuse, should directly contact the administrator.
oLaw enforcement notification - if the resident (abuser or abused) is physically abusive/violent/out of control, call 911 immediately then call the administrator. Resident safety is our #1 priority!

On 3/11/18, the administrator, DON, ADON, QI nurse, MDS nurse, RN charge nurse, social worker, therapy manager, weekend manager on duty, and/or corporate consultant educated 100% of staff on how to supervise and monitor residents at high risk for abuse/resident to resident altercation. After 3/11/18, no facility staff will be allowed to work until this in-service is completed.

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On 3/11/18, the administrator, DON, ADON, QI nurse, MDS-RN, social worker began a weekly IDT behavior team meeting to identify and review residents through the following criteria: 1) admission paperwork, 2) progress note review, 3) incident report review, 4) social work note review, 5) 24 hour report sheet review, 6) other pertinent medical information. The facility will implement interventions to reduce the risk of abuse incidents and to provide focused supervision of high risk behavioral residents.
Beginning 3/11/18, the administrator, DON, ADON, QI nurse, social worker, and/or staff facilitator will educate newly hired staff during orientation regarding high risk behavior residents, what to watch for, what to do, when to report, who to report to, and what to document.

Beginning 3/11/18, the activities director will develop activities based on recommendations from the IDT behavior team beginning in the 3/11/18 meeting. The activities director will ask families for ideas to occupy high risk residents (ideas such as: previous likes, previous occupation skills, hobbies, etc.) based on recommendations from the IDT meeting. The activity department will be required to carry out the care planned activities for high risk behavior residents. High risk behavior resident activities may be facilitated by facility staff, volunteers, or family members.

Beginning 3/11/18, the administrator, DON, ADON, QI nurse, MDS nurse and admissions director will review all newly admitted residents upon admission and re-admission for high risk behaviors. The MDS nurse will generate a 48 hour care plan which includes high risk behaviors.

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On 3/11/18, the RVP completed training with the administrator and DON regarding: 1) complete root cause analysis of resident behaviors, 2) ensuring that appropriate interventions are developed timely, 3) interventions are reviewed regularly for appropriateness, and 4) interventions are sustained through the IDT and QI review processes of repeated review and updated care planning.

On 3/11/18, the RVP completed training with the IDT behavior team regarding: 1) why the team is meeting, 2) what information the team should look at, 3) how to look at root cause, 4) how to make recommendations, 5) being proactive and creative, 6) appropriate and sustainable interventions, 7) teaching staff- looking at all departments as trainers, 8) looking at resident identification, 9) the "5 Whys" of root cause analysis

On 3/11/18, the RVP completed training with the administrative nurse team titled "Immediate Interventions" which covered: 1) immediately remove the abused resident, 2) provide constant supervision for the abuser, 3) provide immediate medical intervention, 4) provide immediate redirection techniques as developed by the IDT behavior team, 5) plan of corrections, what broke, why, audit, training, monitoring.

On 3/11/18, the DON, ADON, QI nurse, MDS nurse, infection control nurse, and staff facilitator, began training all staff on how to provide immediate interventions for resident to resident altercations such as: 1) immediate protection of residents, separate the residents, 2) supervision of aggressive resident to protect others, 3) notify supervisor/nurse, and 4) follow supervisor/nurse's

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(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 600	Continued From page 32 direction. After 3/11/18, no facility staff will be allowed to work until this in-service is completed. The facility's credible allegation of compliance was verified by the survey team on 3/14/18 at 4:52 PM as evidenced by observations of residents, record review of employee training, interviews with staff, residents and family.	F 600		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		4/6/18

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F 842	Continued From page 33 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the	F 842	Jacob’s Creek acknowledges receipt of	

