STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 10/18/2018

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UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

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F 000	INITIAL COMMENTS A complaint survey was conducted from 10/5/18 through 10/7/18 and 10/18/18. Immediate Jeopardy (IJ) was identified at: CFR 483.25 at Tag F689 at a Scope and Severity J. The tag F689 constitued Substandard Quality of Care. Immediate Jeopardy began on 5/19/18 and was removed on 10/6/18. An extended survey was conducted.	F 000		
F 600 SS=J	10/15/18 CMS requested addition of F600 at IJ 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 record review, observation, staff, and	F 600	Date: 10/06/2018	10/20/18

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

Electronically Signed | 10/16/2018

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F 600	Continued From page 1 resident interview the facility failed to prevent abuse for 2 (Resident's #2 and #3) of 3 sampled residents reviewed for abuse. Resident #1, a cognitively impaired resident, made an unwanted advancement into the personal space of Resident #2 and exhibited sexually aggressive behavior toward Resident #3, a cognitively impaired resident. Residents #2 specified the unwanted advancement was upsetting to her and Resident #3 was assessed by facility staff and found to have no physical injuries. Immediate Jeopardy began on 5/19/18 when Resident #1 made an unwanted advancement into the personal space of Resident #2. Immediate Jeopardy was removed on 10/6/18 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity level grid position "D" (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced. Findings included: Resident #1 was admitted to the facility on 1/12/18 and had diagnoses of traumatic brain injury, dementia, dysarthria (slowed or slurred speech), and anarthria (the inability to produce clear speech). The documentation on the most recent quarterly Minimum Data Set (MDS) assessment dated 7/27/18 coded Resident #1 as severely cognitively impaired with trouble concentrating two to six days of the assessment period. Resident #1 was also assessed as having no behaviors and ambulatory with no assistance.	F 600	Corrective action accomplished for those residents found to have been affected by the deficient practice. On 5/19/2018 at 10:00 pm, Resident #1 was observed in the room by the licensed nurse #1. Resident #1 was attempting to put his hands under resident #2□s cover while resident #2 was in bed. Resident #1 was removed from the room by licensed nurse #1. Head to toe skin assessment for resident #2 completed by licensed nurse #1 on 5/19/2018 no injuries noted. Resident #1 was placed on every 15 minutes watch check for 3 days and was discontinued as resident was noted to show no behaviors of wondering, or sexual inappropriate abusive behaviors. Resident #1 & #2 attending physician and responsible party notified. On 9/19/18 at 10:15 pm, Resident # 1, was observed in the room of resident # 3. Resident # 1 was leaning over resident #3and was observed kissing resident #3 on her mouth by certified nursing assistant #1. Resident #1 right hand was observed in resident #3 brief and left hand was observed putting his P& back in his pants. Two Nurse Aides, #1 and #2, saw resident # 1 and immediately removed him from the room. The CNAs reported it to licensed nurse #1 who completed head to toe skin assessment resident # 3 and found no signs of injury. Charge nurse #1 called the administrator at @11:30pm to inform of the incident. He advised the nurse to move patient #1 to the 100 hall which is away from Resident #3. Resident # 1 was immediately moved to another room and placed on 15 minute checks by	

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F 600	Continued From page 2 The documentation in the care plan initiated on 1/31/18 for Resident #1 had problem areas for his inability to express emotion, listen and share information due to auditory and verbal deficits. The care plan for Resident #1 was updated on 5/19/18 with the problem area that stated, "I demonstrate inappropriate behavior towards a female resident." The documentation of the approach on the care plan stated, "Place resident in area where constant observation is possible." a. The documentation in a nursing note, written by Nurse #1, dated 5/19/18 at 10:25 PM for Resident #1 stated, "Resident observed in another female resident's room on 300 hall. He had gotten in females room and was sitting in her (Resident #2) room in the wheel chair, had his hands under her covers and was attempting to touch her inappropriately without [her] consent. Resident (#2) had yelled out and had turned her call bell on to call for help. Resident (#1) was removed from her room and returned to his room and asked to go to bed for the night." Resident #2 had diagnoses of heart failure, seizure disorder, anxiety and depression. The documentation on the most recent quarterly MDS assessment dated 8/31/18 coded Resident #2 as having moderately impaired cognition and requiring extensive assistance of one person with bed mobility. Resident #2 was interviewed on 10/5/18 at 11:13 AM. Resident #2 revealed Resident #1 came in her room at night and put his hand under her bed covers. She stated she hollered and rang the call bell for help until they came and got Resident #1 out of her room. When asked how this made her feel at that time, she revealed it was "upsetting."	F 600	licensed nurse #1 to ensure he did not go in any room other than his own, effective 9/19/18 at 10:45 pm for 3 days until 9/22/18 at 7:00am then was reduced to 30 minutes check as resident exhibited no wandering behavior for 3 days. 30 minutes check was continued for 5 days until 9/26/2018 at 3pm when it was reduced to hourly as resident exhibited no wandering behavior for 5 days. On 9/28/18 Resident was observed walking up and down the hall more often than usual. Licensed nurse #2 increased the monitoring to every 30 minutes completed by certified nurse aides on duty continue until 10/1/18 at 7am when resident was noted ambulating more on hallways. Every 15 minutes checks continue until today. Every 15 minute checks will continue until resident #1 is noted to wander safely on the hallway and exhibited no signs of wandering to other resident□s room. Licensed nurse on duty will monitor to ensure the completion of 15 minutes check. Resident #1 & #3 family members were notified at the time by nurse #1. Both resident□s physicians were notified at the time and no new orders by licensed nurse #1. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. On 10/06/2018, 100% interviews was completed by Assistant Director of Nursing, Director of Social services, Registered nurse supervisor and/or Central Supplies supervisor for all current alert and oriented residents in the facility	

