STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and resident interviews, the facility failed to ensure the resident choices were honored for the provision of incontinence care or their preference of when to go to bed for 4 of 5 residents reviewed for choices (Residents #1, #3, #5, and #6). The findings included:	F 561	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Woodland Hill Center does not admit that the deficiency listed on this form exists, nor does the facility admit to any statements, findings, facts, or conclusions	8/25/18

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

Electronically Signed | 08/21/2018

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F 561	Continued From page 1 1. Resident #1 was admitted to the facility 9/25/17. Cumulative diagnoses included chronic obstructive pulmonary disease, atrial fibrillation, rheumatoid arthritis and contractures of bilateral knees and bilateral hands. A quarterly Minimum Data Set (MDS) dated 7/1/18 indicated Resident #1 was cognitively intact. She required extensive assistance of one person for bed mobility and two-person assist with transfers and toilet use. A care plan dated 12/24/17 and last reviewed and revised on 7/1/18 stated it was very important for Resident #1 to have the opportunity to engage in daily routines that were meaningful to her and she expressed specific preferences relative to her daily routine. Interventions included, in part, that it was important to Resident #1 to choose her bedtime and preferred to go to bed whenever she wanted. A twenty-four-hour facility reported incident report dated 7/12/18 at 12:52 PM stated the facility was made aware of the incident on 7/12/18 at 10:40 AM. The incident date was 7/11/18. Resident #1 stated Nursing Assistant (NA) #3 hurt her while putting her to bed on 7/11/18. Bruises were noted to the left upper arm, top of left hand, right elbow, and right upper arm. Additions/ changes/ updates added to the facility reported incident stated, per Resident #1, she told NA#3 when she approached her that she did not want to go to bed, but the aide proceeded to grab her arm to put her in bed. The resident told the aide "Stop, you're hurting me and I'm going to have a big bruise tomorrow." She stated the aide replied, "I ' m not hurting you" and proceeded to place her in bed turning her fast and hard. Resident was	F 561	that form the basis for the alleged deficiency. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. Resident # 1 is currently having her choices honored for her chosen bedtime. Her minor injuries from this event have resolved. No further incidents have occurred. Alert & oriented residents were interviewed about whether their personal choices are being honored regarding their care. No residents voiced concerns. This was done by the interdisciplinary team. Education was provided to current facility staff, agency staff and contracted staff on resident choice, abuse and safe resident transfers. The education was provided by the interdisciplinary team. Ten Alert & oriented residents will be interviewed by the Interdisciplinary Team weekly for two weeks then monthly for one month, randomly thereafter. The questions will be centered on do staff let you make your own choices/decisions on care. After completion of the Resident Council Minutes, the Interdisciplinary Team will review for any concerns addressed regarding resident choice. Newly admitted residents will be interviewed by Social Services to determine their preferences which will be passed on to nursing to ensure	

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F 561	Continued From page 2 tearful about incident but easily comforted. NA#3 was terminated 7/18/18. A skin assessment dated 7/12/18 at 10:40 AM revealed the following: bruising to the bilateral upper extremities with a bruise on the left upper extremity that measured 10 centimeters (cm) x 10.5 cm, the left hand 6.5 cm x 6.5 cm and the right upper arm that measured 2 cm x 2 cm. On 7/31/18 at 9:40 AM, an interview was conducted with Resident #1. When asked about the incident that occurred the evening of 7/11/18, she stated the nursing assistant (NA#3) came into her room and told her she was going to bed. She said she told NA#3 that she wasn't ready for bed. NA#3 grabbed her by both wrists, got her out of her wheelchair and put her on the bed. Resident #1 stated NA#3 was rough anyway and she told her that she was hurting her. After she was in bed, she told NA#3 that she hurt her arm. NA#3 was not her regular nursing assistant. Resident #3 said her roommate was in the room but was asleep at the time the incident occurred. Her roommate was present in the room at the time of the interview and stated Resident #3 told her the same information the next morning after the incident occurred. On 7/31/18 at 5:01 PM, an interview was conducted with NA#2. She stated Resident #1 was on her regular assignment. NA#2 stated Resident #1 was alert and oriented and could voice her needs. NA#2 said Resident #1 needed assistance to transfer to her bed. She said she asked Resident #1 what time she wanted to go to bed and usually resident #1 told her 9:30 PM or 10:00PM. NA#2 stated Resident #1 was on her assignment on 7/11/18. Another nursing	F 561	appropriate care planned and implemented. The Nursing Home Administrator/Designee will review the audits upon completion and report any concerns voiced to the Director of Nursing and also report on outcomes at the morning meeting for any recommendations or additional training that might be needed. Audits and Resident Council Minutes will be forwarded to the monthly Quality Assurance Performance Improvement Meeting for two months to identify trends and opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	