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F 842	Continued From page 34 facility failed to have accurate and complete documentation in the medical record of a resident to resident altercation for 2 of 5 residents reviewed for complete and accurate records (Resident #1 and Resident #2). The findings included: 1. Resident #2 was admitted to the facility on 3/8/16 with diagnoses of dementia, anxiety disorder, cerebrovascular accident, and depression. The quarterly minimum data set (MDS) assessment dated 12/27/17 revealed Resident #2 was severely cognitively impaired requiring extensive assistance with bed mobility, range of motion impairment of lower extremities, and dependent for locomotion on the nursing unit. Record review of a 24 hour report dated 3/2/18 for second shift (3:00 PM to 11:00 PM) completed by Nurse #2 indicated a nursing report was received from Nurse #3 on first shift (7:00 AM to 3:00 PM) that Resident #2 and Resident #1 were in an altercation. Nurse #2 was interviewed on 3/9/18 at 4:40 PM. Nurse #2 indicated she received report from Nurse #3 on 3/2/18 at the change of shift that there was an altercation between Resident #2 and Resident #1. Nurse #2 indicated she did not know what happened in the altercation or when it occurred. Nurse #2 indicated she made the assumption all the required documentation regarding the altercation and the assessment had been already completed on the first shift (7:00 AM to 3:00 PM) on 3/2/18. Nurse #3 was interviewed on 3/9/18 at 3:52 PM. Nurse #3 confirmed she did give report to Nurse	F 842	the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob's Creek response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Jacob's Creek reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F842 Resident Records – Identifiable Information The plan of correcting the specific deficiency The position of Jacob's Creek Nursing and Rehabilitation Center regarding the process that lead to this deficiency; the facility failed to have accurate and complete documentation in the medical record of a resident to resident altercation for 2 of 5 residents reviewed for complete and accurate records. Facility nurse did not ensure that she documented accurately and completely in the medical record for Resident #2 and Resident #1.	

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F 842	Continued From page 35 #2 at the end of her 7:00 AM to 3:00 PM shift on 3/2/18 regarding an altercation that had occurred between Resident #2 and Resident #1. Nurse #3 stated the altercation occurred between 9:00 AM and 10:00 AM. Nurse #3 stated, "I did not write a note at that time but thought I would later write a note after I finished my medication pass. I did report it off to the oncoming nurse at the end of the shift to [Nurse #2]." Nurse #3 indicated she did not notify anybody of an altercation between Resident #2 and Resident #1 other than Nurse #2 on 3/2/18. Nurse #3 indicated she did not fill out a progress note or an incident report on 3/2/18. Nurse #3 indicated she could not recall the exact day the altercation between Resident #2 and Resident #1 happened, she thought it was on a Wednesday (2/28/18). Review of the medical records of Resident #2 did not reveal any documentation regarding an altercation between Resident #1 and Resident #2 on 3/2/18. Record review of the nursing notes for Resident #2 dated 3/3/18 stated, "Resident was sitting at the entrance into the dining room when another resident was propelling self into the dining room. CNA (certified nursing assistant) observed other resident hitting this resident in the face with a fist. Residents were separated. Administer was contacted at 1901 (7:01 PM). RR (Resident Representative) [Name] was contact at 1910 (7:10 PM) who made a visit to the facility and verbalized understanding. Deputy and detective was contact and made report." Documentation in an incident report for Resident #2 dated 3/3/18 stated, "Resident was sitting in hallway at entrance to dining room. CNA	F 842	Jacob's Creek Nursing and Rehabilitation Center's plan for correcting the deficiency is to ensure that the facility has accurate and complete documentation in the medical records to include Resident #2 and Resident #1. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 3/10/2018, MDS-RN reviewed 100% progress notes from 3/2/2018 through 3/10/2018 to ensure accurate and complete documentation in the medical records. The audit resulted in no negative findings. On 3/10/18 the DON, ADON, QI nurse, and Infection Control Nurse began educating all nursing staff members on documentation expectations with regards to resident to resident altercations and documentation. All nursing staff members were educated prior to working their next scheduled shift by 3/15/18. Any newly hired nursing staff members will be educated on documentation expectations to include accurate and complete documentation in the medical records in orientation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The ADON, MDS-RN and Restorative	