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F 600	Continued From page 3 She indicated she still saw Resident #1 walking in the halls but he had not come into her room after that incident. Nurse #1, a nursing supervisor, was interviewed on 10/5/18 at 4:12 PM. Nurse #1 revealed that she was the nurse on the hall where Resident #1 resided on the evening of 5/19/18 but she usually worked on the first shift (7:00 AM to 3:00 PM). She indicated Resident #1 was removed from the room of Resident #2, redirected to his own room, and went to sleep on the evening of 5/19/18. She stated she called the facility Administrator to notify him of the incident with Resident #1 and Resident #2. Nurse #1 indicated she was directed by the Administrator to "keep an eye on him (Resident #1)." Nurse #1 revealed Resident #1 was checked on every 15 minutes by the nursing staff for "a couple of days" after the 5/19/18 incident. Nurse #2, a nursing supervisor, was interviewed on 10/6/18 at 8:41 AM. Nurse #2 indicated she worked on the second shift (3:00 PM to 11:00 PM) and sometimes third shift (11:00 PM to 7:00 AM) for the hallway where Resident #1 resided in May 2018. Nurse #2 indicated that the first time Resident #1 demonstrated the concerning behavior of going into female resident rooms was on 5/19/18. She said he did have a tendency to wander but was easily redirected. Nurse #2 revealed the nursing staff kept an "eye on him" for a few days after the 5/19/18 incident but after a while the staff "felt like he was okay." Nurse #2 revealed she did not think he would hurt anybody so the nursing staff were watching him. Documentation in a nursing note dated 5/27/18 at 10:39 PM, written by Nurse #3, stated in part, "Resident has been wandering in and out of	F 600	to identify any other resident with an allegation of Abuse and/or Neglect. No other resident, voiced allegation of abuse and/or neglect, or sexual inappropriate behaviors. On 10/06/2018 100% interviews was completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and/or Nurse Manager for all employees on site on 10/6/2018 to identify any awareness of any resident with an allegation of Abuse and/or Neglect. No concerns related to abuse, neglect or sexual misappropriate behavior were voiced. This interview was completed for all staff, to include full time, part time and as needed staff. Any employee not interviewed by 10/06/2018 will not be allowed to work until interviewed. 100% interview of all current alert and oriented residents was completed on 10/6/2018 by Assistant Director of Nursing, Director of Social services, Registered nurse supervisor and/or Central Supplies supervisor to identify any resident which includes Resident #1 who has wandered into their room uninvited and exhibited any inappropriate behavior. No other resident voiced any concern regarding resident #1 or any other resident related to wandering behaviors 100% of all current employees on duty was interviewed by the Executive Director, Director of Nursing, Director of Social Services and Nursing Supervisor on 10/5/2018 and 10/6/2018 to identify if any	

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F 600	Continued From page 4 residents rooms. Resident has been easily redirected this shift." Documentation in a nursing note dated 5/28/18 at 8:52 AM, written by Nurse #3, stated in part, "Resident did have behaviors noted this shift 11 PM -7 AM. Patient was combative with writer and staff trying to keep him out of ladies bedrooms while asleep. Eventually able to redirect resident to his room and continued to monitor him throughout the shift. Supervisor and management made aware." Nurse #3, the nurse who wrote the nursing notes dated 5/27/18 at 10:39 PM and 5/28/18 at 8:52 AM, did not respond to requests for an interview. An interview was conducted Nurse #2 (second shift supervisor) on 10/6/18 at 8:41 AM. Nurse #2 revealed she was not aware of the combative behavior and attempts to get into the female residents rooms of Resident #1 on 5/28/18. An interview was conducted with Nurse #1 (first shift supervisor) on 10/6/18 at 9:32 AM. Nurse #1 revealed she was not aware of the combative behavior and attempts to get into the female residents rooms of Resident #1 on 5/28/18. The DON (Director of Nursing) was interviewed on 10/5/18 at 4:15 PM. The DON indicated she was not made aware of the 5/28/18 behavior of Resident #1. An interview was conducted with the DON on 10/6/18 at 11:31 AM. She indicated that after the 5/19/18 wandering behavior of Resident #1 the care plan was updated with the intervention of 15 minute checks as needed. She indicated that	F 600	wandering behaviors for resident #1 was noted to any resident to include residents with cognitive deficit. No other staff member voiced concerns for any additional residents beside, resident #2, and #3. Any staff member not interviewed by 10/6/2018 at 11:59pm will be not be allowed to work until interviewed. Family members for residents that are not alert and oriented were interviewed by the DON and ADON on 10/06/18 to identify any residents which includes Resident #1 who has wandered into their family member□s room uninvited and exhibited any inappropriate behavior. No family members voiced any concern regarding resident #1 or any other resident related to wandering behaviors. 100% of non interviewable residents had head to toe assessments completed by the Rn Supervisor, SDC and hall nurses on10/5/2018 and 10/6/2018 to look for any signs of abuse or signs of sexual abuse. No signs of abuse or sexual abuse were noted. Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur. Effective 10/06/2018 the ADON, Nurse supervisors, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours. This review will include completed skin assessments, incident reports for the last 24 hours, and Physician orders written in	

