STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING ______ B. WING ______	C 07/11/2018

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F 000	INITIAL COMMENTS The survey team conducted a complaint investigation survey at the facility on 06/20/18. The survey team returned to the facility on 07/09/18 to obtain additional information and exited on 07/11/18. Therefore, the exit date was changed to 07/11/18. During the survey, immediate jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity of "J" CRF 483.12 at tag F607 at a scope and severity of "J" Tags F600 and F607 constituted Substandard Quality of Care. Immediate jeopardy began on 06/01/18 and was removed on 07/11/18. An extended survey was conducted from 07/10/18 through 07/11/18. Event 2R5K11	F 000		
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	F 600		7/11/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/01/2018

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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by:
Based on record review and interviews with the resident, family and facility staff, the facility failed to prevent staff-to-resident physical abuse resulting in bruising, soreness and fear for one of three residents (Resident #1) reviewed for abuse.

Immediate Jeopardy began on 06/01/18 when Resident #1 was physically mishandled during provision of evening care. Nurse Aide #1 held the Resident #1's left arm by the wrist, squeezed and shook it repeatedly after dressing her in bed clothes. The Immediate Jeopardy was removed on 07/11/18 when the facility provided and implemented an acceptable credible allegation of removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and ensure that monitoring systems put in place are effective to prevent resident abuse.

The findings included:

Resident #1 was admitted to the facility in 2010 with diagnoses that included cerebrovascular accident (CVA), hemiplegia/hemiparesis, and diabetes mellitus.

The quarterly Minimum Data Set (MDS) dated 04/06/18 indicated the resident had no cognitive impairment and had a recorded a Brief Interview for Mental Status (BIMS) score of 14 for Resident #1 who needed extensive assistance for all activities of daily living (ADLs) with the exception of independent eating. Resident #1 was frequently incontinent of urine. The resident had left-sided hemiplegia as a result of a CVA. She

F 600

F-600 7/11/2018

This Plan of Correction constitutes The Presbyterian Home of Hawfields written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

Plan of correcting the specific deficiency

It is the policy of The Presbyterian Home of Hawfields to assure residents have the right to be free from abuse. This was achieved for Resident #1 by conducting an
investigation when Resident #1 voiced the allegation, completing an initial allegation report and reporting the allegation to Division of Health Service Regulation (DHSR) on 6/2/2018 by the Licensed Nurse #2. The Nurse Aide in which the allegation was made was instructed to leave the facility and was not scheduled to work in the facility thereafter. Resident #1 was assessed by licensed Nurse #2 on 6/2/2018, by the Director of Nursing on 6/4/2018 and the Nurse Practitioner on 6/4/2018. X-Rays were ordered 6/4/2018 to evaluate the scapula area and findings were negative for fracture or dislocation of the left extremity. The care plan for Resident #1 was updated on 6/4/2018 by

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received anti-coagulant therapy.

The June 2018 Medication Administration Record showed that Resident #1 was receiving Plavix, a blood thinner, and Neurontin, a pain medication.

Resident #1's nursing care plan updated 06/14/18 and signed by the interdisciplinary team indicated that she had an ADL self-care performance deficit. The resident required one-person assistance for bed mobility, bathing, dressing, eating, toileting, and personal hygiene as well as one-person assistance with the sit-to-stand lift.

In an interview on 06/20/18 at 11:00 a.m., Resident #1 stated that she was alone in her room lying in her bed on the evening of Friday 06/01/18, the date of the incident. Nurse Aide #1 had just finished helping her into a patient gown. The aide was squeezing her hand "so hard I could see stars." The resident told her to stop but the aide didn't say anything. Then Nurse Aide #1 pulled on her arm so hard she "was afraid my arm would pop loose." Resident #1 stated that the aide continued to manipulate her arm despite her protests to stop. Nurse Aide #1 had checked her brief during the interaction but she did not need changing. When asked, Resident #1 characterized the actions of the aide as intentional mishandling.

Resident #1 stated Nurse Aide #1 had cared for the resident on several previous occasions but Resident #1 had no concerns about the care provided. Resident #1 mentioned the demeanor of Nurse Aide #1 when she entered the room on 06/01/18, stating "she didn't even greet me or talk to me."

F 600

MDS Coordinator to include a two person assist at all times.

The Director of Nursing also interviewed nurses and nurse aides familiar with Nurse Aide #1 on 6/4/2018 to determine if other concerns had been voiced about the care she provided. The Director of Nursing reported the allegation to the Alamance County Sheriff□s Department On 6/11/2018.

Skin inspections were started immediately and completed on 7/11/2018 on all residents by the licensed staff nurses. No issues were identified. All alert and oriented residents were interviewed by the licensed staff nurses on 6/4/2018 asking if they has been rough handled by any staff.

Procedures for implementing the plan Of Correction

The Administrator, Director of Nursing, Social Worker and MDS nurse conducted an in-depth analysis of the mechanisms, policies, training of staff relative to Abuse prevention implemented the following plan:
" Ensure all staff is educated on abuse. Education and training on Abuse will continue to be provided to all staff upon hire in the facility orientation. The Abuse and Neglect Policy and Procedure will continue to be given to new employees, posting of abuse policy and procedures throughout the facility visible to

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On 06/11/18 the DON typed a summary of conversations she had with Resident #1 and a family member. Resident #1 told the DON that Nurse Aide #1 had " ...started squeezing her arm as hard as she could, took both her hands to grab her hand and just squeezed it with force, pulled her arm in all directions as hard as she could and stated it felt like she was trying to break it." There were no witnesses to the incident.

During the interview on 06/20/18 at 11:00 a.m., Resident #1 stated her left shoulder and arm were still sore. She admitted that she cried the night of the incident but didn't see the night nurse to tell her. When she woke the next morning on Saturday 06/02/18, she described being ambivalent about deciding to report what had happened. She did not report it to a nurse aide because she "didn't want to hear any excuses or anything stupid." She decided to report it to the Social Worker because "it could get worse or it might happen to someone who can't talk."