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assistant, NA#3 was helping her and said she would assist with putting Resident #1 to bed. NA#2 said it was around 9:45PM-10:00 PM. She did not go and observe Resident #1 after NA#3 put her in bed.

On 8/1/18 at 7:33 AM, an interview was conducted with Nurse #4 who stated she had been working at the facility since March 2018. Regarding choices, she stated all residents have a right to choose when they go to bed and staff should honor the resident's choice.

On 8/1/18 at 11:35 AM, an interview was conducted with the Center Nurse Executive who stated her expectation was that all residents' choices be honored and Resident #1 should have been able to choose what time she went to bed.

On 8/2/18 at 10:32 AM, a telephone interview was conducted with NA#3. She stated she was nice to her residents and was very passionate. NA#3 said Resident #1 was not on her assignment and she did not put her to bed on 7/11/18.
2. Resident #3 was admitted to the facility on 5/23/14.

Resident #3 ' s quarterly Minimum Data Set (MDS) dated 6/1/18 review revealed the resident had adequate hearing, clear speech, and can understand and was understood. The resident had impaired vision and required glasses. The cognition was intact. The resident required extensive assistance of 2 staff members for transfer, bathing, bed mobility, dressing, and all other activities of daily living (ADL) except the meal was set up. The resident ' s active diagnoses were anemia, cerebral vascular accident, hemiplegia, hereditary and idiopathic

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neuropathy, and contracture of the left hand and wrist.

The care plan dated 6/12/18 revealed goals and interventions documented for transfer deficit, ADL dependence related to chronic disease, total extensive assistance, cardiac deficit and diuretic, anemia, at risk for falls, pain, at risk for skin breakdown and pressure ulcer, and incontinence of bowel and bladder.

On 7/31/18 at 10:00 am an interview was conducted with Resident #3 who stated Nursing Assistant (NA) #1 was short with her during communication or did not communicate when she provided care. The resident felt like the NA rushed her and did not care about the resident. The resident had to direct and re-direct the NA to complete the incontinence and personal care she preferred (i.e. peri care or items within reach). The resident had not informed any facility staff but discussed the concern regarding care provided by NA #1 at the resident council meeting last week.

On 8/1/18 at 8:45 am an interview was conducted with Resident #3 who stated she informed the facility during last week ' s resident council meeting about NA #1 who needed to be reminded of the resident ' s choices during care (i.e. rush through incontinence care and did not feel clean and there was lack of communication). The facility member present during the meeting was the Director of Activities who informed the meeting members she would bring the concerns to the Unit Managers. The concern was also placed in the resident council meeting minutes last week.

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On 8/1/18 at 10:00 am an interview was conducted with the Unit Manager who stated she was informed last week of the concerns voiced during resident council regarding NA #1 ' s care provided to the residents was rushed and not thorough and a meeting had not yet been planned. The Unit Manager had not had the opportunity to plan a meeting to date.

On 8/1/18 at 9:00 am an interview was conducted with the Administrator who stated that NA #1 was terminated for repeatedly arriving to the facility late for her shift. The Administrator also stated that she would expect the NAs to honor the resident ' s request for choice of personal care needs by following the resident ' s direction and their care plan.

