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	345296	A. BUILDING _____ B. WING _____	C 07/13/2018

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F 600 SS=D	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, resident, staff, and Medical Doctor interviews the facility failed to implement effective measures to protect cognitively impaired residents (Resident #224 and #106) from being slapped by a cognitively intact Resident (Resident #39) for 2 of 4 residents sampled for abuse. The facility failed to manage the physical behaviors of Resident #39 which resulted in 2 cognitively impaired residents being slapped. The findings included: Resident #39 was readmitted to the facility on 02/16/18 with diagnoses that included intellectual disability. Review of the quarterly minimum data set (MDS) dated 04/23/18 revealed that Resident #39 was cognitively intact and exhibited no behaviors	F 600	1. Resident had physical altercation on May 20 leading to this resident slapping the other on the hand. Again on July 3rd this same resident became startled by another resident and slapped his hand as well. All staff educated on updated abuse policy on 7/12-13/18 by Administrator. Educated to separate residents immediately should any abuse arise and prevent any further issue in that moment. 2. Staff being re-educated weekly by Administrator, DON and SDC to insure knowledge of updated abuse policy x 8 weeks. Staff questioned about any further abuse issues weekly x 8 weeks. Alert and oriented Residents interviewed weekly to make sure they feel safe x 8 weeks. Non-interview able residents are having skin checks conducted weekly x 8 weeks.	8/6/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/30/2018

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F 600	Continued From page 1 during the assessment reference period. The MDS further revealed that Resident #39 required supervision to limited assistance from staff with her activities of living (ADLs). Resident #224 admitted to the facility on 04/15/16 with diagnoses that included dementia, anxiety, and depression. Resident #224 was discharged from the facility on 06/07/18. Review of the quarterly MDS dated 04/30/18 revealed that Resident #224 had long and short-term memory problems and was moderately impaired in cognition for daily decision making. The MDS indicated wandering behaviors occurred 1 to 3 days during the reference period and no physical behaviors were identified on the MDS. The MDS further revealed that Resident #224 required limited assistance with her ADLs. Resident #106 was admitted to the facility on 01/09/18 with diagnoses that included dementia, depression, and post-traumatic stress disorder. Review of the quarterly minimum data set (MDS) dated 04/16/18 revealed that Resident #106 was moderately cognitively impaired and no behaviors were present during the reference period. The MDS further revealed that Resident #106 was independent with his activities of daily living. Review of a care plan for Resident #39 with a problem onset date of 01/02/18 and updated on 04/19/18 read in part, Resident #39 at times will use inappropriate behavior such as hitting staff on their bottoms, take belongings of staff and difficult at times to redirect to give those items back. She will touch other items in dining room such as cups and bowls. The goal of the care plan read,	F 600	3.QA committee to monitor monthly the progress of this education x 2 months to see if additional training is warranted. 4. Scott Davis is responsible for implementing this POC 5. Corrective action completed 8/6/18.	

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Resident #39 will decrease incidents of inappropriate behavior by 3 times or fewer incidents over the next 90 days. The interventions included: monitor for hunger, thirst, and toileting needs, administer medications as ordered, assess for pain, Social Worker (SW) to assist as needed, reorient and redirect as needed, encourage family visits, offer emotional reassurance as needed, encourage participation in activities of interest, upon approach speak in a calm tone, allow her to verbalize needs, wants, and desires, and monitor and document all mood and behavioral symptoms.

Review of a "Resident to Resident Abuse Investigation and Intervention" dated 05/20/18 read in part, in the dining room Resident #39 got her wheelchair stuck on Resident #224's wheelchair. Resident #224 grabbed Resident #39's wheelchair to pull the wheelchair free from the entanglement and Resident #39 swatted her hand at Resident #224 who then returned the swat to Resident #39. At that time Resident #39 threw her hand back and slapped Resident #224 on the hand/forearm. The interventions to prevent abuse from reoccurring read in part, the residents were separated and 15-minute checks were initiated. The form was signed by Nurse #1.

An interview and observation was made of Resident #39 on 07/10/18 at 9:07 AM. Resident #39 was in a day room at the end of the hall that she resided on. Resident #39 recalled the incident that occurred in the dining room on 05/20/18. Resident #39 stated that Resident #224 "would not get out of my way so I hit her on the arm" and "then she got out of my way." She added "I did not like her and I could not stand to be around her" "she aggravated me." Resident

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#39 again confirmed that she had hit Resident #224 because she was in her way.

An interview was conducted with Nurse #1 on 07/10/18 at 3:16 PM. Nurse #1 confirmed that she was working on 05/20/18 and was called to the dining room by a staff member but could not recall which one. When she arrived in the dining room she was informed by the Ward Clerk (WC) that Resident #39 had got her wheelchair stuck on Resident #224's wheelchair. Resident #39 then swatted at Resident #224 who returned the swat at which time Resident #39 slapped Resident #224 on the hand/forearm but could not recall which one. Nurse #1 stated that she took Resident #39 to her room to calm down. She added that she then returned to the dining room to check on Resident #224 and she was angry but denied any pain and there was no redness or other injury to her arm. Nurse #1 stated that immediately following the incident she contacted the Administrator and he directed her as to what they needed to do and which paper work to complete. She added that she contacted both Resident #39 and #224 families and made them aware and she placed the incident in the Medical Doctor (MD) book. Nurse #1 stated that they initiated 15-minute checks on Resident #39 and #224 and by the end of her shift both had calmed down and Resident #39 was in her room playing solitaire on her computer. She stated that Resident #39 was alert and oriented and knew right from wrong. She added that Resident #39 would often throw a "hissy fit" if something did not go her way or if someone did something she did not like but she had not seen her hit any other resident before.