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F 600	Continued From page 5 after the 5/28/18 behavior of Resident #1 documented in the nursing notes the resident's care plan was updated with the interventions of frequent monitoring as needed and redirection with rest as needed. b. The documentation in an incident report regarding Resident #1 dated 9/19/18 at 10:15 PM stated, "Resident (#1) was observed in another resident's room (female Resident #3) by 2 staff member, leaning over resident kissing her on the mouth and had his right hand in her (incontinence) brief and his left hand on his penis. When staff entered room, he was removed from her room, placed on another hall and 15 minute checks were started on resident." The documentation on the incident report indicated the family of Resident #1 was notified at 11:30 PM, no injuries were noted as well as notification of the physician, DON, and Administrator. Resident #3 had diagnoses of aphasia and history of cerebral vascular accident. Documentation in an annual MDS assessment dated 8/6/18 coded Resident #3 as severely cognitively impaired with cognitive decision making skills and she was totally dependent on one or two people for all activities of daily living. Resident #3 was observed on 10/5/18 at 11:28 AM to be lying on her back in a low bed. The resident made moaning sounds but did not communicate verbally. The documentation in an incident report, written by Nurse #1, regarding Resident #3 dated 9/19/18 at 10:15 PM stated, "Resident (#3) was observed lying in her bed, another resident was standing over her kissing her in the mouth and	F 600	the last 24 hours to ensure that inappropriate behaviors documented that may indicate possible abuse, neglect, misappropriation of resident□s properties and/or injuries of unknown sources is identified and investigated thoroughly and ensure measures are put in place to prevent resident□s abuse before it happened. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. Any negative findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. Effective 10/06/2018, week end Registered Nurse supervisor and/or designated licensed nurse will review reviewing clinical documentation for the last 24 hours. Then this review will include completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that inappropriate behaviors documented that may indicate possible abuse, neglect, misappropriation of resident□s properties and/or injuries of unknown sources is identified and investigated thoroughly and ensure measures are put in place to prevent resident□s abuse before it happened. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the week end supervisor report form and	

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F 600	Continued From page 6	F 600		

had his hand in her brief. Resident was not yelling out for help, was lying there calmly." The documentation in the incident report indicated there were no injuries noted as well as notification of the physician, DON and Administrator.

Nurse #1, a nursing supervisor, was interviewed on 10/5/18 at 4:12 PM. Nurse #1 confirmed she was the nurse on the hall when Resident #1 was found in the room of Resident #3 on 9/19/18. Nurse #1 indicated she was notified by two nurse aides that Resident #1 was inappropriately touching Resident #3. She said Resident #1 was immediately returned to his room, Resident #3 was assessed for any injuries, and the Administrator was notified of the incident. Nurse #1 revealed the Administrator instructed her to move Resident #1 to another room on another hallway. Nurse #1 revealed she moved the resident to another hallway immediately and 15 minute checks were initiated for Resident #1. Nurse #1 stated she asked the two nurse aides on the hall to write statements regarding the incident. Nurse #1 stated the facility social worker was notified the next day of the events on the evening of 9/19/18.

The documentation of the incident from NA (Nurse Aide) #1 stated, "At 10:15 PM call light was on in Room [Number] and noticed there was a wheelchair by bed A. As I entered the room [I] saw [Resident #1] bent over kissing [Resident #3] in her mouth, his right hand was in her brief, his left hand was putting his private part back in his pants, after asked him what he was doing, I called for the nurse he then exited the room."

The documentation of the incident from NA #2 stated, "I was in hallway after CNA (certified

maintained in the daily clinical meeting binder.

Effective 10/6/2018, the center interdisciplinary team, which includes Director of Nursing, MDS nurse #1, MDS number #2, Registered nurse, Social worker #1, and Activity Coordinator #1, Executive director initiated a process for reviewing any resident who is noted with inappropriate wandering behaviors to identify the root cause of the behavior exhibited and put forth an appropriate intervention to prevent escalation of the behaviors and hence prevent abuse before it happened. Intervention to include but not limited to prompt psychiatric evaluation, social service consultation, one on one care, and/or medication evaluation will be implemented when appropriate to prevent possibility of abuse. Any identified issues will be addressed promptly and plan of care developed as indicated. This review will take Monday through Friday effective 10/06/2018

Effective 10/06/2018, week end RN supervisor and/or designated licensed nurse reviewing any resident who is noted with inappropriate wandering behaviors to identify the root cause of the behavior exhibited and put forth an appropriate intervention to prevent escalation of the behaviors and hence prevent abuse before it happened. Intervention to include but not limited to prompt psychiatric evaluation, social service consultation, one on one care, and/or medication evaluation will be implemented when