Resident #1 stated that she left her room the morning after the incident in her wheelchair to go to the Social Worker's office and encountered Nurse #1 along the way. She reported the incident involving Nurse Aide #1 to her. Nurse #2 then joined the conversation and she shared the incident with her also. Resident #1 stated that the nurses thanked her for letting them know and assured her that Nurse Aide #1 would not work with her again. Resident #1 verified that she has not seen the aide since.

In the interview, Resident #1 confirmed that she had lived in the facility about eight years. She stated the incident "frightened me so much it will be awhile till [until] I feel safe in here."

F 600

employees, families and residents, issue these policies and procedures to employees on a quarterly basis and at their Annual Employee in-service. Information on abuse will be e-mailed to any Contract Agency the facility may use for contract staff and confirmation of receipt of the information by each agency staff member will be obtained. The Director of Nursing and/or Administrator will keep a log of signatures verifying that confirmation. Agency staff will be included in the Abuse in-service trainings provided by the facility.

" The Director of Nursing began re-educating all staff (including agency staff) on abuse and types of abuse and how to report allegations of abuse on 6/29/2018. The Social Worker also re-educated staff starting 7/11/2018. The re-education sessions were completed on 7/11/2018.

" Starting 6/29/2018, the facility will begin issuing written updates/reminders regarding Abuse Prevention to facility staff and Agency staff bi-weekly for at least 2 months.

" Resident Rights will continue to be reviewed at Monthly Resident Council Meetings by the Social Worker. Reporting of abuse and neglect has also been added as a topic of discussion in resident care plan meetings.

Monitoring

The Director of Nursing and/or designee will observe delivery of care to residents during facility rounds daily x 5 days, then

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In an interview on 07/09/18 at 11:15 a.m., Resident #1 confirmed that she had been on Plavix for many years. She denied noticing any tendency to bruise easily. She stated that when the pain began (after the incident), she started "looking for any damage [bruising] a few days later." She stated she was interviewed by an officer from the Sheriff ' s Office. Later she was shown photographs of her left arm. She stated that at first she did not recognize her arm in the photos but now did remember the officer taking pictures. She described the bruising as darker and bigger than a fingerprint. When asked about pain after the incident, she confirmed that she had Tylenol available to take on an as-needed basis but she did not request any in the days following the incident.

In a phone interview on 06/20/18 at 2:50 p.m., Nurse Aide #1 confirmed she was working on the evening of 06/01/18 and was assigned to Resident #1. She stated that she was making her rounds and had stopped to help the resident dress for bed. She told the resident she was not touching her arm when the resident confronted her. She stated she was pulling on the draw sheet and thought the resident's arm may have been pinned. She did not believe that she mishandled Resident #1 in any way or that she was being too rough. Resident #1 did not seem unduly irritable to her that evening and she stated that she was not irritated with the resident.

In the same interview Nurse Aide #1 stated that she worked for a staffing agency and had been a nurse aide for eight years. This was the first time anyone had accused her of roughness. She felt her assignments at the facility were manageable

F 600

weekly x 3 weeks, then monthly x 1 month started on 8/3/2018. The Director of Nursing will share the results of the observations with the Quality Assurance Committee during the monthly Quality Assurance Meetings for 3 months. The Quality Assurance Committee will determine continued monitoring needs and/or make recommendations.

Person Responsible for Implementing The Plan

Administrator and Director of Nursing

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and she did not feel rushed to complete care. Nurse Aide #1 stated she had worked with Resident #1 on several other occasions and there was no indication of a strained relationship.

A written statement was obtained by the facility on 06/02/18 Nurse Aide #1. In it the aide wrote that she was providing care to Resident #1 on the evening of 06/01/18. When she pulled back the bed covers, "[Resident #1] stated 'Let go of my arm' ...The resident kept stating the same quote as I was cleaning her up and getting her brief changed. I continued to inform the resident I was not touching her arm."

In an interview on 06/20/18 at 1:20 p.m., Nurse #1 confirmed that Resident #1 had reported the allegation of abuse to her around lunch time on 06/02/18. Nurse #1 was assigned to another hall and was walking to get her lunch when the resident approached her. During their conversation, Nurse #2 joined them. Nurse #1 stated that she allowed Nurse #2 to begin the paperwork and she returned to her hall.

In an interview on 07/09/18 at 12:00 p.m., Nurse #1 stated that Resident #1 was sensitive about her weak left side and most aides that work with her knew that. Nurse #1 stated that she had worked at the facility for 16 years and has known the resident for about 10 years. She found Resident #1 reliable and, if the resident said an incident took place, it should be checked out. She described the resident as alert and oriented and had never seen her confused.

In an interview on 06/20/18 at 1:30 p.m., Nurse #2 confirmed that she joined the conversation between Nurse #1 and Resident #1. The resident

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repeated to her that Nurse Aide #1 was rough with her the evening before (06/01/18). The resident was "still a little upset and worried" as she gave details of the incident.
Resident #1 could not identify Nurse Aide #1 by name but was able to describe her. Nurse #2 discovered that the aide was working in the facility that day. She contacted her, asked her to provide a written statement, and instructed her to leave the facility.

In an interview on 07/09/18 at 1:30 p.m., Nurse #2 stated that she assessed Resident #1 in her room on 06/02/18. The resident denied pain at the time but stated her arm was "a little sore." Nurse #2 noted that she saw two dark circles on the resident ' s inner left forearm about four inches above her wrist. Resident #1 described the aide ' s care as rougher than normal care should be. "She really was rough with me, grabbed my arm." Nurse #2 stated that the resident seemed relieved to learn the aide was sent home.