A review of the July 2018 resident council meeting revealed documentation that the residents, voiced concern with a nursing assistant on Hall 400 (particulars were not provided).

3. Resident #5 was admitted to the facility on 12/26/17.

The quarterly Minimum Data Set (MDS) dated 5/24/18 review revealed the resident had adequate hearing, clear speech, and was understood and understands. The cognition was intact. The resident required extensive assistance of two staff for all transfers, and one staff member for all other activities of daily living except meals were set up. The active diagnoses were cerebral vascular accident, hemiplegia, dysarthria, and a paralytic gait.

The care plan dated 5/29/18 reviewed had goals and interventions for ADL deficit, at risk for

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cardiac complications and fall, at risk for decreased mobility, at risk for discomfort, potential for skin breakdown, incontinent of bowel and bladder (intervention was to assist or provide care as needed), and urinary catheter secondary to neurogenic bladder.

On 7/31/18 at 10:10 am an interview was conducted with Resident #5 who stated she had a concern about how NA #1 who provided personal care. The resident felt NA #1 was short when she spoke to the resident because she was rushing through care and not following the resident ' s requests. Due to the rushing, occasionally things got forgotten (i.e. not leaving tissues or the call bell within reach). The resident felt the NA ' s rushing was impatience with her responding with short answers or being ignored by the NA.

On 8/1/18 at 8:45 am an interview was conducted with Resident #5 who stated she informed the facility during last week ' s resident council meeting about NA #1 who needed to be reminded of the resident ' s choices (i.e. not to rush and provide thorough incontinence care) and forgetting things (i.e. leave call bell within reach) during care. The facility member present during the meeting was the Director of Activities who informed the meeting members she would bring the concerns to the Unit Managers. The concern was also placed in the resident council meeting minutes last week.

On 8/1/18 at 9:00 am an interview was conducted with the Administrator who stated that NA #1 was terminated for repeatedly arriving to the facility late for her shift. The Administrator also stated that she would expect the NAs to honor the resident ' s request for personal care needs as

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requested, according to the resident ' s care plan and facility policy (i.e. drink and call bell within reach).

A review of the July 2018 resident council meeting revealed documentation that the resident, voiced concern with a nursing assistant on Hall 400 (particulars were not provided).

4. Resident #6 was admitted on 5/16/16.

Review of Resident #6 ' s quarterly Minimum Data Set (MDS) dated 7/3/18 revealed the resident had adequate hearing, clear speech, and was understood and understands. Cognition was intact. The resident required extensive assistance of one person for all ADLs except transfer was two persons and meal was one-person limited assistance. Active diagnoses were heart failure, cerebral vascular accident, pulmonary hypertension, and unilateral osteoarthritis of the knee.

The care plan dated 7/14/18 review revealed goals and interventions for ADL deficit, cardiac disease, diuretic therapy, potential for fluid volume overload, at risk for fall, pain management, potential for skin breakdown, and incontinence of bowel and bladder.

On 7/31/18 at 4:20 PM an interview was conducted with Nurse #1 who cared for Resident #6 and stated that the resident complained about NA #1 recently. The complaint was "providing assistance the nursing assistant ' s way and communication -- could not remember specifics." Nurse #1 informed the Unit Manager. Nurse #1 stated she had not observed any concerns with communication with residents or staff by NA #1;

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however, NA #1 was always late past the time for the first incontinence rounds. NA #1 arrived whenever she wanted. NA #1 was counted on the schedule and the lateness caused the Unit Manager to reassign coverage for incontinence care for sufficient staffing on each hall.

On 7/31/18 at 4:55 pm an observation was done of NA #1 who provided incontinence care to Resident #6. NA #1 wheeled the resident to her room. The resident requested her incontinence care be done in the large shower room bathroom. NA #1 asked the resident if she wanted to get into her bed and the resident stated no she wanted to "use the bathroom in the large shower room it was easier to stand." NA #1 wheeled the resident to the large shower room that was vacant. NA #1 was directed by the resident to wheel her to the sink. NA #1 again asked the resident if she would get into her bed for incontinence care, "wouldn ' t it be easier." The resident stated no I want to stand at the sink to be washed and have a new undergarment placed. NA #1 asked don ' t you want to get into bed and the resident replied, "no I do not like to have incontinence care in my bed." NA #1 provided incontinence care as the resident requested after three resident requests.