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F 600	Continued From page 7 nursing assistant) asked [Resident #3 what he was doing.] He was over [Resident #3's] bed and he had his private part out and then he put [it] back in his pants." An interview was conducted with the social worker on 10/5/18 at 4:56 PM. The social worker indicated that she was notified of the behavior of Resident #1 on the morning of 9/20/18. The social worker indicated the nursing staff were assessing the well-being of Resident #3 and that she did not assess Resident #3 on 9/20/18. Nurse #2, the second shift nursing supervisor, was interviewed on 10/6/18 at 8:41 AM. She stated the behavior on the evening of 9/19/18 was not the usual behavior for Resident #1. She indicated he did not usually have problematic behavior but would wander in the hallways. The DON was interviewed on 10/5/18 at 4:15 PM. The DON indicated she was notified of the behavior of Resident #1 on the morning of 9/20/18. She stated that the intervention put in place after the incident was the removal of the resident to another hallway, every 15 minutes a documented check of the resident, a mental health consult, checking of the urine for possible urinary tract infections as needed, redirection, and the encouragement of facility activities. The DON provided documentation of the 15 minute monitoring of the resident initiated on 9/19/18 and indicated that the monitoring time interval varied as the concern for the behavior of Resident #1 varied. The DON indicated the nurses staff varied the monitoring interval for the resident based on the amount of wandering he was doing. The DON stated if Resident #1 was walking around more the interval was every 15 minutes to check on	F 600	appropriate. Intervention to include but not limited to prompt psychiatric evaluation, social service consultation, one on one care, and/or medication evaluation will be implemented when appropriate to prevent possibility of abuse. Any identified issues will be addressed promptly and plan of care developed as indicated. This review will take Saturday and Sunday through Friday effective 10/06/18. Executive Director, Director of Nursing, Certified Dietary Manager, Director of Social Services and/or Staff Development Coordinator conducted re-education for current scheduled staff, full time, part time and as needed employee for all departments started on 10/5/2016. This education included identifying wandering residents, the facility□s abuse and neglect prohibition policy including prevention, protection, investigation, and notification, as well as, appropriate actions to be taken to prevent abuse from happening by early identification of warning signs from wandering residents. This education will be completed by 10/6/2018, any employee not educated by 10/06/2018 will not be allowed to work until educated on this requirement. Effective 10/6/2018, this education will be added on new hires orientation for all new facility employees. This education will also be provided annually for all staff effective 10/06/2018. The facility plans to monitor its performance to make sure that solutions are sustained. Effective 10/07/2018 the Administrator,	

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F 600	Continued From page 8 him. A review of the documentation on the location and behavior monitoring for Resident #1 indicated that various time intervals were used to monitor the resident. The documentation shows that on 9/19/18 beginning at 10:15 PM Resident #1 was monitored every 15 minutes until 6:45 AM on 9/20/18. There was no location/behavior log documentation for 9/20/18 from 7:00 AM to 9/21/18 at 2:30 PM. An interview was conducted with NA #3 on 10/6/18 at 8:04 AM. NA #3 stated that on 9/20/18 -9/21/18 she was assigned to Resident #1 on the first shift and part of the second shift. NA #3 indicated she monitored the resident every 15 minutes or 30 minutes depending what was on written on the behavior log on the clip board. NA# 3 indicted the nursing assistants did not determine the monitoring interval for Resident #1. NA #3 stated Resident #1 has been monitored every day since he arrived on the hallway. NA #3 stated she was told Resident #1 had been in a ladies room, had done something inappropriate and had to be moved to another hall. NA#3 stated that Resident #1 was being monitored so he did not go into female resident rooms. An interview was conducted with NA #4 on 10/6/18 at 7:45 AM. NA #4 indicated she was assigned to Resident #1 on 9/20/18 on the second shift and monitored the resident every 15 minutes. NA #5 was interviewed on 10/6/18 at 8:10 AM. NA #5 indicated Resident #1 was being monitored so	F 600	Director of Nursing, and/or Director of Social Services will review clinical documentation for the last 24 hours. This review will include, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that inappropriate behaviors documented that may indicate possible abuse, neglect, misappropriation of resident□s properties and/or injuries of unknown sources is identified and investigated thoroughly and ensure measures are put in place to prevent resident□s abuse before it happened. Any issues identified during this monitoring process will be addressed promptly by the DON, ADON, SDC and/or Registered Nurse supervisor. Findings from this monitoring process will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow ups are done. This monitoring process will take place daily (Monday - Friday) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 10/7/2018, Executive Director and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 he did not go into other people's rooms. NA #5 indicated she would monitor the resident every 15 to 30 minutes based on what was on the monitoring sheet at the nurses station. NA #5 indicated she was assigned to Resident #1 on 9/20/18-9/21/18 for the third shift. She stated she monitored the resident every 15 or 30 minutes on 9/20/18. NA #5 stated once or twice Resident #1 got up to use the bathroom but the majority of the time she went in to check on him he was still sleeping. The documentation on the location and behavior monitoring for Resident #1 for 9/21/18-9/25/18 indicated the resident was monitored every half hour. The documentation for the location and behavior monitoring for Resident #1 for 9/26/18-9/27/18 changed to every hour. Documentation indicated on 9/28/18 Resident #1 was monitored every half hour. There was no documentation for monitoring of Resident #1 for 9/29/18-9/30/18. The documentation indicated the behavior monitoring resumed for every 15 minutes from 10/1/18 to 10/6/18. Documentation in a physician's progress note dated 10/1/18 stated, "[Patient] has been moved to 100 Hall because he was caught sexually molesting another resident. Because adequate communication with him is impossible, we felt that the only way to help was to remove him from the hall he was on. There have been no incidents since then." The physician was interviewed on 10/6/18 at 10:45 AM. The physician indicated Resident #1 can't communicate due to a traumatic brain injury which left him unable to hear and speak clearly. He stated he was notified of both the incident	F 600	The title of the person responsible for implementing the acceptable plan of correction Effective 10/06/2018 the facility executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	