In the interview, Nurse #2 judged Resident #1 to be a reliable historian. Nurse #2 stated that she has been employed at the facility for eight years. As MDS Coordinator, she did not have daily contact with Resident #1 but assessed her as alert and oriented. She had not noticed any periods of confusion during interactions with her.

An Initial Allegation Report of "Resident Abuse" was completed on 06/02/18 by Nurse #2 and submitted the same day to the state agency. The report indicated that the alleged abuse occurred on 06/01/18 and was reported by Resident #1 the following day. The Allegation Details section documented that "[Nurse Aide #1] was being

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rough with her arm when getting her ready for bed." The reporting nurse (Nurse #2) indicated that on physical exam she saw "a small dark area that appeared to be very dry. It does not appear to be any new injuries to her arm. No swelling seen. She [Resident #1] stated that she is upset that someone would be that rough."

The Investigation Report completed and submitted on 06/06/18 referred to an undated assessment in which the "resident stated pain of 4 out of 10, 10 being the worst." In a later interview on 07/09/18 at 4:30 p.m., the DON stated that she conducted this pain assessment on 06/04/18.

In an interview on 06/20/18 at 9:25 a.m., Resident #1's family member stated that she learned of the incident from a phone call by Nurse #1 on 06/02/18 who said that "an aide had gotten rough" with the resident. The family member stated that when she had the opportunity to visit Resident #1 on 06/10/18 the resident complained that her arm was "still burning." She stated that Resident #1 was "stressed" because she didn't feel safe. She indicated that Resident #1 had been on Plavix since 2001 or 2002. She has never known her to bruise easily.

Resident #1 was seen by Nurse Practitioner #1 on Monday 06/04/18 at 2:27 p.m. The NP documented that the resident stated "my shoulder and back hurt ...Pain is 2-3 on a scale of 10." Upon examination, "PROM [passive range of motion] elicits no increase in pain but palpation of her medial upper back is tender ...Some ecchymosis noted left forearm, inner wrist." X-rays were ordered 06/04/18 to evaluate "painful scapula area." The results were negative for

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fracture and dislocation of the left shoulder.

In an interview on 06/20/18 at 12:40 p.m., Nurse Practitioner (NP) #1 stated that she was first notified of the incident on Monday 06/04/18 by the DON. Resident #1 was "upset" as she told her that a nurse aide "pulled on me really hard in the bed." She stated that the ecchymosis noted on physical exam revealed that the bruising was "not fresh." She explained that it was not the bright purple or red of an acute bruise nor was it the green of a healing bruise. NP #1 stated her conclusion that the "bruising was suspicious" and the color was consistent with them being generated a few days prior to her exam.

In an interview on 07/09/18 at 8:05 a.m., NP #1 described the bruising. She indicated there were "at least" two bruises: one round bruise about three centimeters (cm) in diameter on the inner left wrist and one oblong bruise about five cm by two cm near the antecubital area of the left forearm. She stated that she saw Resident #1 monthly for a comprehensive exam. She was not aware of any tendency for Resident #1 to bruise easily based on Plavix use and did not remember noting bruising on her monthly exams. She described an "excellent memory" and had not witnessed any periods of confusion.

In an interview on 06/20/18 at 1:45 p.m., the DON stated that she first heard of the allegation of abuse on the morning of 06/04/18, two days after it was reported to Nurse #1 and Nurse #2. The DON spoke with the resident and did a pain assessment which she recorded on the Investigation Report dated 06/06/18. The resident estimated her pain level as 4 on a 10-point scale with 10 being the highest pain. Resident #1 told

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her the aide was pulling on her arm when dressing her for bed. When she directed her to stop pulling and yanking, she reported that the aide commented that "you must not want my help." Resident #1 corrected her with "that ' s not what I said."

In the interview, the DON described the demeanor of Resident #1 on 06/04/18 as matter-of-fact. Only at the end of their conversation did the resident hang her head down and state "I don't want to be here anymore." Her later conversations with the resident and a family member were summarized in a typed statement on 06/11/18. Resident #1's assertion that the aide "was trying to break" her left arm led the DON to report the incident to local law enforcement on 06/11/18.

In an interview on 07/09/18 at 4:30 p.m., the DON described the bruising she saw on her initial physical assessment of Resident #1. There were two bruises on her left arm next to each other. Each were about one inch in diameter, darker than her skin color, and similar but not identical to "hand prints." She stated that she did interview the alleged perpetrator Nurse Aide #1. She stated the aide "stuck by her written statement" obtained on 06/02/18. She indicated the aide was "shocked" by the allegation. The DON did not believe Nurse Aide #1 entered the room of Resident #1 with the intention of deliberately hurting her.

In the interview, the DON stated her belief that Resident #1 was a reliable historian; however, "little things [in her story] were a little different" as the investigation went on. She concluded that the allegation was unsubstantiated. The final

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Investigation Report was faxed to the state agency on 06/21/18.

In the interview on 07/09/18, she shared her expectation that staff members were sensitive to the physical limitations of residents for whom they provided care and that they handle residents carefully. She expected that staff members follow facility policy in reporting abuse allegations to her or the social worker immediately.

In the 07/09/18 interview, the DON admitted that the investigation of the abuse allegation was delayed until two days after it was first reported to a staff member. As part of the delayed follow-up, she stated that she spoke with other residents who were assigned to Nurse Aide #1 but no one mentioned being mishandled during care. The DON stated that she also interviewed nurses and nurse aides familiar with Nurse Aide #1 but none had prior concerns about the care she had provided.

In an interview on 06/20/18 at 3:30 p.m., the Administrator stated that he first learned of the abuse allegation about noon on 06/02/18 when he phoned the facility about another matter. He was not aware at the time that the DON had not been informed of the incident. He knew the matter was later reported to local law enforcement. He shared his expectation that residents were free from unnecessary roughness during care. He expected that the staff member to whom abuse is reported should notify the DON or social worker immediately and that an investigation should begin as soon as the report is received.