An interview was conducted with the WC on

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07/11/18 at 8:34 AM. The WC confirmed that she was working on 05/20/18 as the manager on duty and was in the dining room helping get the residents to their seats and ready to eat dinner. The WC added that she was the only staff member in the dining room because the Nursing Assistants (NAs) where bringing residents into the dining room and returning to the units to get other residents. She stated Resident #39 was trying to get to her table and her wheelchair got entangled with Resident #224's wheelchair. She explained Resident #224 tried to pull Resident #39's wheelchair through and get them untangled and Resident #39 swatted at Resident #224's hand to get it off of her wheelchair and Resident #224 then swatted back but made no contact with Resident #39. The WC stated that at that point Resident #39 slapped Resident #224 on the hand/forearm but could not recall which hand/forearm but stated it "made a loud pop." The WC stated she went over and checked Resident #224's arm and saw no redness, marks, or bruising and then went to notify Nurse #1 who immediately responded to the dining room. The WC stated that Resident #39 got her wheelchair unstuck and began to roll herself out of the dining room down to her room. The WC stated that she believed that Resident #39 was alert and oriented and aware of what she was doing but Resident #224 "had no clue" what she was doing. The WC stated that after Nurse #1 came to the dining room and Resident #39 had gone to her room she completed a statement of the incident and then left the facility at the end of her shift. She added that she only worked the weekends and had not seen Resident #39 exhibit any physically aggressive behaviors before.

Review of a "Resident to Resident Abuse

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Investigation and Intervention" dated 07/03/18 read in part, Resident #106 reported to Nurse #2 that he came into the day room to look at his garden and he moved a wheelchair from the corner of the room and Resident #39 slapped him. No injuries were observed. Interventions to prevent abuse from reoccurring and notification of responsible party read in part, Resident #106 and #39 families were notified. The Administrator was notified. The form was signed by Nurse #2.

An interview was conducted with Resident #106 on 07/10/18 at 5:57 PM. Resident #106 recalled the incident with Resident #39 on 07/03/18. He stated, "it is unbelievable what she did to me." Resident #106 explained he had gone to the day room at the end of the hall to check on his garden and he had moved an empty chair in the corner so he could see out of the window. He added that Resident #39 raised her hand and slapped him on the right arm and "it was a full swing and it stung." Resident #106 stated he told Resident #39 "if you do anymore of your shenanigans I will get the law enforcement in here to get you because you are not going to sit there and hit me." Resident #106 stated the he was not scared of Resident #39 but was always on his guard because Resident #39 lived next door to him. He added that he had told the Nurse but could not recall which one. Resident #106 described another incident with Resident #39 sometime earlier this year. He stated he was in the front lobby and he had gotten a phone call from a friend of his and Resident #39 had grabbed the phone out of his hand and was screaming "this is my phone." Resident #106 stated that the nurses had to come and get Resident #39 so he could finish his conversation on the phone.

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An interview and observation was made of Resident #39 on 07/10/18 at 9:07 AM. Resident #39 was in a day room at the end of the hall that she resided on. She was observed to be working a large puzzle with another resident who resided at the facility. Resident #39 recalled the incident that occurred in the day room on 07/03/18. Resident #39 stated that on 07/03/18 she hit Resident #106 on the arm because he moved a chair and "I did not like that." She added that Resident #106 "aggravated her" and that was why she hit him. Resident #39 stated the facility staff told me I was not supposed to hit anyone after the incident and I have not hit anyone else.

An interview was conducted with Nursing Assistant (NA) #1 on 07/11/18 at 1:23 PM. She stated she was working on 07/03/18 and heard Resident #39 in the day room raise her voice. She stated she went to check on her and Resident #106 was in the day room and stated that he had moved a chair so he could check on his garden and Resident #39 had slapped him on the arm. She added that Resident #39 stated "he bumped my chair." NA #1 stated she left Resident #39 and #106 in the day room and went to get Nurse #2. She added that Nurse #2 immediately came down to day room and Resident #106 told her the same thing that he had told me. NA #1 stated that Nurse #2 moved the chair out of the way but Resident #106 returned to his room at that time. She added that Resident #39 stayed in the day room and both were quiet during the rest of her shift. NA #1 added that she had never been instructed to do frequent monitoring with Resident #39 due to her inappropriate behaviors.