On 8/1/18 at 9:00 am an interview was conducted with the Administrator who stated that NA #1 was terminated for repeatedly arriving to the facility late for her shift. The Administrator also stated that she would expect the NAs to honor the resident ' s request for personal care needs.

A review of the July 2018 resident council meeting revealed documentation that the residents, voiced concern with a nursing assistant on Hall 400 (particulars were not provided).

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F 600 SS=G	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 observation, medical record review, resident and staff interviews, the facility failed to prevent staff to resident abuse for one of three residents reviewed for abuse. Resident #1 sustained bruising and pain when a staff member transferred her from her wheelchair to her bed by grabbing her wrists. Resident #1 was physically abused when a nursing assistant physically placed her into bed against her wishes which resulted in the resident experiencing bruises to her left upper arm, top of left hand, right elbow, and right upper arm and pain. The findings included: Resident #1 was admitted to the facility 9/25/17. Cumulative diagnoses included chronic obstructive pulmonary disease, atrial fibrillation, rheumatoid arthritis and contractures of bilateral knees and bilateral hands.	F 600	Resident # 1 currently resides in the center, without signs of abuse. She is currently having all her needs met and preferences followed. The minor injuries she received related to this event have healed. Alert & oriented residents were interviewed about whether they felt they are being abused (verbal, physical or sexual) by staff, another resident or anyone else. No residents voiced concerns. Non-verbal residents and residents who are not alert and oriented have been assessed for any signs of injuries/abuse. No other residents noted to be effected. Education was provided to current facility staff, agency staff and contracted staff on	8/25/18

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F 600	Continued From page 10 A care plan originally dated 12/24/17 and last reviewed on 6/25/18 indicated Resident #1 was at risk for injury or complications related to the use of anticoagulation therapy. Interventions included, in part, anticoagulants given as ordered. Labs as ordered. Observe for complaints of pain of bone, abdomen or joint. Observe for active bleeding, i.e. hematuria, bruising, etc. A care plan dated 4/1/18 and last reviewed on 6/25/18 stated Resident #1 exhibited or was at risk for bruising/skin tears as evidenced by frail fragile skin. Interventions included, in part, observe skin condition daily with ADL (activities of daily living) care and report abnormalities. A quarterly Minimum Data Set (MDS) dated 7/1/18 indicated Resident #1 was cognitively intact. She required extensive assistance of one person for bed mobility and two-person assist with transfers and toilet use. A review of physician orders for July 2018 revealed Resident #1 had orders for Prednisone (corticosteroid) 5 milligrams by mouth daily and Plavix (anti-blood clotting medication) 75 milligrams by mouth daily. A skin assessment dated 7/11/18 revealed Resident #1 had a skin tear on the left medial shin/calf area. No bruises were noted. A twenty-four-hour facility reported incident report dated 7/12/18 at 12:52 PM stated the facility was made aware of the incident on 7/12/18 at 10:40 AM. The incident date was 7/11/18. Resident #1 stated Nursing Assistant (NA#3) hurt her while putting her to bed on 7/11/18. Bruises were noted	F 600	Abuse/Neglect, Newly hired staff will be educated on abuse prevention upon hire. Ten Alert & oriented residents will be interviewed by the Interdisciplinary Team weekly for two weeks then monthly for one month, then randomly thereafter. The questions will be centered on whether they felt they are being abused (verbal, physical or sexual) by staff, another resident or anyone else. Ten non-interviewable residents will be assessed for injury weekly for two weeks then monthly for one month. After completion of the Resident Council Minutes, the Interdisciplinary Team will review for any concerns addressed regarding resident abuse/neglect. The Nursing Home Administrator/Designee will review the audits upon completion and report any concerns voiced to the Director of Nursing and also report on outcomes at the morning meeting for any recommendations or additional training that might be needed. Audits and Resident Council Minutes will be forwarded to the monthly Quality Assurance Performance Improvement Meeting for two months to identify trends and opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued compliance and the Center Executive Director is responsible for the follow up.	