The Administrator was informed of the Immediate

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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
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Jeopardy on 07/10/18 at 10:46 a.m. On 07/11/18 at 3:45 p.m., the facility provided the following credible allegation of removal:

"Resident #1 is alert and oriented x 4 [oriented to person, place, time and situation] with a BIMS score of 15. The resident reported that she was abused by an agency CNA [certified nurse aide] one day earlier. Incident reported on the morning of 06/02/2018. Resident stated that the CNA was being rough with her arm when getting ready for bed. On investigation, resident stated that CNA took her arm and squeezed it as hard as she could, pulled her arm as hard as she could, stated it felt like she was purposely trying to break it and then the CNA took both her hands and placed them on resident's hand and squeezed her hand as hard as she could. On assessment findings it appeared to be bruising on the left forearm. The agency CNA failed to follow the care plan for this resident which states that 2 people should be working with this resident at all times. The agency CNA was terminated from employment at the facility on and reports were filed with DHSR [Department of Health Service Regulation] on 06/02/2018. The resident is doing okay and continues to reside in the facility. Based on information supplied by the resident and her daughter a week after the initial report, the sheriff's department was contacted and their investigation continues."

"Presbyterian Home of Hawfields will continue to ensure all staff are educated and reeducated on abuse. The Abuse and Neglect Policy and Procedure Policy will continue to be given to new employees, abuse policy and procedures are posted throughout the facility visual for employees, families and resident to read, issued

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quarterly to all employees, and reissued at the Annual Employee In-service. For employees and agency staff that are out on leave will also be educated on abuse on return as well as information on abuse will be mailed out biweekly. Information on abuse will be emailed to the agency with confirmation that it has been sent out to their agency staff that staff at Presbyterian Home of Hawfields. DON and or administrator will keep a log of signatures confirmation that they received the information on abuse and the agency staff will be included in in-service training on abuse to ensure safety and evaluation will be done per DON or administrator."

"Also, families and resident are educated on abuse during care plan meetings and during resident council meetings. Families and residents are educated on reporting these findings immediately."

"DON reeducated staff on abuse and types of abuse and when to report allegations of abuse immediately. All staff, including DON reeducated on abuse and there will be updates and information sent out with employees biweekly as well as agency staff. This was started on 06/29/18 and was in progress."

"The Abuse and Neglect Policy and Procedure Policy will continue to be given to new employees, Education and training on abuse will immediately start upon hire and orientation reissued quarterly to all employees and reissued at the Annual Employee in-service. Policy and procedure has been updated on abuse to report serious bodily injury within 2 hours of any alleged violation involving abuse or has resulted in serious bodily injury and 24 hours if the alleged violation does

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not involve abuse and has not resulted in serious bodily injury. Also, investigation will start immediately. Policy also includes updates on who to contact in such event. Policy has updates on the role of the administrator, role of the investigator, and reporting. Immediately, skin checks were done on all residents for signs of abuse, spoke with all a/o [alert and oriented] residents on abuse and if they have been rough handled by any staff including agency at any given time, and updated physicians and NPs on abuse as well. This was completed on 07/11/2018 and nothing was found on assessments."

"Presbyterian Home of Hawfields will continue to ensure that incidents and accidents are being reported to resident's nurse, nurse supervisor on duty, DON, and Social Worker. DON will report to administrator immediately."

"The nursing staff as well as DON has been reeducated on the proper chain of command to follow when incidents and accidents occur. Education completed on 06/04/2018."

"The nursing staff was reeducated to notify DHSR within 2 hours of any alleged violation involving abuse or has resulted in serious bodily injury and 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. Also, investigation will start immediately. This was completed on 07/10/2018."

"DON or designee will use a QA [quality assurance] audit tool every week for a month and then bi monthly for the next five months for review of proper procedures on reporting. It will be reviewed weekly by the DON, Administrator and/or designee. Residents and family members

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will also be updated on the abuse policy as well as knowing where and who to report to in such event. Residents and families will be educated on different types of abuse and what abuse may look like. This will take place during care plan meetings and will be done by DON, Social Worker and or designee. Care plan meetings for each resident are done quarterly each year and as needed. During every resident council meeting there will also be reeducation on abuse policy. Resident council meetings are held monthly each year. DON, administrator or designee will monitor incident reports, skin assessments, and abuse policy to ensure resident safety. This will be monitor quarterly for six (6) months. All residents were given skin checks and interviewed about any type of potential abuse. This was completed by 07/11/2018."

"QA Committee will review the QA Action Plan once a month for six (6) months and revise the action plan to ensure continued compliance."

"DON and administrator will be responsible for implementing and evaluating the plan of correction."

The credible allegation of immediate jeopardy removal was validated on 07/11/18 at 5:45 p.m. The Abuse/Neglect Policy and Procedure was updated to include reporting of allegations of abuse and serious bodily harm within two hours to the N.C. Department of Health and Human Services. Updates on the roles of the Administrator and the investigator in cases of suspected abuse or neglect were added.