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F 842	Continued From page 36 observed male resident (Resident #1) propelling self into dining room when he (CNA #7) heard arguing and observed male resident hitting this resident (Resident #2) in the face with his fist. Resident stated that man hit her in the face and wanted deputy called." Nurse aide (NA) #7 was interviewed on 3/10/18 at 12:20 PM. NA #7 indicated he was working at the nurses station on 3/3/18 around the time of the evening meal when he heard Resident #2 and Resident #1 arguing. NA #7 indicated he immediately went to the residents. NA #7 indicated he observed that Resident #2 was in a reclining chair in a corner with Resident #1 facing her in his wheel chair. NA #7 indicated Resident #1 had Resident #2 "pinned against the wall." NA #7 indicated he observed Resident #1 repeatedly hitting Resident #2 with his fist in her face. NA #7 indicted he immediately separated Resident #1 and Resident #2. The nursing supervisor (Nurse #6) was interviewed on 3/10/18 at 11:30 AM. Nurse #6 indicated on 3/3/18 she heard something was happening so she went to the unit where Resident #2 and Resident #1 were located. Nurse #6 indicated NA #7 reported to her Resident #1 hit Resident #2 in the face. Nurse #6 indicated she spoke with Nurse #2 who told her that this was the second time that week Resident #1 had hit Resident #2. Nurse #6 indicated she was unable to locate any documentation in the medical record regarding a previous altercation between Resident #2 and Resident #1 in the medical records. The facility Administrator on 3/10/18 at 12:30 PM provided a screen shot of text messages between	F 842	Nurse will utilize audit tool to ensure continued compliance with accurate and complete documentation in the medical records. These audit tools will be completed daily 5 times a week for 4 weeks, weekly for 4 weeks, monthly for 4 months. The title of the person responsible for implementing the acceptable plan of correction The Administrator is responsible for the implementation of the acceptable plan of correction.	

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Nurse #2 and Nurse #3 on 3/3/18. A text message from Nurse #3 confirmed an altercation had happened between Resident #1 and Resident #2 prior to 3/3/18 on a Wednesday. The text messages indicated Nurse #2 was informing Nurse #3 she needed to back date documentation of skin assessments and incident reports as well as notify administrative staff and resident representatives regarding the 2/28/18 altercation.

Nurse #2 confirmed in an interview on 3/10/18 at 4:40 PM that Nurse #6 asked her to call Nurse #3 on 3/3/18. Nurse #2 indicated she did speak with Nurse #3 on 3/3/18 and told her she needed to do an incident report for the altercation she observed between Resident #2 and Resident #1. Nurse #2 revealed she did not know when the altercation between the residents Nurse #3 observed occurred.

The facility Administrator was interviewed on 3/10/18 at 8:36 AM. She indicated Nurse #6 called her on 3/3/18 at 5:59 PM and informed her Resident #1 hit Resident #2 in the face. The Administrator indicated that Nurse #6 notified her Resident #1 had a previous altercation with Resident #2 earlier in the week. The Administrator stated she was informed by Nurse #6 that the she told the resident representative of Resident #2 that an altercation had occurred between Resident #2 and Resident #1 on Wednesday, 2/28/18.

An interview with Nurse #3 on 3/10/18 at 3:52 PM revealed she filled out an incident report on Monday 3/5/18 for events that occurred on 2/28/18.

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The incident report for Resident #2 dated 2/28/18 had a nursing description of the incident that stated, "Male resident observed in hallway arguing with this resident. Male resident heard yelling "get out of my room" This resident yelled back "someone shoot him." Male resident hit this resident in the face/nose with his hand. Male resident reports this resident was in his room. However, both residents were observed in the hallway outside of resident's room at time of altercation."