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Resident #1 had with Resident #2 and Resident #3. He stated Resident #2 was scared a little bit by Resident #1 coming in her room but he did not touch her. He stated he was not aware of any other additional incidents since Resident #1 was moved to another hallway.

The Administrator was interviewed on 10/5/18 at 4:15 PM. The Administrator confirmed he was notified of the 9/19/18 incident by a phone call from Nurse #1 late that night. He stated he did not recall sending a report to the state regarding the 9/19/18 incident with Resident #1 and acknowledged it was the facility policy to do so.

The DON was interviewed on 10/6/18 at 4:24 PM. She indicated it was her expectations that for the safety of the residents Resident #1 should have been and was removed from the situation. The DON said the priority was to keep the residents safe. She stated it was her expectation that residents be assessed, family notified, proper reporting, care planning, staff in-services as needed, and incident reports filled out after an allegation of sexual abuse.

On 10/15/18 at 6:00 PM the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation of immediate jeopardy removal on 10/17/18.

The credible allegation of immediate jeopardy removal indicated:

The creation of this Letter of Credible allegation constitutes a written allegation of compliance. Preparation and submission of this letter does not constitute an admission or agreement by the provider of the truth of the facts alleged or the

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correctness of the conclusions set forth by the surveyor agency. This letter is solely prepared because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

Date: 10/06/2018

Corrective action accomplished for those residents found to have been affected by the deficient practice.

On 5/19/2018 at 10:00 pm, Resident #1 was observed in the room by the licensed nurse #1. Resident #1 was attempting to put his hands under resident #2's cover while resident #2 was in bed. Resident #1 was removed from the room by licensed nurse #1. Head to toe skin assessment for resident #2 completed by licensed nurse #1 on 5/19/2018 no injuries noted. Resident #1 was placed on every 15 minutes watch check for 3 days and was discontinued as resident was noted to show no behaviors of wondering, or sexual inappropriate abusive behaviors. Resident #1 & #2 attending physician and responsible party notified.

On 9/19/18 at 10:15 pm, Resident # 1, was observed in the room of resident # 3. Resident # 1 was leaning over resident #3 and was observed kissing resident #3 on her mouth by certified nursing assistant #1. Resident #1 right hand was observed in resident #3 brief and left hand was observed putting his P ... back in his pants. Two Nurse Aides, #1 and #2, saw resident # 1 and immediately removed him from the room. The CNAs reported it to licensed nurse #1 who completed head to toe skin assessment resident

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3 and found no signs of injury. Charge nurse #1 called the administrator at @11:30pm to inform of the incident. He advised the nurse to move patient #1 to the 100 hall which is away from Resident #3. Resident # 1 was immediately moved to another room and placed on 15 minute checks by licensed nurse #1 to ensure he did not go in any room other than his own, effective 9/19/18 at 10:45 pm for 3 days until 9/22/18 at 7:00am then was reduced to 30 minutes check as resident exhibited no wandering behavior for 3 days. 30 minutes check was continued for 5 days until 9/26/2018 at 3 PM when it was reduced to hourly as resident exhibited no wandering behavior for 5 days. On 9/28/18 Resident was observed walking up and down the hall more often than usual. Licensed nurse #2 increased the monitoring to every 30 minutes completed by certified nurse aides on duty continue until 10/1/18 at 7 AM when resident was noted ambulating more on hallways. Every 15 minutes checks continue until today. Every 15 minute checks will continue until resident #1 is noted to wander safely on the hallway and exhibited no signs of wandering to other resident's room. Licensed nurse on duty will monitor to ensure the completion of 15 minutes check. Resident #1 & #3 family members were notified at the time by nurse #1. Both resident's physicians were notified at the time and no new orders by licensed nurse #1.

Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.

On 10/06/2018, 100% interviews was completed by Assistant Director of Nursing, Director of

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Social services, Registered nurse supervisor and/or Central Supplies supervisor for all current alert and oriented residents in the facility to identify any other resident with an allegation of Abuse and/or Neglect. No other resident, voiced allegation of abuse and/or neglect, or sexual inappropriate behaviors.

On 10/06/2018 100% interviews was completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and/or Nurse Manager for all employees on site on 10/6/2018 to identify any awareness of any resident with an allegation of Abuse and/or Neglect. No concerns related to abuse, neglect or sexual misappropriate behavior were voiced. This interview was completed for all staff, to include full time, part time and as needed staff. Any employee not interviewed by 10/06/2018 will not be allowed to work until interviewed.