Agency and permanent staff in all departments were re-educated by the Social Worker on the

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F 600	Continued From page 15 prevention and reporting of abuse and neglect. The training record was reviewed. The in-service offered on 07/11/18 included information on types of abuse and the immediate reporting of suspected or witnessed resident abuse or neglect. Using the proper chain of command was a topic of review with staff members. Re-education was in progress for second-shift nursing and dietary staff. Written reminders about Incident and Accident reporting and proper notification of management were posted at nurses ' stations throughout the facility. A copy of the new employee orientation packet was reviewed for inclusion of abuse and neglect prevention and reporting. Documentation was provided of random interviews of residents and family members for knowledge of how to identify abuse or neglect and how to report it. Documentation that skin assessments had been completed or were in progress on some units was provided. Interviews were conducted with residents, nurse aides, nurses, a nursing supervisor and a dietary supervisor to confirm understanding of the facility policy on abuse and neglect and the need for immediate reporting using the chain of command. Resident rights were currently being reviewed at monthly Resident Council meetings. The Social Worker stated she recently started to include identification and reporting of abuse and neglect as a topic of discussion during resident care plan meetings.	F 600		

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F 600	Continued From page 16 The monitoring tool for staff knowledge of identifying and reporting abuse was reviewed. The tool included a section to indicate if the Quality Assurance Action Plan needed revision and what revisions were needed.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the staff members, the facility failed to develop a revised reporting component of the abuse policy that reflected allegations of abuse must be reported immediately, but not later than two hours after the allegation was made when the allegation involved abuse and follow its abuse policy for investigating abuse for one of three residents reviewed (Resident #1) for staff-to-resident abuse. Immediate Jeopardy began on 06/01/18 when Resident #1 was physically mishandled during provision of evening care. Nurse Aide #1 held the Resident #1's left arm by the wrist, squeezed and shook it repeatedly after dressing her in bed	F 607	F-607 7/11/2018 This Plan of Correction constitutes The Presbyterian Home of Hawfields written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Plan of correcting the specific deficiency	7/11/18

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clothes. The Immediate Jeopardy was removed on 07/11/18 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and ensure that monitoring systems put in place are effective to prevent abuse of residents.

The findings included:

Resident #1 was admitted to the facility in 2010 with diagnoses that included cerebrovascular accident (CVA), hemiplegia/hemiparesis, and diabetes mellitus.

The quarterly Minimum Data Set (MDS) dated 04/06/18 recorded a Brief Interview for Mental Status (BIMS) score of 14 for Resident #1 who needed extensive assistance for all activities of daily living (ADLs) with the exception of independent eating. Resident #1 was frequently incontinent of urine. The resident had left-sided hemiplegia as a result of a CVA. She received anti-coagulant therapy.

Resident #1's nursing care plan updated 06/14/18 and signed by the interdisciplinary team indicated that she had an ADL self-care performance deficit. The resident required one-person assistance for bed mobility, bathing, dressing, eating, toileting, and personal hygiene as well as one-person assistance with the sit-to-stand lift.

The facility's Abuse Neglect Policy and Procedure signed 09/09/16 by the Administrator and former Director of Nursing (DON) was reviewed.

It is the policy of The Presbyterian Home of Hawfields to have developed, written and implemented policies and procedures that a) Prohibit and prevent abuse, b) establish procedures for investigating such allegations, and c) start immediate documentation.

After further review of the facility policy titles Abuse Neglect Policy by the Administrator, Director of Nursing and Social Worker, we determined the need for revisions to the policy and procedures for investigating allegations of abuse and reporting those allegations consistent with The Centers of Medicare Services (CMS) requirements, specifically to include: a) reporting of abuse to the State Agency immediately, but no later than two hours after the allegation was made when the allegation involved abuse and b) guidelines for conducting the investigation to include
Director of Nursing or designated nurse in charge of completing the investigation.

Procedure

The facility policy Abuse Neglect□ was updated to include reporting allegations of abuse or abuse resulting in serious bodily injury immediately but no later than two hours to the State Agency, and within 24 hours if the alleged violation involving abuse does not involve abuse and has not resulted in serious bodily injury. The policy also includes what staff person to

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F 607	Continued From page 18 a. The facility abuse policy did not include a component to report allegations of abuse immediately to the state agency, but not later than two hours after the allegation was made. Resident #1 reported an allegation of abuse to Nurse #1 and Nurse #2 on 06/02/18. She identified the alleged perpetrator as Nurse Aide #1. Nurse #2 entered details of the incident on an Initial Allegation Report. The Date and Time Facility Became Aware of Incident was listed on the report as "06/02/18 1:30 p.m." The report was faxed to the state agency on 06/02/18 at 4:37 p.m. In an interview on 07/09/18 at 1:30 p.m., Nurse #2 indicated that her submission was not within the required timeframe due to a delay in gathering identifying information about the alleged perpetrator from the aide's staffing agency. Nurse #2 stated that the form required a Date of Birth and Social Security number. Nurse #2 attributed the delay in the staffing agency's response to the fact that it was a weekend. b. The facility's Abuse Neglect Policy stated that "An immediate investigation will be made." In an interview on 06/20/18 at 1:30 p.m., Nurse #2 stated that she obtained a written statement from Nurse Aide #1, after receiving Resident #1's report of alleged abuse. She instructed the aide to leave the facility. She interviewed and assessed the resident for injuries. It was her understanding that management would take the lead in the actual investigation of the abuse allegation upon their return to work.	F 607	contact when allegations of abuse are made, who is responsible for completing and submitting the report to the State Agency. The Director of Nursing, Social Worker and Administrator will also be contacted immediately when allegation are made. The Director of Nursing educated staff on the policy revisions when emphasis on the reporting abuse resulting in serious bodily injury immediately, but no later than 2 hours to the state agency and within 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. Investigation and documentation will start immediately. This education was completed on 7/11/2018. Monitoring The Director of Nursing will use a Quality Assurance (QA) audit tool to review all allegation of abuse to determine compliance with the investigation and reporting requirements. Audits will be conducted every week for a month then bi-monthly for the next five months. The Director of Nursing will report results in the facility Quality Assurance Committee (monthly for 3 months). The Quality Assurance Committee will determine continued monitoring needs and/or make recommendations. Person Responsible for Implementing The Plan	

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There was no documentation of a statement given by Resident #1 on 06/02/18 providing any details of the incident. No nursing progress notes were present in the medical record for the dates of 06/02/18 or 06/03/18 that documented if a pain assessment was done or if the medical provider was notified.