An interview was conducted with Nurse #2 on 07/11/18 at 11:02 AM. Nurse #2 stated that on

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07/03/18 Resident #106 reported to her that Resident #39 had slapped him on his arm after he moved an empty wheelchair so he could look out the window at his garden. She stated that she observed his arms and saw no red mark or bruises and she had no idea what set Resident #39 off or why she slapped him. Nurse #2 stated that Resident #39 spent a lot of time in the day room working puzzles and maybe she felt like that was her space. Nurse #2 stated that after the incident both residents returned to their room which were very close to each other and she completed the Resident to Resident Altercation form and notified the Administrator. Nurse #2 stated she only worked part time and was not very familiar with Resident #106 but was more familiar with Resident #39. She stated Resident #39 was alert and oriented and was fully aware of what she was doing. Nurse #2 stated that no increased monitoring or supervision was initiated for Resident #39 following this instance but stated that Resident #106 returned to his room and they had no further contact that evening.

An interview was conducted with the Social Worker (SW) on 07/10/18 at 5:34 PM. The SW stated she was not working when the incident on 05/20/18 occurred. She stated when she returned to the facility on Monday 05/21/18 they talked to Resident #39 and her family member and told them if Resident #39 became upset she needed to talk to staff instead of acting without thinking. She stated her understanding of the incident of 05/20/18 was that after it occurred they kept the 2 residents separated. The SW further explained Resident #39 would swat staff on the bottom, take water bottles off the medication carts, things that she thought were playful and mischievous but to her knowledge had not hit any other

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residents until the incident on 05/20/18. She added that Resident #39's family member was very influential in Resident #39's life and her daily decision making. She stated that a previous roommate had reported that when she asked Resident #39 to turn the volume down on the television Resident #39 responded "I don't have to my family member says I don't." The SW stated Resident #39 does know right from wrong and they had educated both Resident #39 and her family member about how to control her emotions and have encouraged the family member to reinforce that behavior when she visited Resident #39. The SW stated that the only thing they did after the event of 05/20/18 was to get the family member involved but that the family member had the same reactionary outburst as Resident #39 and became belligerent with the facility staff. She added the family member refused any psychiatric services for Resident #39 and because the family refused any psychiatric services and refused to discuss more appropriate placement the facility was limited as to what they could do for Resident #39. The SW was not aware of any increased monitoring or changes to Resident #39's plan of care that occurred after she hit Resident #106 on 07/03/18 and could not recall if the Medical Doctor had been notified by the nursing staff.

An interview was conducted with the Director of Nursing (DON) on 07/10/18 at 3:50 PM. The DON stated she could not recall if the facility had called her or if she found out about the incident on 05/20/18 when she returned to the facility on Monday 05/21/18. She stated her understanding of the incident was that Resident #39 slapped Resident #224 on the arm but could not recall which one and the staff had separated the 2

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residents and they called the Administrator and he handled the investigation. The DON stated that Resident #224 had no injuries from the slap. She added that Resident #39 had "mental retardation but is much more alert and functions at a high level" and she does know right from wrong. The DON added that most of the time Resident #39 was pleasant but did have self-control issues but she could not recall if she had ever hit anyone before 05/20/18. The DON reviewed the nursing notes for Resident #39 and stated that after the 05/20/18 incident in the dining room she had another incident with her roommate on 05/20/18. She explained that Resident #39 picked up the roommate's hand and slung it over the bed and threw a remote in the bed next to the roommate. As the DON continued to read Resident #39's nursing notes she stated that on 05/28/18 she entered another resident's rooms and began pulling on the resident's ears and called her ugly. She added that the facility SW had talked to her after the incident on 05/28/18 about keeping her hands to herself and not touching other residents and Resident #39 stated she would not do that again. Further review of the nursing notes the DON stated that on 07/03/18 Resident #39 hit Resident #106 but to her knowledge no formal investigation had been completed and no increased monitoring was done following the incident. The DON stated that after each of those incidents no increased monitoring had been ordered and no changes to Resident #39's plan of care were made to monitor and control her inappropriate behaviors.

A follow up interview was conducted with the DON on 07/13/18 at 11:52 AM. The DON stated that looking back at the incident that occurred on 05/20/18 she believed the facility should have

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placed Resident #39 on 1 to 1 monitoring with staff until she had deescalated and then placed her on 15-minute checks for a longer time frame to prevent her from grabbing and flinging the arm of her roommate. The DON stated that the incident on 05/20/18 set the stage for Resident #39's behaviors and because she was childlike she felt like she could continue to hit residents to get her way and they should have increased their monitoring of Resident #39. She added that more detailed staff interviews would have been very helpful as well. The DON stated she expected all the residents to be kept safe during and after the investigation and for the incident to be thoroughly investigated.

An interview was conducted with the Administrator on 07/10/18 at 4:15 PM. The Administrator stated that Nurse #1 called him on 05/20/18 and reported an incident in the dining room between Resident #39 and #224. He stated he walked Nurse #1 through what needed to be done and which paperwork needed to be completed. The Administrator stated Nurse #1 handled the investigation which included the Resident to Resident Abuse Investigation and Intervention and 2 staff statements. He stated they immediately started 15-minute checks on both residents and offered a room change to Resident #39 and initially her family declined and they further declined any psychiatric services. The Administrator explained over a year ago Resident #39's family member had consented to psychiatric services and the psychiatrist made a recommendation for a medication and the family member stated Resident #39 did not need the medication and she immediately stopped the psychiatric services. He added within a week Resident #39 requested a room change and it

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was provided to her. The Administrator stated they were able to discharge Resident #224 rather quickly to a more appropriate setting and had been working with Resident #39 ever since then. He added Resident #39 was alert and oriented and but had the mind of a child and was very reactionary when things happened and she was unable to control her emotions.