100% interview of all current alert and oriented residents was completed on 10/6/2018 by Assistant Director of Nursing, Director of Social services, Registered nurse supervisor and/or Central Supplies supervisor to identify any resident which includes Resident #1 who has wandered into their room uninvited and exhibited any inappropriate behavior. No other resident voiced any concern regarding resident #1 or any other resident related to wandering behaviors

100% of all current employees on duty was interviewed by the Executive Director, Director of Nursing, Director of Social Services and Nursing Supervisor on 10/5/2018 and 10/6/2018 to identify if any wandering behaviors for resident #1 was noted to any resident to include residents with cognitive deficit. No other staff member voiced

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concerns for any additional residents beside, resident #2, and #3. Any staff member not interviewed by 10/6/2018 at 11:59 PM will be not be allowed to work until interviewed.

Family members for residents that are not alert and oriented were interviewed by the DON and ADON on 10/06/18 to identify any residents which includes Resident #1 who has wandered into their family member's room uninvited and exhibited any inappropriate behavior. No family members voiced any concern regarding resident #1 or any other resident related to wandering behaviors. 100% of non interviewable residents had head to toe assessments completed by the RN Supervisor, SDC and hall nurses on 10/5/2018 and 10/6/2018 to look for any signs of abuse or signs of sexual abuse. No signs of abuse or sexual abuse were noted.

Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur.

Effective 10/06/2018 the ADON, Nurse supervisors, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours. This review will include completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that inappropriate behaviors documented that may indicate possible abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources is identified and investigated thoroughly and ensure measures are put in place to prevent resident's abuse before it happened. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and

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appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. Any negative findings will be documented on the "daily clinical meeting form" and maintained in the daily clinical meeting binder.

Effective 10/06/2018, week end Registered Nurse supervisor and/or designated licensed nurse will review reviewing clinical documentation for the last 24 hours. Then this review will include completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that inappropriate behaviors documented that may indicate possible abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources is identified and investigated thoroughly and ensure measures are put in place to prevent resident's abuse before it happened. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the "week end supervisor report form" and maintained in the daily clinical meeting binder.

Effective 10/6/2018, the center interdisciplinary team, which includes Director of Nursing, MDS nurse #1, MDS number #2, Registered nurse, Social worker #1, and Activity Coordinator #1, Executive director initiated a process for reviewing any resident who is noted with inappropriate wandering behaviors to identify the root cause of the behavior exhibited and put forth an appropriate intervention to prevent escalation of the behaviors and hence prevent abuse before it happened. Intervention to include but not limited to prompt psychiatric evaluation, social service consultation, one on one care, and/or medication evaluation will be implemented when appropriate

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to prevent possibility of abuse. Any identified issues will be addressed promptly and plan of care developed as indicated. This review will take Monday through Friday effective 10/06/2018

Effective 10/06/2018, week end RN supervisor and/or designated licensed nurse reviewing any resident who is noted with inappropriate wandering behaviors to identify the root cause of the behavior exhibited and put forth an appropriate intervention to prevent escalation of the behaviors and hence prevent abuse before it happened. Intervention to include but not limited to prompt psychiatric evaluation, social service consultation, one on one care, and/or medication evaluation will be implemented when appropriate. Intervention to include but not limited to prompt psychiatric evaluation, social service consultation, one on one care, and/or medication evaluation will be implemented when appropriate to prevent possibility of abuse. Any identified issues will be addressed promptly and plan of care developed as indicated. This review will take Saturday and Sunday through Friday effective 10/06/18.

Executive Director, Director of Nursing, Certified Dietary Manager, Director of Social Services and/or Staff Development Coordinator conducted re-education for current scheduled staff, full time, part time and as needed employee for all departments started on 10/5/2016. This education included identifying wandering residents, the facility's abuse and neglect prohibition policy including prevention, protection, investigation, and notification, as well as, appropriate actions to be taken to prevent abuse from happening by early identification of "warning signs" from wandering residents. This education will be completed by 10/6/2018, any employee not

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educated by 10/06/2018 will not be allowed to work until educated on this requirement. Effective 10/6/2018, this education will be added on new hires orientation for all new facility employees. This education will also be provided annually for all staff effective 10/06/2018.

The facility plans to monitor its performance to make sure that solutions are sustained.

Effective 10/07/2018 the Administrator, Director of Nursing, and/or Director of Social Services will review clinical documentation for the last 24 hours. This review will include, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that inappropriate behaviors documented that may indicate possible abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources is identified and investigated thoroughly and ensure measures are put in place to prevent resident's abuse before it happened. Any issues identified during this monitoring process will be addressed promptly by the DON, ADON, SDC and/or Registered Nurse supervisor. Findings from this monitoring process will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow ups are done. This monitoring process will take place daily (Monday - Friday) for 2 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.

Effective 10/7/2018, Executive Director and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or

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modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.

The title of the person responsible for implementing the acceptable plan of correction Effective 10/06/2018 the facility executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.

Compliance Date 10/06/2018

The credible allegation was verified on 10/18/18 at 5:30 PM as evidenced by record review, observation, staff and resident interviews.

Interviews were conducted with a sample of staff members from all three shifts to verify re-education was conducted for all employees regarding identifying wandering residents, abuse policies and procedures, proper reporting, appropriate actions to be taken for residents with wandering behaviors, wandering assessment completion requirements per protocol and provision of safety for all residents. The same sample of staff members were interviewed to assure the facility interviewed them regarding additional residents effected by the wandering behavior of Resident #1.