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F 600	Continued From page 11	F 600		

to the left upper arm, top of left hand, right elbow, and right upper arm. Additions/ changes/ updates added to the facility reported incident stated, per Resident #1, she told NA#3 when she approached her that she did not want to go to bed, but the aide proceeded to grab her arm to put her in bed. The resident told the aide "Stop, you ' re hurting me and I ' m going to have a big bruise tomorrow." She stated the aide replied, "I ' m not hurting you" and proceeded to place her in bed turning her fast and hard. Resident #1 was tearful about the incident but easily comforted. NA #3 was terminated 7/18/18. The allegation was substantiated. Other employment actions: alleged perpetrator-NA#3 was suspended pending investigation. Training was initiated immediately to refresh staff on proper technique for a gait belt transfer of resident. Corrective actions taken-- NA#3 was suspended. Abuse training initiated immediately. Training initiated to refresh staff on proper technique for a gait belt transferring of residents. Will report to the board of nursing. Alert and oriented residents were questioned to rule out alleged abuse. Cognitively impaired residents had skin checked. Other staff questioned. Pain evaluation, skin check and change in condition of involved resident.

Law enforcement was notified on 7/12/18 at 12:35 PM. A review of the police report dated 7/12/18 revealed no charges were filed.

A skin assessment dated 7/12/18 at 10:40 AM revealed the following: bruising to the bilateral upper extremities with a bruise on the left upper extremity that measured 10 centimeters (cm) x 10.5 cm, the left hand 6.5 cm x 6.5 cm and the right upper arm that measured 2 cm x 2 cm.

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A change in condition form dated 7/12/18 stated bruising was noted to the left upper arm, top of left hand and right upper arm. The back of the left-hand ecchymosis (bruised area) area measured 6.5 cm x 6.5 cm; right elbow discoloration 3.5 cm x 2 cm; left upper arm ecchymosis area 10 cm x 10.5 cm. right upper arm ecchymosis 2 cm x 2cm. with Resident #1 noting pain in left upper arm.

A Lift transfer repositioning evaluation form dated 7/13/18 stated Resident #1 could weight bear and stand consistently for a stand to pivot transfer. A gait/ transfer belt was required for transfers. The evaluation did not specify one or two -person assist.

A review of NA#3 ' s employment record revealed she was hired on 5/15/18 and received abuse training on 5/18/18.

An x-ray report dated 7/13/18 stated the following: Conclusion: x-rays were completed for the left elbow joint, left forearm, left hand and wrist, left shoulder and left humerus with no fracture or other significant bone or joint abnormality noted.

As part of the investigation, the Social Worker conducted an interview with Resident #1 on 7/12/18 at 10:40 AM. The interview was part of the witness investigation statements. Resident #1 stated that last night (7/11/18) a nursing assistant came into her room and told Resident #1 that she was going to put her to bed. Resident #1 said she told the nursing assistant that she didn ' t want to go to bed. However, the nursing assistant insisted that she was "told to put her to bed" and she was going to proceed with putting her to bed. Resident #1 reported that the nursing

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assistant grabbed her arm to transfer her to the bed and the resident yelled out "Let go of me. You are hurting me". Resident #1 stated the nursing assistant responded, "I ' m not hurting you". The resident resounded "You are hurting me and I ' m going to have a big bruise on me tomorrow." Resident #1 said the nursing assistant continued to get her ready for bed and proceeded to change her brief. Resident #1 included "She turned me so fast and hard. I thought I was going to roll out of bed." When asked to describe the nursing assistant, the resident gave a description and name of NA#3. Resident #1 was noted to be cognitively intact at the time of the interview.