In an interview on 06/20/18 at 1:45 p.m., the DON confirmed that she was notified on 06/04/18, two days after it was first reported to Nurses #1 and #2. She admitted that the investigation of the abuse allegation was delayed and that interviews of other residents for potential mishandling during their care was not done immediately after the allegation was reported.

c. The facility's Abuse Neglect Policy stated "The investigation must include an outline of the steps taken in the investigation...Investigation files related to alleged, suspected or confirmed cases of abuse and/or neglect will be maintained in the Administrator's office." The policy did not specify who was in charge of conducting the investigation.

In an interview on 06/20/18 at 1:45 p.m., the DON stated that she was responsible for conducting the investigation but that she did not keep an outline or a file of paperwork documenting her facility investigation. She stated that she entered the information she gathered directly on the Initial Allegation Report and Investigation Report forms provided by the state. The DON stated that she spoke with other residents about the care Nurse Aide #1 provided and any possible roughness but she could not provide documentation of who she interviewed and when.

Provider's plan of correction: Administrator and Director of Nursing

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The Investigation Report submitted 06/06/18 included the statement, "Also spoke with other workers (CNAs [certified nurse aides] and nurses) that worked that day about details they may know." There was no documentation or elaboration on who was interviewed or the results of those interviews.

In the interview, she shared her expectation that any nurse accepting a report of alleged abuse or neglect would follow the Abuse Neglect Policy that included notifying management and beginning an immediate investigation.

In an interview on 06/20/18 at 3:30 p.m., the Administrator stated that he was informed of the abuse allegation on 06/02/18, the same day it was reported by Resident #1, when he phoned the office about another matter. He did not notify the DON and assumed that Nurse #2 had contacted her or would contact her. He was unaware of the required two-hour timeframe to report allegations of abuse to the state agency. It was his expectation that staff members meet this timeframe and follow the guidance provided by the facility's Abuse Neglect policy.

The Administrator was informed of the Immediate Jeopardy on 07/10/18 at 10:46 a.m. On 07/11/18 at 4:00 p.m., the facility provided the following credible allegation of immediate jeopardy removal:

"Resident #1 is alert and oriented x 4 [oriented to person, place, time and situation] with a BIMS score of 15. Resident reported that she was abused by an agency CNA [certified nurse aide] one day earlier. Incident reported on the morning of 06/02/2018. Resident stated that the CNA was

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F 607	Continued From page 21 being rough with her arm when getting ready for bed. On investigation, resident stated that CNA took her arm and squeezed it as hard as she could, pulled her arm as hard as she could, stated it felt like she was purposely trying to break it and then the CNA took both her hands and placed them on resident's hand and squeezed her hand as hard as she could. On assessment findings it appeared to be bruising on the left forearm. The agency CNA failed to follow the care plan for this resident which states that 2 people should be working with this resident at all times. The agency CNA was terminated from employment at the facility on and reports were filed with DHSR [Department of Health Service Regulation] on 06/02/2018. The resident is doing okay and continues to reside in the facility. Based on information supplied by the resident and her daughter a week after the initial report, the sheriff's department was contacted and their investigation continues." "Presbyterian Home of Hawfields will continue to ensure all staff including DON are being educated and reeducated on abuse. The Abuse and Neglect Policy and Procedure Policy will continue to be given to new employees, Education and training on abuse will immediately start upon hire and orientation, abuse policy and procedures are posted throughout the facility visual for employees, families and resident to read, reissued quarterly to all employees, and reissued at the Annual Employee in-service. Policy and procedure has been updated on abuse to report within 2 hours of any alleged violation involving abuse or has resulted in serious bodily injury and 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. Also, investigation will start immediately.	F 607		

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F 607	Continued From page 22 Policy also includes updates on who to contact in such event. Policy has updates on the role of the administrator, role of the investigator, and reporting." "DON and or designee will use QA [Quality Assurance] audit tool to monitor and evaluate the outcomes of the abuse policy quarterly and make changes accordingly." "DON reeducated staff on abuse and types of abuse and when to report allegations of abuse immediately. DON has also been educated on abuse and reporting. All staff members are instructed to notify department heads immediately in event of incidents and accidents. Department heads will notify DHSR [Department of Health Service Regulation] within 2 hours of any alleged violation involving abuse or has resulted in serious bodily injury and 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. Also, investigation will start immediately and will be completed within five working days." "Presbyterian Home of Hawfields will continue to ensure that incidents and accidents are being reported to resident's nurse, nurse supervisor on duty, DON, and Social Worker. DON will report to administrator immediately. All staff members will be reeducated on the proper chain of command to follow when incidents and accidents occur. This was completed by 07/11/18." "All staff members will be educated on reporting abuse allegations and serious bodily injury accidents or incidents to Department of Health and Human Services within 2 hours of notification. For employees and agency staff that	F 607		

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are out on leave will also be educated on abuse on return as well as information on abuse will be mailed out biweekly. Information on abuse will be emailed to the agency with confirmation that it has been sent out to their agency staff that staff at Presbyterian Home of Hawfields. DON and or administrator will keep a log of signatures confirmation that they received the information on abuse and the agency staff will be included in in-services training on abuse to ensure safety and evaluation will be done per DON or administrator. This was completed by 7/11/18."

"DON or designee will use a QA [quality assurance] audit tool every week for a month and then bi monthly for the next five months for review of proper procedures on reporting. It will be reviewed weekly by the DON, Administrator and/or designee for six months."

"QA Committee will review the QA Action Plan once a month for six (6) months and revise the action plan to ensure continued compliance."

"DON and administrator will be responsible for implementing and evaluating the plan of correction."

The credible allegation of immediate jeopardy removal was validated on 07/11/18 at 5:45 p.m.