A follow up interview was conducted with the Administrator on 07/11/18 at 11:17 AM. The Administrator stated after the incident on 05/20/18 he contacted Resident #39's family member about helping them control Resident #39's behavior. The family member became very belligerent with the staff and the meeting quickly became counterproductive. The Administrator stated he felt like Resident #39 would be more appropriate in a group home setting where there were less residents but the family had absolutely refused for that to happen and became belligerent while attempting to discuss it. The Administrator stated after the 15-minute checks were completed after the 05/20/18 incident Resident #39 did well and most of the time she was pleasant and no additional increased monitoring had been initiated for Resident #39 even after the other incidents of inappropriate behaviors and hitting Resident #106 on 07/03/18. The Administrator stated he was aware of the incident that occurred on 07/03/18 with Resident #106 and #39 but really had no idea what had occurred. He stated the Resident to Resident Abuse investigation had been completed and the residents were separated but no further investigation was completed. He again confirmed that no 15-minute checks were initiated following the incident and again stated he was very limited with what he could do for Resident #39 due to the

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F 600	Continued From page 12 family refusing to allow any psychiatric services and possible discharge to a more appropriate setting. The Administrator confirmed that Resident #106 and #39 lived very close to one another. An interview with the Corporate Director of Clinical Services (CDCS) was conducted on 07/12/18 at 9:30 AM. The CDCS stated that initially the Administrator believed that Resident #224 was the issue and very quickly got her discharged but looking at the whole picture they realized that something set Resident #39 off and caused her to lash out with both incidents when Resident #39 hit Resident #224 and #106. The CDCS stated that the Administrator had conducted more interviews on 07/12/18 that were lacking when the incident first occurred and helped him see the bigger picture. An interview was conducted with the Medical Doctor (MD) on 07/12/18 at 3:14 PM. The MD stated he expected the residents in the facility to be kept safe and free from abuse. The MD stated he was aware of Resident #39's inappropriate behavior but the facility had tried to find more appropriate placement for her and the family refused and they had recommended a psychiatric evaluation and again the family refused. He stated he believed Resident #39 was more appropriate for a group home that was designed to deal with individuals in her condition but that the family was very unreasonable and placed a lot of pressure on the facility.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and	F 607		8/6/18

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F 607	Continued From page 13 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 observations, record review, resident and staff interviews the facility failed to implement their abuse policy and procedures and thoroughly investigate an allegation of resident to resident abuse for 1 of 3 residents sampled for abuse (Resident #106). The findings included: A review of the facility's Abuse/Neglect/Misappropriation of Resident Property Policy that contained no date was made. The policy read in part, "all allegations of resident abuse, neglect, misappropriation of resident property, and involuntary seclusion be promptly reported, thoroughly investigated and further prevented while investigation is in progress." The policy further read, "when an incident or suspected incident of resident abuse, neglect, or misappropriation of resident property is reported, the Executive Director (Administrator) will appoint a facility representative to investigate the incident." The facility representative investigating shall do the following: interview the person reporting the incident, interview any witness to the incident, interview the resident, review of the	F 607	1. Resident was involved in physical altercation on May 20 resulting in her slapping another resident on the hand. On July 3rd same resident slapped another resident on the hand after she became startled. Failed to follow Policy and did not separate immediately to prevent further issue as well as not providing 1:1 supervision. All staff in-serviced on 7/12 and 7/13 as to updated Abuse Policy by the Administrator and the steps to take to prevent, stop and report resident to resident abuse. 2. Staff being educated weekly x 8 weeks by Administrator, DON and SDC as to any resident to resident abuse issues. Re - educated weekly x 8 weeks on the update policy and must verbalize their understanding. Additionally all new staff is familiarized with the new policy and educated as to its importance. 3. QA committee to monitor monthly the progress of this education x 2 months to see if additional training is warranted.	

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F 607	Continued From page 14 residents medical record, interview with staff members (all shifts) that have had contact with the resident during the period of the alleged incident, interview with the residents roommate, family member, and visitors as appropriate, review all circumstances surrounding the incident, outcome of investigation, corrective action and date and times persons notified. Resident #39 was readmitted to the facility on 02/16/18 with diagnoses that included intellectual disability. Review of the quarterly minimum data set (MDS) dated 04/23/18 revealed that Resident #39 was cognitively intact and exhibited no behaviors during the assessment reference period. The MDS further revealed that Resident #39 required supervision to limited assistance from staff with her activities of living (ADLs). Resident #106 was admitted to the facility on 01/09/18 with diagnoses that included dementia, depression, and post-traumatic stress disorder. Review of the quarterly minimum data set (MDS) dated 04/16/18 revealed that Resident #106 was moderately cognitively impaired and no behaviors were present during the reference period. The MDS further revealed that Resident #106 was independent with his activities of daily living. Review of a "Resident to Resident Abuse Investigation and Intervention" dated 07/03/18 read in part, Resident #106 reported to Nurse #2 that he came into the day room to look at his garden and he moved a wheelchair from the corner of the room and Resident #39 had slapped him. No injuries were observed. Interventions to	F 607	4. Scott Davis is responsible for this POC. 5. Corrective action achieved on 8/6/18.	