On 7/31/18 at 9:40 AM, an interview was conducted with Resident #1. When asked about the incident that occurred the evening of 7/11/18. She was unsure of the exact time, but it was nearing bedtime. She said she told NA#3 that she wasn ' t ready for bed. NA#3 grabbed her by both wrists, got her out of her wheelchair and put her on the bed. Resident #1 stated NA#3 was rough anyway and she told her that she was hurting her. After she was in bed, she told NA#3 that she hurt her arm. NA#3 was not her regular nursing assistant. Resident #1 said her roommate was in the room but was asleep at the time the incident occurred.

A witness statement given by NA #3 dated 7/12/18 at 11:10 AM was reviewed. NA #3 stated she did not remember taking care of Resident #1 on 7/11/18. She said she helped everyone even if they were not on her assignment and might have helped Resident #1 to bed. NA#3 stated she was very gentle with all residents and she did put a few to bed. NA#3 stated she remembered seeing bruises on Resident #1 ' s arm several

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days ago but did not report it to the nurse. NA#3 stated she helped Resident #1 a lot, felt like this was a conspiracy and that the nurse told Resident #1 to say NA#3 was the one who bruised her.

On 8/2/18 at 10:32 AM, a telephone interview was conducted with NA #3. She said she was nice to her residents and very passionate and caring. When asked about the incident with Resident #1 on 7/11/18, she said Resident #1 was not on her assignment and she did not put her to bed that night. NA#3 added that she had put her in bed in the past but needed to use 2 people and she didn ' t do anything wrong.

A witness statement given by NA#2 via telephone dated 7/12/18 at 4:40 PM was reviewed. NA#2 stated she provided care for Resident #1 on evening shift (3:00 PM-11:00 PM) on 7/11/18 but did not put her to bed that evening. NA#2 said she was running behind and asked NA#3 to put Resident #1 to bed. She said she did not see Resident #1 after that since it was 10:30 PM. NA#2 stated she asked NA#3 how it went and she said "fine".

On 7/31/18 at 5:01 PM, an interview was conducted with NA#2 and she stated that Resident #1 was on her assignment on 7/11/18. She stated Resident #1 used her call bell to notify staff of her needs. NA#2 stated Resident #1 needed assistance to change her brief, transfer to the bed and get dressed. She said she asked Resident #1 what time she wanted to go to bed on 7/11/18 and Resident #1 wanted to go to bed between 9:30 PM--10:00PM. NA#2 stated, during the evening of 7/11/18, NA#3 was helping her and said she would assist with putting Resident #1

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into bed. She indicated it was around 9:45PM-10:00 PM. NA#2 stated she did not see Resident #1 after she was put into bed by NA#3.

On 7/31/18 at 4:10 PM, an interview was conducted with the Center Nurse Executive. She stated Resident #1 did not tell anyone about the incident until 7/12/18. When Resident #1 got up on 7/12/18, she went around and told everybody that NA#3 had been rough with her and put her to bed when she didn.t want to go to bed and NA#3 caused bruises to her left arm. She told the Activity Director who brought her to the Center Nurse Executive ' s office, the Administrator and gave her whole statement to the Social Worker regarding the incident that occurred on 7/11/18 related to the bruises and not letting her go to bed when she wanted. The Center Nurse Executive said she suspended NA#3, obtained interviews from the alert and oriented residents on NA #3 ' s assignment and nursing staff performed skin checks on the remainder of nursing assistants on NA #3 ' s assignment. The investigation concluded the incident did occur on 7/11/18 and NA#3 was terminated.