An interview with the QI nurse on 3/10/18 at 10:44 AM revealed she reviewed and revised the incident report dated 2/28/18 on Wednesday, 3/7/18. The QI nurse revealed the Administrator and the Director of Nursing signed off on the incident report dated 2/28/17 on Thursday, 3/8/18.

Record review revealed there was no documentation in the medical record of Resident #2 for the events described on the 2/28/18 incident report.

The facility DON was interviewed on 3/9/18 at 4:00 PM. She stated her expectations for reporting, notification of family, and documentation of altercations between residents was given to the nurses during orientation to the facility. The DON said the nurses were expected to document physical altercations and initiate incident reports so that the multidisciplinary team could identify what interventions or actions were necessary.

The facility Administrator was interviewed on 3/10/18 at 8:36 AM. She stated her expectations were for any changes in condition, to include

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behaviors and altercations, the family and the physician were to be notified. The Administrator acknowledged that steps would have been taken to protect Resident #2 if the complete and accurate documentation had been completed by Nurse #3 in a timely manner prior to 3/3/18.

2. Resident #1 was admitted on 9/9/09 with diagnoses of schizophrenia, dementia, and Alzheimer's disease. The quarterly MDS dated 1/11/18 revealed Resident #1 was moderately cognitively impaired with physical behaviors 1 to 3 days of the assessment period.

Nursing notes and Medication Administration records dated 2/23/18 to 3/1/18 revealed Resident #1 was being monitored every 15 minutes for behavior. An interview with the QI (Quality Improvement) Nurse on 3/10/18 at 10:44 AM revealed Resident #1 had been on 15 minute visual checks since 2/5/18 as an intervention after Resident #1 hit a resident in the dining room.

Nurse #2 was interviewed on 3/9/18 at 4:40 PM. Nurse #2 indicated she received report from Nurse #3 on 3/2/18 at the change of shift that there was an altercation between Resident #2 and Resident #1. Nurse #2 indicated she did not know what happened in the altercation or when it occurred. Nurse #2 indicated she made the assumption all the required documentation regarding the altercation and the assessment had been already completed on the first shift (7:00 AM to 3:00 PM) on 3/2/18.

Nurse #3 was interviewed on 3/9/18 at 3:52 PM. Nurse #3 confirmed she did give report to Nurse #2 at the end of her 7:00 AM to 3:00 PM shift on 3/2/18 regarding an altercation that had occurred

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between Resident #2 and Resident #1. Nurse #3 stated the altercation occurred between 9:00 AM and 10:00 AM. Nurse #3 stated, "I did not write a note at that time but thought I would later write a note after I finished my medication pass. I did report it off to the oncoming nurse at the end of the shift to [Nurse #2]." Nurse #3 indicated she did not notify anybody of the altercation between Resident #2 and Resident #1 other than Nurse #2 on 3/1/18. Nurse #3 indicated she did not fill out any progress notes or an incident reports regarding the altercation on 3/2/18. Nurse #3 indicated she could not recall the exact day the altercation between Resident #2 and Resident #1 happened, she thought it was on a Wednesday.

Review of the medical records of Resident #1 did not reveal any documentation regarding an altercation between Resident #1 and Resident #2 on 3/2/18.

Record review of the nursing notes for Resident #1 dated 3/3/18 stated, "Resident was propelling self into dining room where other (Resident #2) was sitting outside of dining room area. CNA (Certified Nursing Assistant) observed resident to be punching resident in the face with a fist. Residents [were] separated. Administer was contacted. [Resident Representative] case worker was contacted. 1 on 1 put in place. Deputy and detective where contacted to come to facility. Room change to 200 hall."

Documentation on an incident report for Resident #1 dated 3/3/18 stated in the nursing description, "At [5:58 PM], CNA reports female resident in hallway in Geri-chair near dining room. This resident was wheeling self in wheel chair from his room to dining room. The two residents were

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heard arguing, CNA witnessed this resident hit female resident in the face with his hands into a fist. Upon this nurse observing the scene, this resident was in the dining room and female resident he hit was sitting in the hallway. When asked why he hit the resident he told me to "get the hell out" and started swinging at nurse attempting to hit staff."