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prevent abuse from reoccurring and notification of responsible party read in part, Resident #106 and #39 families were notified. The Administrator was notified. The form was signed by Nurse #2.

An interview was conducted with Resident #106 on 07/10/18 at 5:57 PM. Resident #106 recalled the incident with Resident #39 on 07/03/18. Resident #106 explained he had gone to the day room at the end of the hall to check on his garden and he had moved an empty chair in the corner so he could see out of the window. He added that Resident #39 raised her hand and slapped him on the right arm and "it was a full swing and it stung." Resident #106 stated the he was not scared of Resident #39 but was always on his guard because Resident #39 lived next door to him. He added that he had told the Nurse but could not recall which one.

An interview and observation was made of Resident #39 on 07/10/18 at 9:07 AM. Resident #39 was in a day room at the end of the hall that she resided on. She was observed to be working a large puzzle with another resident who resided at the facility. Resident #39 recalled the incident that occurred in the day room on 07/03/18. Resident #39 stated that on 07/03/18 she hit Resident #106 "on the arm because he moved a chair and I did not like that." She added that Resident #106 "aggravated her" and that was why she hit him. Resident #39 stated the facility staff told me I was not supposed to hit anyone after the incident.

An interview was conducted with Nursing Assistant (NA) #1 on 07/11/18 at 1:23 PM. She stated she was working on 07/03/18 and heard Resident #39 in the day room raise her voice.

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She stated she went to check on her and Resident #106 was in the day room and stated he had moved a chair so he could check on his garden and Resident #39 had slapped him on the arm. She added Resident #39 stated "he bumped my chair." NA #1 stated she left Resident #39 and #106 in the day room and went to get Nurse #2. She added Nurse #2 immediately came down to the day room and Resident #106 told her the same thing that he had told me. NA #1 stated Nurse #2 moved the chair out of the way but Resident #106 returned to his room at that time. She added Resident #39 stayed in the day room and both were quiet during the rest of her shift.

An interview was conducted with Nurse #2 on 07/11/18 at 11:02 AM. Nurse #2 stated on 07/03/18 Resident #106 reported to her that Resident #39 had slapped him on his arm after he moved an empty wheelchair so he could look out the window at his garden. Nurse #2 stated after the incident both residents returned to their room which were very close to each other and she completed the Resident to Resident Altercation form and notified the Administrator. Nurse #2 confirmed that no increased monitoring was initiated and no other changes to Resident #39's plan of care were made. She stated she completed the form and notified the Administrator.

An interview was conducted with the Director of Nursing (DON) on 07/10/18 at 3:50 PM. The DON stated she was aware of the incident with Resident #106 but to her knowledge no formal investigation was completed and no increased monitoring or other changes to Resident #39's plan of care was made following the incident. The DON stated she used to complete all the

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F 607	Continued From page 17 investigation of abuse but over the time the Administrator had taken over that role and she assisted as needed. A follow up interview was conducted with the DON on 07/13/18 at 11:52 AM. The DON stated that looking back at the incident that occurred on 07/03/18 she believed they should have placed Resident #39 on 1 to 1 care with staff until she had deescalated and then placed her on 15-minute checks for a period of time. She added that detailed staff interviews and statements should have been completed as part of the investigation. The DON stated she expected allegations of abuse to be thoroughly investigated. An interview was conducted with the Administrator on 07/11/18 at 11:17 AM. The Administrator stated he was aware of the incident that occurred on 07/03/18 with Resident #106 and #39 but really had no idea what had occurred. He confirmed no further investigation had been completed because he believed they had exhausted their efforts of a psychiatric evaluation and more appropriate placement with Resident #39's family. He stated the Resident to Resident Abuse investigation had been completed and the residents were separated. He confirmed no increased monitoring or other changes to Resident #39's plan of care were made following the incident and again stated he was very limited with what he could do for Resident #39 due to the family refusing to allow any psychiatric services and possible discharge to a more appropriate setting.	F 607		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		8/6/18

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F 689	Continued From page 18 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to maintain water temperatures at safe levels to avoid putting residents at risk for burns at resident bathroom sinks in 2 of 6 sampled rooms (Room #611 and #619). Findings Included: A review of a facility document titled "Water Temperature Log - Baths, Spas, DW (dish washing) Machine and Washing Machine" from May 14th, 2018 through July 9th, 2018 revealed water temperatures were recorded on a weekly basis on all halls. A review of a water temperature log dated 07/09/18 indicated the most recent recorded water temperature documented on the 600 hall revealed Room #614 had a recorded water temperature of 116 degrees Fahrenheit (F). On 07/09/18 at 3:17 PM an observation of hot water at the sink in resident room #611 revealed the water to be warm when first turned on but after a short time the water became hot to touch, reddened skin and an observation of steam was rising from the sink.	F 689	1.Water temperatures checked on each hall immediately by Maintenance and adjusted to proper limits on 7/9/18. 2. Every hall checked daily from 7/9/18 thru 7/27/18 by Maintenance to ensure compliance with temperature requirements. Each hall to be checked weekly thereafter to ensure compliance going forward. 3. QA to monitor results for July and make recommendations. QA to receive weekly water temperature results x 3 months thereafter to review. 4. Scott Davis is responsible for this POC. 5. Corrective Action was achieved 8/6/18.	