On 7/31/18 at 4:48 PM, an interview was conducted with Nurse #1 who worked on 7/11/18 during the evening shift. She stated she was not aware of the incident with Resident #1and NA#3 until 7/12/18 when the Center Nurse Executive called her. She said she was on the hall providing care and administration of medications until around 11:00PM-11:15 PM on 7/11/18 and did not hear any screaming, no disruption. When she came in to talk to the Center Nurse Executive on 7/12/18, Resident #1 asked her didn ' t she hear her screaming? She said she did not hear anything out of the ordinary on 7/11/18 and did

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F 600	Continued From page 16 not hear Resident #1 screaming. On 8/1/18 at 11:35 AM, a second interview was conducted with the Center Nurse Executive who stated all facility staff should be educated regarding choices and abuse and that all resident ' s choices be honored. All residents should be free from abuse and abuse would not be tolerated at the facility.	F 600		
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, review of the facility abuse training and staff interviews, the facility failed to thoroughly investigate after Resident #1 sustained bruising and pain when a staff member transferred her from her wheelchair to her bed by	F 610	Resident # 1 currently resides in the center, without signs of abuse. She is currently having all her needs met and preferences followed. The minor injuries she received related to this event have	8/25/18

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F 610	Continued From page 17 grabbing her wrists on 7/11/18. The findings are: Resident #1 was admitted to the facility 9/25/17. Cumulative diagnoses included chronic obstructive pulmonary disease, atrial fibrillation, rheumatoid arthritis and contractures of bilateral knees and bilateral hands. A quarterly Minimum Data Set (MDS) dated 7/1/18 indicated Resident #1 was cognitively intact. She required extensive assistance of one person for bed mobility and two-person assist with transfers and toilet use. A skin assessment dated 7/11/18 revealed Resident #1 had a skin tear on the left medial shin/calf area. No bruises were noted. A twenty-four-hour facility reported incident report dated 7/12/18 at 12:52 PM stated the facility was made aware of the incident on 7/12/18 at 10:40 AM. The incident date was 7/11/18. Resident #1 stated Nursing Assistant (NA#3) hurt her while putting her to bed on 7/11/18. Bruises were noted to the left upper arm, top of left hand, right elbow, and right upper arm. Additions/ changes/ updates added to the facility reported incident stated, per Resident #1, she told NA#3 when she approached her that she did not want to go to bed, but the aide proceeded to grab her arm to put her in bed. The resident told the aide "Stop, you ' re hurting me and I ' m going to have a big bruise tomorrow." She stated the aide replied, "I ' m not hurting you" and proceeded to place her in bed turning her fast and hard. Resident #1 was tearful about the incident but easily comforted. NA #3 was terminated 7/18/18. The allegation was substantiated. Other employment actions: alleged perpetrator-NA#3 was suspended	F 610	healed. All alert & oriented residents were interviewed on August 1, 2018 about whether they felt they are being abused (verbal, physical or sexual) by staff, another resident or anyone else. Audit results were reviewed with the Center Nurse Executive for any additional follow up. All residents have subsequently had their skin assessed for any signs of injury, no additional findings noted. This was reviewed by the CNE. The Administrator, Director of Nursing and Interdisciplinary Team have been educated by the Regional Nurse on how to conduct a complete and thorough investigation, to include appropriate resident and staff interviews, and assessments of non-interviewable residents Current staff, including agency staff and contracted staff have been re-educated on Abuse Prevention and Reporting. The education was provided by the interdisciplinary team Upon hire, any new employee, agency staff or contracted staff will be provided with abuse/neglect and resident choice training. Monthly audits of all new hires, agency staff and contracted staff will be completed for 3 months to verify that all have received the required training. . Ten Alert & oriented residents will be interviewed by the Interdisciplinary Team	