Interviews were conducted with a sample of alert and oriented residents on all of the halls of the facility to verify they had been interviewed regarding wandering residents coming in their room uninvited and exhibiting inappropriate

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F 600	Continued From page 19 behavior. Family members for residents who were not alert and oriented were interviewed to verify they were contacted by the facility regarding any concerns for abuse or inappropriate behavior by wandering residents. Three residents that were at risk for wandering/behaviors were reviewed and all had care plans in place to address wandering behaviors and appropriate interventions in place. Observations were made of the wandering residents with no concerns noted regarding inappropriate behavior. Documentation of wandering risk assessments, in-service records, and the current behavior/wandering log for Resident #1, skin assessments of non-interviewable residents, audit tools, and clinical round checklists were reviewed. All of the evidence indicated the facility had completed the corrective action by 10/6/18.	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 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	F 607		10/20/18

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F 607	Continued From page 20 §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to report an alleged violation of sexually inappropriate behavior to the state agency within 24 hours and an investigative report within 5 working days for 1 (Resident #3) of 3 sampled residents reviewed for potential violations of abuse. Findings included: The documentation in the facility abuse prevention, intervention, reporting, and investigation policies and procedures revealed the following reporting and response steps were to be taken. The facility Executive Director was to be promptly notified of suspected or alleged incidents. The Executive Director, in conjunction with the Director of Nursing, was to notify the State licensing/certification agency. Notices to the state agency were to be submitted per requirements with the minimum notice of name of resident, room number, type of abuse, date and time the alleged incident occurred, names of all persons involved in the incident, and immediate action taken. A completed copy of the Abuse Report and written summaries of witness interviews, if any, are provided to the Executive Director per center and state guidelines. All alleged violations and all sustained incidents were to be reported to the state agency and to all other required agencies and all necessary corrective action taken depending on the results of the investigation. Resident #1 was admitted to the facility on	F 607	Date: 10/06/2018 Corrective action accomplished for those residents found to have been affected by the deficient practice. On 5/19/2018 at 10:00 pm, Resident #1 was observed in the room by the licensed nurse #1. Resident #1 was attempting to put his hands under resident #2□s cover while resident #2 was in bed. Resident #1 was removed from the room by licensed nurse #1. Head to toe skin assessment for resident #2 completed by licensed nurse #1 on 5/19/2018 no injuries noted. Resident #1 was placed on every 15 minutes watch check for 3 days and was discontinued as resident was noted to show no behaviors of wondering, or sexual inappropriate abusive behaviors. Resident #1 & #2 attending physician and responsible party notified. On 9/19/18 at 10:15 pm, Resident # 1, was observed in the room of resident # 3. Resident # 1 was leaning over resident #3. Resident #1 observed kissing resident #3 on her mouth by certified nursing assistant #1. Resident #1 right hand was observed in resident #3 brief and left hand was observed putting his P& back in his pants. Two Nurse Aides, #1 and #2, saw resident # 1 and immediately removed him from the room. The CNAs reported it to licensed nurse #1 who completed head to toe skin assessment resident # 3 and found no signs of injury. Charge nurse #1 called the administrator at @11:30pm to	

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F 607	Continued From page 21 1/12/18 and had diagnoses of traumatic brain injury, dementia, dysarthria, and anarthria. The documentation on the most recent quarterly Minimum Data Set (MDS) assessment dated 7/27/18 coded Resident #1 as severely cognitively impaired with trouble concentrating two to six days of the assessment period. Resident #1 was also assessed as having no behaviors and ambulatory with no assistance. The documentation in the care plan initiated on 1/31/18 for Resident #1 had problem areas for his inability to express emotion, listen and share information due to auditory and verbal deficits. Resident #3 had diagnoses of aphasia and history of cerebral vascular accident. Documentation in an annual MDS assessment dated 8/6/18 coded Resident #3 as severely cognitively impaired with cognitive decision making skills and she was totally dependent on one or two people for all activities of daily living. The documentation in an incident report regarding Resident #1 dated 9/19/18 at 10:15 PM stated, "Resident (#1) was observed in another resident's room (female Resident #3) by 2 staff member, leaning over resident kissing her on the mouth and had his right hand in her (incontinence) brief and his left hand on his penis. When staff entered room, her was removed from her room, place on another hall and 15 minute checks were started on resident." The documentation on the incident report indicated the family of Resident #1 was notified at 11:30 PM, no injuries were noted as well as notification of the physician, DON, and Administrator.	F 607	inform of the incident. He advised the nurse to move patient #1 to the 100 hall which is away from Resident #3. Resident # 1 was immediately moved to another room and placed on 15 minute checks by licensed nurse #1 to ensure he did not go in any room other than his own, effective 9/19/18 at 10:45 pm for 3 days until 9/22/18 at 7:00am then was reduced to 30 minutes check as resident exhibited no wandering behavior for 3 days. 30 minutes check was continued for 5 days until 9/26/2018 at 3pm when it was reduced to hourly as resident exhibited no wandering behavior for 5 days. On 9/28/18 Resident was observed walking up and down the hall more often than usual. Licensed nurse #2 increased the monitoring to every 30 minutes completed by certified nurse aides on duty continue until 10/1/18 at 7am when resident was noted ambulating more on hallways. Every 15 minutes checks continue until today. Every 15 minute checks will continue until resident #1 is noted to wander safely on the hallway and exhibited no signs of wandering to other resident□s room. Licensed nurse on duty will monitor to ensure the completion of 15 minutes check. Resident #1 & #3 family members were notified at the time by nurse #1. Both resident□s physicians were notified at the time and no new orders by licensed nurse #1. On 10/16/2018, the initial report and 5 day report were sent to the Department of Health and Human Services, for resident #3□s alleged violation of sexually inappropriate behaviors that happened on	