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On 07/09/18 at 3:43 PM an observation of hot water at the sink in resident room #619 revealed water to be warm but quickly became too hot to touch with observations of steam rising from the sink.

An interview on 07/11/18 at 3:56 PM with Resident #274 who lived in Room #611 and was moderately impaired in cognition for daily decision making revealed she had just taken a shower and reported "we had a heck of a time getting the water cool enough for my shower."

An interview with the Maintenance Director on 07/11/18 at 3:38 PM revealed he had the water temperatures checked once per week, on Monday. He reported the Maintenance Assistant was responsible for checking the water temperatures with a digital thermometer and he expected that water temperatures be in the 100 -112 degrees F range in resident rooms and common areas. He also stated he expected the water temperatures to be adjusted down if the water temped at a higher temp when tested. At this time the Maintenance Director retrieved the thermometer that was used for water temperature testing and proceeded to temp the water in resident room #619. The water in resident room #619 revealed a temperature of 117.2 degrees F. The Maintenance Director stated "that's way too hot, I'll have to get [the Maintenance Assistant] to turn it down." The Maintenance Director then proceeded to check the water temperature in resident room #611 where it revealed a temperature of 118.3 degrees F. After this reading, the Maintenance Director stated he needed to go and turn down the water temperature on the hall.

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F 689	Continued From page 20 On 07/11/18 at 4:07 PM a follow up interview with the Maintenance Director revealed when he checked the digital readout on the hot water tank on the 600 hall he reported it was set to 120 degrees F. He reported he did not know why or how it came to be set so high. He stated that 120 degrees F was "way too hot" and there was no way he would have set the water temperature so high. During an interview with the Administrator on 07/11/18 at 4:45 PM he stated it was his expectation that water temperature levels be within the regulation. He further reported he was having the maintenance department check water temperatures twice a week but he had no idea why the water temped so high. He stated it was unacceptable for the water on the 600 hall to temp at 118 degrees F.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		8/7/18

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F 690	Continued From page 21 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, urology staff, and medical doctor interviews the facility failed to change a resident's catheter as recommended by the Urologist for 1 of 1 resident sampled with an indwelling catheter (Resident #17). The findings included: Resident #17 admitted to the facility on 08/03/10. His current diagnoses include penile cancer. Review of the most recent quarterly minimum data set (MDS) dated 04/03/18 revealed Resident #17 was cognitively impaired and required extensive assistance with his activities of daily living. The MDS further revealed Resident #17 required an indwelling catheter.	F 690	1. Resident had recommendation by Urologist to change catheter and Medical Director was not comfortable with facility staff changing catheter. After this decision was made it was not communicated to Urologist in a timely manner. Catheter was changed on 7/13/18 by staff after MD's spoke and agreed to change it. DON educated Nurse Supervisors on 8/6/18 and 8/7/18 to always follow up with specialist on recommendations our MD does not agree with. 2. 100% of residents charts will be audited to ensure any consults have been followed up on. And communication has been made to appropriate Doctor. Nursing administration to audit 10% of active	

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F 690	Continued From page 22 Review of a care plan for Resident #17 dated 03/27/18 and updated 04/17/18 read, Resident #17 had an indwelling catheter related to urinary retention secondary to circumcision procedure and the risk of urinary tract infection. The goal of the care plan read, Resident #17 will maintain a patent catheter drainage system daily x 90 days. The interventions included: urology consult as needed and change catheter and bag as ordered and as needed for occlusion or leak. Review of a Report of Consultation dated 04/20/18 from the Urologist read, post-operative circumcision and indwelling catheter. Discussed with family the diagnosis of pathology. Treatment would be a penectomy (surgical removal of the penis) but due to age and co-morbidities I would recommend observation. The diagnoses were listed as penile cancer. The recommendations included: change catheter every 3 to 4 weeks. Will follow up in 4 weeks. Review of Resident #17's medical record revealed no order to change the catheter as recommended by the urologist on 04/20/18. Review of Resident #17's physician order sheet dated 07/01/18 through 07/31/18 revealed no order to change the indwelling catheter. An observation of Resident #17 was made on 07/09/18 at 4:24 PM. Resident #17 was resting in bed with eyes open. He was observed to have indwelling catheter that was anchored to his right inner leg and was draining clear yellow fluid. An observation of catheter care was made on 07/11/18 at 1:00 PM. Nursing Assistant (NA) #1	F 690	resident charts weekly x 2 months to ensure compliance. 3. QA to review results for July audit. Will review nursing administration audits of 10% x 2 months to ensure compliance. QA to monitor results and recommend any additional measures. 4. Nancy Bumgarner is responsible for this POC 5. Corrective Action will be achieved by 8/7/18.	

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was observed to clean the penis and catheter tubing with good clean technique. The catheter bag had approximately 300 cc of yellow fluid in it and NA #1 stated she would empty the bag just prior to the end of her shift.