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F 610	Continued From page 18 pending investigation. Training was initiated immediately to refresh staff on proper technique for a gait belt transfer of resident. Corrective actions taken-- NA#3 was suspended. Abuse training initiated immediately. Training initiated to refresh staff on proper technique for a gait belt transferring of residents. Will report to the board of nursing. Alert and oriented residents were questioned to rule out alleged abuse. Cognitively impaired residents had skin checked. Other staff questioned. Pain evaluation, skin check and change in condition of involved resident. On 7/31/18 at 9:20 AM, an interview was conducted with NA#4 who stated she was agency staff and received her abuse training in May at another nursing home facility. On 8/1/18 at 7:40 AM, an interview was conducted with Nurse #3. She stated she received an in-service in November 2017 when she was hired and did not remember any recent in-services about abuse. On 8/1/18 at 8:10 AM, an interview with Housekeeper #1 who said housekeeping, dietary and laundry were a contract company. She indicated, to her knowledge, she could not remember any abuse training by her company or by the facility. She said in-services were done by the contract company . On 8/1/18 at 9:44 AM, an interview was conducted with the Housekeeping Supervisor. He stated they complete abuse training on hire and the most recent training was in May 2018. Training was done online, and corporation would send him an update if anyone had not completed the training.	F 610	weekly for two weeks then monthly for one month. The questions will be centered on whether they felt they are being abused (verbal, physical or sexual) by staff, another resident or anyone else. Ten non-interviewable residents will be assessed for injury weekly for two weeks then monthly for one month. After completion of the Resident Council Meeting, the Interdisciplinary Team will review for any concerns addressed regarding resident abuse/neglect. The Nursing Home Administrator/Designee will review the audits upon completion and report any concerns voiced to the Center Nurse Executive and also report on outcomes at the morning meeting for any recommendations or additional training that might be needed. Regional Nurse will review future self-reports and subsequent investigations, for 3 months and then randomly thereafter, to ensure investigations are thorough and education is complete. New Hire Audits, Resident Audits and Resident Council Minutes will be forwarded to the monthly Quality Assurance Performance Improvement Meeting for two months to identify trends and opportunities for improvement. Quality Assurance reviews deficiencies annually, member□s complete audits of deficiencies to ensure continued compliance and the Center Executive	

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F 610	Continued From page 19 A review of the nurse aide registry revealed NA #3 was terminated 7/18/18. The nurse aide registry expiration date was 10/31/19, hire date 5/15/18 and abuse training last completed 5/18/18. Background check was completed prior to her hire date. A review of the abuse in-service done on 7/12/18 revealed a total of twenty-eight staff were educated regarding abuse. There was no documentation that the abuse in-service was conducted on the unit where Resident #1 resided. The total number of facility staff was 41 and there was a total of 24 agency staff working in the facility The census was 67 at the time of the complaint investigation. A review of skin checks revealed none were completed on any on 7/12/18. The Social Worker did not interview all interviewable residents in the facility on 7/12/18. What is your source? On 8/1/18 at 11:35 AM, a second interview was conducted with the Center Nurse Executive who stated her expectation was that all residents who were interviewable to be interviewed and all facility staff to be educated regarding choices and abuse and that all resident ' s choices be honored. A review of skin checks revealed there were eight residents who received skin checks on 7/17/18. There were no skin checks noted for 7/12/18. Eight alert and oriented residents who were on NA#3 ' s assignment were interviewed by the Social Worker as evidenced by her documentation on 7/12/18.	F 610	Director is responsible for the follow up.	

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F 610	Continued From page 20 On 8/1/18 at 1:39 PM, an interview was conducted with the Unit manager for 300/400 hall. She stated she came in around 12 noon on 7/12/18. There was an afternoon clinical meeting and the situation was brought up at that time and that was when the investigation began. The Unit Manager said she educated staff present on 7/12/18 (day/evening) and staff present on 300/400 on 7/13/18 but she was unable to find the in-service sign in sheet. The Unit Manager stated she did not do any interviews with alert and oriented residents. Nursing staff did not interview any on station 1. The skin checks dated 7/17/18 were routine skin checks . On 8/1/18 at 2:00 PM, an interview was conducted with the Social Worker who stated she interviewed the interviewable residents who had been on NA #3 ' s assignment and was under the impression that was her permanent assignment. She was not aware all interviewable residents should have been interviewed. On 8/1/18 at 2:30 PM, a second interview was conducted with the Administrator. She said the facility should have done a facility wide investigation by talking to all the alert and oriented residents and performing skin checks on the non-interviewable residents. Abuse in-servicing should have been done for all employees-agency staff and Woodland Hill staff.	F 610		