The Abuse/Neglect Policy and Procedure was updated to include reporting of allegations of abuse and serious bodily harm within two hours to the N.C. Department of Health and Human Services. The policy was amended to include the start of an immediate investigation and the timeline for its completion. Updates on the roles of the Administrator and the investigator in cases

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	345363	A. BUILDING ______ B. WING ______	C 07/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

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F 607	Continued From page 24 of suspected abuse or neglect were added. Agency and permanent staff in all departments were re-educated by the Social Worker on abuse and neglect prevention and reporting. The training record was reviewed. The in-service included information on types of abuse and the immediate reporting of suspected or witnessed resident abuse or neglect. Using the proper chain of command was a topic of review with staff members. Re-education was in progress for second-shift nursing and dietary staff. Written reminders of Incident and Accident reporting and proper notifications were posted at nurses' stations throughout the facility. A copy of the new employee orientation packet was reviewed for inclusion of abuse and neglect prevention and reporting. Documentation was provided of random interviews of residents and family members for knowledge of how to identify abuse or neglect and how to report it. Interviews were conducted with nurse aides, nurses, a nursing supervisor and dietary supervisor to confirm understanding of the facility policy on abuse and neglect and the need for immediate reporting using their chain of command. Resident rights were currently being reviewed at monthly Resident Council meetings. The Social Worker stated she recently started to include identification and reporting of abuse and neglect as a topic of discussion during resident care plan meetings.	F 607		

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F 607	Continued From page 25 The monitoring tool for staff knowledge of identifying and reporting abuse was reviewed. The tool included a section to indicate if the Quality Assurance Action Plan needed revision and what revisions were needed.	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(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 and staff interviews the facility failed to notify the state agency within two hours and to conduct a thorough investigation of an allegation of staff-to-resident physical abuse resulting in bruising to a resident's arm for one of three residents reviewed for abuse (Resident #1). The findings included:	F 610	F-610 7/11/2018 This Plan of Correction constitutes The Presbyterian Home of Hawfields written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency	7/11/18

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F 610	Continued From page 26 Resident #1 was admitted to the facility in 2010 with diagnoses that included cerebrovascular accident (CVA), hemiplegia/hemiparesis, and diabetes mellitus. The quarterly Minimum Data Set (MDS) dated 04/06/18 indicated the resident had no cognitive impairment and had a Brief Interview for Mental Status (BIMS) score of 14. The MDS specified that Resident #1 needed extensive assistance for all activities of daily living (ADLs) with the exception of being independent with eating. Resident #1 was frequently incontinent of urine. The resident had left-sided hemiplegia as a result of a CVA. She received anti-coagulant therapy. Resident #1's nursing care plan updated on 06/14/18 and signed by the interdisciplinary team indicated that she had an ADL self-care performance deficit. The resident required one-person assistance for bed mobility, bathing, dressing, eating, toileting, and personal hygiene as well as one-person assistance with the sit-to-stand lift. a. The facility failed to report an allegation of staff-to-resident abuse to the state agency within two hours of the resident's report. Resident #1 reported an allegation of abuse to Nurse #1 and Nurse #2 on 06/02/18. She identified the alleged perpetrator as Nurse Aide #1. Nurse #2 entered details of the incident on an Initial Allegation Report. The Date and Time Facility Became Aware of Incident was listed on the report as "06/02/18 1:30 p.m." The report was faxed to the state agency on 06/02/18 at 4:37 p.m.	F 610	exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Plan of correcting the specific deficiency It is the policy of The Presbyterian Home of Hawfields to have Investigate/Prevent/Correct Alleged Violation in response to allegations of abuse, have evidence that all alleged violations are thoroughly investigated, prevent further potential abuse while the investigation in process and report the results of all investigations to the Administrator or his or her designated representative and to other officials in accordance to State law, including the State Agency a) within five (5) working days of the incident and b) immediately but not later than two (2) hours after the allegation is made if the events that cause the allegation involve abuse or result in seriously bodily injury, or not later than c) twenty four (24) hours if the alleged violation does not involve abuse and do not result in seriously bodily injury and if the alleged violation is verified appropriate action taken. After further review of the facility policy titled Abuse Neglect Policy by the Administrator, Director of Nursing and Social Worker, we determined the need for revisions to the policy and procedures for investigating allegations of abuse and reporting those allegations consistent with	

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F 610

Continued From page 27

In an interview on 07/09/18 at 1:30 p.m., Nurse #2 indicated that her submission was not within the required timeframe due to a delay in gathering identifying information about the alleged perpetrator from the aide's staffing agency. Nurse #2 stated that the form required a Date of Birth and Social Security number. Nurse #2 attributed the delay in the staffing agency's response to the fact that it was a weekend.

b. The facility failed to conduct a thorough investigation of the alleged incident.

In an interview on 06/20/18 at 1:45 p.m., the Director of Nursing (DON) confirmed that she was notified of the allegation on 06/04/18, two days after Resident #1 first reported the abuse to Nurses #1 and #2. She admitted that investigation of the abuse allegation was delayed and that interviews of other residents for potential mishandling during their care was not done immediately after the allegation was reported.

In the interview, the DON stated that she was responsible for conducting the investigation but that she did not keep an outline or a file of paperwork documenting her facility investigation. She stated that she entered the information she gathered directly on the Initial Allegation Report and Investigation Report forms provided by the state. The DON stated that she spoke with other residents about the care Nurse Aide #1 provided and any possible roughness but she could not provide documentation of who she interviewed and when she interviewed them.

The Investigation Report submitted 06/06/18 included the statement, "Also spoke with other workers [CNAs (certified nurse aides) and

F 610

The Centers of Medicare Services (CMS) requirements, specifically to include: a) reporting allegations of abuse to the State Agency immediately, but no later than two hours after the allegation was made when the allegation involved abuse b) and guidelines for conducting the investigation to include who was in charge of completing the investigation.

Procedures

The facility policy titled Abuse Neglect was updated to include guidelines on investigating and reporting allegations of abuse or abuse resulting in serious bodily injury immediately but no later than two hours to the State Agency, and within 24 hours if the alleged violation involved abuse does not involve abuse and has not resulted in seriously bodily injury. The policy includes specific information and guidelines on what staff person to contact when allegations of abuse are made, who is responsible for completing and submitting the report to the State Agency, details on
gathering information, action to take to protect the resident during the investigation, documentation requirements of the investigation findings and where the documentation is maintained.