An interview was conducted with NA #1 on 07/11/18 at 1:53 PM. NA #1 stated she routinely cared for Resident #17 and was familiar with his care. She stated Resident #17 had a catheter and she provided catheter care at least once a shift and emptied his bag at the end of her shift or sooner if it was getting full. NA #1 stated the catheter was anchored to one of his legs and the nurses took care of that.

An observation of Resident #17 was made on 07/12/18 at 4:02 PM. Resident #17 was resting in bed with his eyes open. He was observed to have an indwelling catheter that was anchored to his right inner leg and was draining clear yellow fluid.

An interview was conducted with Nurse #4 on 07/12/18 at 4:32 PM. Nurse #4 stated she routinely cared for Resident #17 and was familiar with his needs. She stated Resident #17 had some sort of problem with his penis and went to the Urologist and they had do perform a circumcision and during that procedure they inserted the indwelling catheter. Nurse #4 stated Resident #17 periodically returned to the Urologist for follow up but they had not removed the catheter. She stated the NAs provided catheter care every shift and as needed and that generally catheters were changed every month and as needed. Nurse #4 indicated that generally they placed it on the treatment administration record so the nurse was aware when it needed to be changed. Nurse #4 stated she had never

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changed Resident #17's catheter and was not sure who had. She stated Resident #17 has had no problems with his catheter, no leakage, no occlusion, no recent infections, and he denied any pain associated with the catheter. Nurse #4 stated if the Urologist wrote recommendations on the consult report that would be given to the Medical Doctor (MD) for approval and then the order was written by the supervisor.

An interview was conducted with the Supervisor on 07/12/18 at 5:02 PM. The Supervisor stated when Resident #17 returned from the Urologist on 04/20/18 the facility MD stated he did not feel comfortable with the facility staff changing the catheter due to the diagnosis of penile cancer and his recent circumcision so the order was not written. The Supervisor stated when Resident #17 returned to the Urologist on 05/25/18 she believed they had changed the catheter. The Supervisor stated it was late on a Friday evening when Resident #17 returned to the facility and she could not reach out to the Urologist for clarification but someone should have reached out to the Urologist on Monday morning.

An interview was conducted with the MD who was also the facility Medical Director on 07/13/18 at 11:08 AM. The MD stated Resident #17 had carcinoma of the penis and the facility did not have the expertise to insert a catheter into people who had a structural issue which would make for a difficult insertion. He added that would be left up the experts at the Urology clinic. The MD stated if catheter could be changed easily then changing the catheter monthly would be fine.

A telephone interview with the Urology Nurse (UN) was conducted on 07/13/18 at 11:25 AM.

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The UN stated that per the Urologist recommendations the facility should be changing Resident #17's catheter every 3-4 weeks. She stated that to her knowledge there was no structural issue that would make the change difficult but she would try to get in touch with the Urologist to be sure because he was out of the office today.

A follow up telephone interview with the UN was conducted on 07/13/18 at 11:33 AM. The UN stated she was able to speak to the Urologist who confirmed that Resident #17's catheter should be changed every 3-4 weeks and since his circumcision there was nothing structural that would make the change difficult and changing the catheter could be done easily at the facility.

An interview was conducted with the Director of Nursing (DON) on 07/13/18 at 11:47 AM. The DON stated she recalled Resident #17 returning to the facility following his circumcision with an indwelling catheter. She stated the Supervisor had talked to the MD and he did not want the facility staff changing the catheter and the Supervisor was supposed to reach out to the Urologist for clarification and that did not happen. She added Resident #17 returned late after office hours on a Friday evening and then the Supervisor forgot to call on the next business day. The DON stated she expected for the Supervisor to reach out to the Urology clinic and get clarification of the order and for the catheter to be changed at the Urologist recommendations.

A follow up interview with the DON was conducted on 07/13/18 at 12:19 PM. The DON stated the MD and Urologist had spoken via phone and the facility would change the catheter

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F 690	Continued From page 26 today as instructed by the Urologist. A follow up interview was conducted with the MD on 07/13/18 at 2:53 PM. The MD stated he had spoken to the Urologist and it would be fine for the facility staff to change the catheter as instructed by the Urologist.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, Hospice nurse and Medical Doctor interviews the facility failed to administer oxygen at 3 liters as prescribed for 1 of 1 resident sampled for Hospice services (Resident #175). The findings included: Resident #175 admitted to the facility on 06/15/18 with diagnoses that included: acute respiratory failure with hypoxia (absence of enough oxygen in the blood to sustain bodily functions) and malignant neoplasm of the lung. Review of the comprehensive minimum data set (MDS) dated 06/22/18 indicated that Resident #175 was cognitively intact and no refusal of care	F 695	1. O2 order was written and was not noted on the MAR for 3 liters. Order was subsequently changed to 3 liters and O2 concentrator changed to reflect that. Resident remained at baseline O2 readings per nurse observation. 2. 100% of current residents have had orders audited and implemented correctly to ensure all are up to date. Nursing Administration to audit 10% of active residents weekly x 2 months to ensure orders carried over accurately. Nurses educated on proper procedure for noting orders on 8/6/18 and 8/7/18 by DON. 3.QA to monitor July audit results. QA to	8/7/18