Nurse aide (NA) #7 was interviewed on 3/10/18 at 12:20 PM. NA #7 indicated he was working at the nurses station on 3/3/18 when he heard Resident #2 and Resident #1 arguing. NA #7 indicated he immediately went to the residents. NA #7 indicated he observed that Resident #2 was in a reclining chair in a corner with Resident #1 facing her in his wheel chair. NA #7 indicated Resident #1 had Resident #2 "pinned against the wall." NA #7 indicated he observed Resident #1 repeatedly hitting Resident #2 with his fist in her face. NA #7 indicted he immediately separated Resident #1 and Resident #2 and one to one monitoring of Resident #1 was put in place.

The nursing supervisor (Nurse #6) was interviewed on 3/10/18 at 11:30 AM. Nurse #6 indicated on 3/3/18 she heard something was happening so she went to the unit where Resident #2 and Resident #1 were located. Nurse #6 indicated NA #7 reported to her Resident #2 hit Resident #1 in the face. Nurse #6 indicated she spoke with Nurse #2 who told her that this was the second time that week Resident #2 had hit Resident #1. Nurse #6 indicated she was unable to locate any documentation in the medical record of Resident #1 regarding a previous altercation between Resident #2 and Resident #1.

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The facility Administrator on 3/10/18 at 12:30 PM provided a screen shot of text messages between Nurse #2 and Nurse #3 on 3/3/18. A text message from Nurse #3 confirmed an altercation had happened between Resident #1 and Resident #2 prior to 3/3/18 on a Wednesday. The text messages indicated Nurse #2 was informing Nurse #3 she needed to back date documentation of skin assessments and incident reports as well as notify administrative staff and resident representatives regarding the 2/28/18 altercation.

Nurse #2 confirmed in an interview on 3/10/18 at 4:40 PM that Nurse #6 asked her to call Nurse #3 on 3/3/18. Nurse #2 indicated she did speak with Nurse #3 on 3/3/18 and told her she needed to do an incident report for the altercation she observed between Resident #2 and Resident #1. Nurse #2 revealed she did not know when the altercation between the residents Nurse #3 observed occurred.

The facility Administrator was interviewed on 3/10/18 at 8:36 AM. She indicated Nurse #6 called her on 3/3/18 at 5:59 PM and informed her Resident #1 hit Resident #2 in the face. The Administrator indicated that Nurse #6 notified her Resident #1 had a previous altercation with Resident #2 earlier in the week. The Administrator stated she was informed by Nurse #6 that the she told the resident representative of Resident #2 that an altercation had occurred between Resident #2 and Resident #1 on Wednesday, 2/28/18.

An interview with Nurse #3 on 3/10/18 at 3:52 PM revealed she filled out an incident report on Monday 3/5/18 for events that occurred on

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F 842	Continued From page 43 2/28/18. The incident report for Resident #1 dated 2/28/18 had a witness statement from Nurse #3, "Resident was in the hallway and verbally arguing with another resident. [Resident #1]. Nurse heard them arguing, he said, "Get out of my room." She yelled, someone shoot him. Then nurse saw [Resident #1] hit [Resident #2] in the nose with fist. Nurse ran over to separate them. Separated them. Nurse told [Resident #1] that you do not hit anyone. Nurse asked what was wrong that he hit her. He said she was in my room. Clearly, she was not. They both were in the hallway, near his doorway. No injuries noted." An interview with the QI nurse on 3/10/18 at 10:44 AM revealed she reviewed and revised the incident report dated 2/28/18 on Wednesday, 3/7/18. The QI nurse revealed the Administrator and the Director of Nursing signed off on the incident report dated 2/28/17 on Thursday, 3/8/18. Record review revealed there was no documentation in the medical record of Resident #1 for the events described on the 2/28/18 incident report.	F 842		