The Director of Nursing, Social Worker and MDS Coordinator educated staff on the policy revision with emphasis on the reporting mechanism and timeframes and

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F 610	Continued From page 28 nurses] that worked that day about details they may know." There was no documentation or elaboration on who was interviewed or the results of those interviews. An updated Investigation Report was faxed to the state agency on 06/21/18. The Investigation End Date was listed as "still under investigation" 19 days after the allegation of abuse was reported by Resident #1. The Corrective Action section on the Investigation Report submitted to 06/06/18 included the following details: "Updated care plan for resident to be a two-person assist at all times." The Corrective Action section on the revised report submitted 06/21/18 was similar: "Made sure care plan was stating two-person assist at all times with resident." An inspection of the nursing care plan book on the unit 07/09/18 revealed that the current nursing care plan specified that Resident #1 required "1-person assistance" for ADLs. In an interview on 06/20/18 at 1:45 p.m., the DON shared her expectation that any nurse accepting a report of alleged abuse or neglect would notify the state agency within the required timeframes, notify facility management and begin an immediate investigation. In an interview on 07/09/18 at 4:30 p.m., the DON acknowledged that the nursing care plan for Resident #1 present on the unit on 07/09/18 had not been updated to reflect the need for two staff members to provide care. She stated that this was an important strategy for making Resident #1 feel safe and preventing further incidents. She	F 610	that education was completed on 7/11/2018. Monitoring The Director of Nursing will us a Quality Assurance (QA) audit tool to review all allegations of abuse to determine compliance with the investigation and reporting requirements. Audits will be conducted every week for a month then bi-monthly for the next 5 months. The Director of Nursing will report results in the facility Quality Assurance Committee (monthly for 3 months). The Quality Assurance Committee will determine continued monitoring needs and/or make recommendations. Person Responsible for Implementing The Plan Administrator and Director of Nursing	

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F 610	Continued From page 29 shared her expectation that the MDS Coordinator updated all copies of the nursing care plan based on her attendance at the interdisciplinary care plan meetings. In an interview on 06/20/18 at 3:30 p.m., the Administrator stated that he was informed of the abuse allegation on 06/02/18, the same day it was reported by Resident #1, when he phoned the office about another matter. He did not notify the DON and assumed that Nurse #2 had contacted her or would contact her. He was not aware of the required two-hour timeframe to report allegations of abuse to the state agency. He shared his expectation that staff members meet the required timeframes for reporting allegations of abuse and for completing the investigation. He was unsure if the facility investigation had been completed or was still ongoing. He stated that he and the DON were waiting for the Sheriff's Office to finish their investigation so the information could be incorporated into the facility's investigation to assist them with a determination of substantiation.	F 610		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a	F 838		8/11/18

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F 838	Continued From page 30	F 838		

substantial modification to any part of this assessment. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide

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F 838 Continued From page 31
services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for its resident population competently during day-to-day operations or in an emergency situation.

Findings included:

The facility could not provide documents to demonstrate it had conducted an evaluation of the facility's resident population, including the number and type of residents accepted and care required by the resident population, staff competencies, physical environment, and cultural, ethnic, and religious factors that may affect residents' care. Facility resources such as services provided, personnel, contracts with third parties, and resident records management were also not documented.

An All-Hazards Planning and Resource Manual and a notebook of Appendices were reviewed; however, most of the worksheets were blank. The Manual's All Hazards Emergency Plan was signed on 03/23/2009 by the Administrator, the Maintenance Director and former Director of

F 838

F-838 8/11/2018

This Plan of Correction constitutes The Presbyterian Home of Hawfields written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

Plan of correcting the specific deficiency

It is the policy of The Presbyterian Home of Hawfields to have a completed and documented facility-wide assessment according to Code of Federal Regulations (CFR 483.70(e). that includes determination of resources necessary to care for its resident population completely during day-to-day operations or in emergency situations. After further review of the Facility Wide Assessment, by the

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F 838	Continued From page 32 Nursing. The Plan was signed as reviewed by the Administrator on 04/27/17. The list of staff contacts was last updated 03/28/17 and failed to include a recent change in nursing management. In an interview on 07/11/18 at 1:45 p.m., the Administrator stated that the Dietary and Maintenance departments may have some elements of the needed facility assessment. He did not mention information from other departments. The Administrator could not provide any summary documents to demonstrate that evaluations of the resident population, staff competencies and facility resources had been conducted. The Administrator pointed out the facility's participation in a local medical center's mass casualty exercise conducted on 09/14/18 but a facility self-assessment was not part of this exercise. He stated his awareness of the requirement to complete a comprehensive facility assessment but did not offer an explanation of why the assessment had not been done or who was responsible for its completion.	F 838	Administrator it was determined revisions were necessary to include additional components as outlined in (CRF 483.7(e). Procedure Administrator and Staff Development Coordinator compiled a team consisting of Director of Nursing, Social Worker, Activities Director, Dietary Manager, Maintenance Supervisor, Office Manager and Housekeeping and Laundry Supervisor. The team met to evaluate the facility resident population and identify the resources needed to provide the necessary person centered care and services the residents require. The Centers of Medicare Services (August, 2017) assessment tool template was used to guide this evaluation and record findings of the assessment. The Facility Wide Assessment will be completed by 8/11/2018. Monitoring The Facility Wide Assessment was added to the facility Quality Assurance Committee to ensure it is reviewed and updated at least annually or whenever there is facility plans for any change that would require a modification to any part of the assessment. Person Responsible for Implementing The Plan	

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F 838	Continued From page 33	F 838	Administrator and Staff Development Nurse	