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F 695	Continued From page 27 was noted. The MDS further indicated that Resident #175 required oxygen and had no shortness of breath during the reference period. Resident #175 required extensive assistance by 2 staff members with his activities of daily living. The MDS further revealed that Resident #175 required hospice services. Review of a physician order dated 06/26/18 read, oxygen at 3 liters due to decreased oxygen saturation. An observation and interview of Resident #175 was made on 07/09/18 at 3:48 PM. Resident #175 was lying in bed with eyes open. He was alert and verbal and was observed to have oxygen in place via nasal cannula at 2 liters via concentrator next to his bed. He was in no acute distress and was noted a have a small pulse oximeter (used to measure the amount of oxygen in the blood) on his bedside table. Resident #175 stated the pulse oximeter was his personal one and he kept a close eye on his number. He placed the pulse oximeter on his finger but did not turn it on. He stated he was not having any shortness of breath at that time. An observation of Resident #175 was made on 07/10/18 at 9:53 AM. Resident #175 was lying in bed with his eyes closed. He was observed to have oxygen in place via nasal cannula at 2 liters via concentrator next to his bed. He appeared to be resting comfortably and was not in any acute distress. An observation of Resident #175 was made on 07/11/18 at 9:44 AM. Resident #175 was lying in bed with his eyes closed. He was observed to have oxygen in place via nasal cannula at 2 liters	F 695	review weekly 10% audit done by Nursing Administration x 2 months and recommend follow up as needed. 4. Nancy Bumgarner- DON is responsible for this POC. 5.8/7/18 will be our completion date.	

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via concentrator next to his bed. He appeared to be resting comfortably and was not in any acute distress.

An interview was conducted with Nursing Assistant (NA #1) on 07/11/18 at 1:34 PM. NA #1 stated at times Resident #175 complained of not sleeping well and was not able to breath well despite having his oxygen on. NA #1 stated she was not able to do anything with his oxygen but make sure he had it on. She added the nurses were required to makes sure it was on the right setting. NA #1 stated if the oxygen was not on Resident #175 she would immediately tell the nurse so oxygen could be reapplied.

An interview was conducted with the Hospice Nurse (HN) for Resident #175 on 07/11/18 at 2:15 PM. The HN stated she visited Resident #175 1-2 times a week and he was currently ordered 3 liters of oxygen because Nurse #3 had contacted us a few weeks ago when Resident #175 was having some confusion and decreased oxygen saturation levels. The HN stated she talked with the medical doctor (MD) and they agreed to increase his oxygen to 3 liters knowing that his disease process was going to limit how effective the oxygen would be. She added he appeared comfortable on the 3 liters and the confusion had resolved. The HN added that generally when she checked his oxygen level during her visit it would be in the mid to upper 80's which appeared to be his baseline.

An observation of Resident #175 was made on 07/12/18 at 8:13 AM. Resident #175 was lying in bed with his eyes open and was alert and verbal. He was observed to have oxygen in place at 2 liters via concentrator next to his bed. As

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Resident #175 was talking be appeared to become short of breath but would quickly recover while not talking. Resident #175 stated sometimes he did get short of breath but was ok and placed his pulse oximeter on his index finger and the reading was 89%.

An interview with Resident #175 was conducted on 07/12/18 at 11:10 AM. Resident #175 stated his oxygen was his life saver as his right lung was full of cancer. Resident #175 stated they keep my oxygen at a comfortable level for me and all I want to do is get strong enough to go home and die peacefully.

An interview was conducted with Nurse #3 on 07/12/18 at 11:24 AM. Nurse #3 stated a couple of weeks ago Resident #175 became confused and his oxygen saturation level dropped to 68% and she had contact his HN. The HN spoke with the MD and they increased his oxygen to 3 liters and they believed he was entering the next stage of dying. Nurse #3 stated that generally Resident #175's oxygen level was in the 80's which was his usual reading but the MD did not wish to increase the oxygen any further. Nurse #3 stated Resident #175 had his own pulse oximeter but it seemed to not be accurate so she was in his room often checking his oxygen level. Nurse #3 confirmed with Resident #175's oxygen concentrator at his bedside that the oxygen level was at 2 liters. She also reviewed the medication administration record (MAR) which indicated that he was supposed to be on 2 liters and she stated that might be why oxygen was set at 2 liters. Nurse #3 stated she took the order to increase the oxygen on 06/26/18 and she sure he was supposed to be on 3 liters but may have gotten busy and forgot to finish carrying out the order.

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F 695	Continued From page 30 An interview was conducted with the Director of Nursing (DON) on 07/13/18 at 11:44 AM. The DON stated Nurse #3 wrote the order and then got distracted and forgot to go back and carry out the new order. She further stated they had a 2-check system for end of month orders and it was missed by mistake at that time as well. The DON stated she expected Resident #175 to be on 3 liters of oxygen as prescribed. An interview was conducted with the MD on 07/13/18 at 2:54 PM. The MD stated he expected oxygen to be administered as ordered and Resident #175 had lung cancer and oxygen levels in the 80's was pretty good for his condition.	F 695		