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F 607	Continued From page 22 The documentation in an incident report regarding Resident #3 dated 9/19/18 at 10:15 PM stated, "Resident (#3) was observed lying in her bed, another resident was standing over her kissing her in the mouth and had his hand in her brief. Resident was not yelling out for help, was lying there calmly." The documentation in the incident report indicated there were no injuries noted as well as notification of the physician, DON and Administrator. Nurse #1, a nursing supervisor, was interviewed on 10/5/18 at 4:12 PM. Nurse #1 confirmed she was the nurse on the hall when Resident #1 was found in the room of Resident #3 on 9/19/18. Nurse #1 indicated she was notified by two nurse aides that Resident #1 was inappropriately touching Resident #3. She said Resident #1 was immediately returned to his room, Resident #3 was assessed for any injuries, and the Administrator was notified of the incident. Nurse #1 revealed the Administrator instructed her to move Resident #1 to another room on another hallway. The Director of Nursing and the Administrator were interviewed on 10/5/18 at 4:15 PM. The Administrator confirmed he was notified of the 9/19/18 incident by a phone call from Nurse #1 late that night. He stated he did not recall sending a report to the state regarding Resident #1's sexually inappropriate behavior toward Resident #3 on 9/19/18 and acknowledged it was the facility policy to do so. The Director of Nursing indicated she was notified of the 9/19/18 incident on the morning of 9/20/18 and did not send a send a report to the state agency. The Director of Nursing confirmed that a report should have been sent to the state agencies.	F 607	9/19/2018, with resident #1 named as an alleged perpetrator. These reports were completed and submitted by the Director of Nursing, and reviewed by the facility Administrator. Local Law enforcement, area ombudsmen and Adult protective services were all notified of this alleged incident on 10/16/2018 as well. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. On 10/06/2018, 100% interviews was completed by Assistant Director of Nursing, Director of Social services, Registered nurse supervisor and/or Central Supplies supervisor for all current alert and oriented residents in the facility to identify any other resident with an allegation of Abuse and/or Neglect. No other resident, voiced allegation of abuse and/or neglect, or sexual inappropriate behaviors. On 10/06/2018 100% interviews was completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and/or Nurse Manager for all employees on site on 10/6/2018 to identify any awareness of any resident with an allegation of Abuse and/or Neglect. No concerns related to abuse, neglect or sexual misappropriate behavior were voiced. This interview was completed for all staff, to include full time, part time and as needed staff. Any employee not interviewed by 10/06/2018 will not be allowed to work until interviewed.	

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F 607	Continued From page 23	F 607	100% audit of all current residents clinical documentation from 9/19/2018 to current (10/16/2018) was completed by the Director of Social Services, Medical Record Supervisor and Activity Director to determine if there is any documentation that indicate sexual inappropriate behaviors or any other indication of abuse or neglect in any resident□s medical records, and if any, determine whether an initial report within two hours, and an investigative reports within 5 working days were completed and reported to the state agency and other officials as required by regulation. The audit revealed no other incident of abuse, or sexual inappropriate behaviors documented in residents medical records, without proper follow through. This audit was completed on 10/16/2018. Findings of this audit is documented on Abuse Reporting audit tool located at the facility compliance binder. 100% audit was completed by the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator of all incident reports completed within the last 30 days to identify any incident that may indicate abuse, neglect or injuries of unknown source and ensure that a proper investigation was completed and initial report within two hours, and an investigative reports within 5 working days were completed and reported to the state agency and other officials as required by regulation. The audit revealed no other incident of abuse, neglect or injury of unknown source noted. This audit was completed on 10/16/2018. Findings of this	

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F 607	Continued From page 24	F 607	audit is documented on incident reports audit tool located at the facility compliance binder. Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur. Effective 10/16/2018, Facility will report any allegation of abuse, neglect, sexual inappropriate behaviors and/or injury of unknown source immediately but not later than two hours after the allegation is made or witnessed to the facility Executive Director and to other state officials including the State Survey Agency in the accordance with State law. Chief Clinical officer completed an education on facility abuse prohibition policy and procedure to the facility Executive Director and Director of Nursing on 10/06/2018. The education included the seven components of abuse to include, screening, prevention, identification, protection, investigation, notification and reporting. The education emphasized on the methodologies to prevent, identify and report abuse, neglect or injury of unknown source per the facility□s abuse/neglect policy and procedures. Effective 10/06/2018 the ADON, Nurse Supervisors, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours. This review will include completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that inappropriate behaviors documented that	

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may indicate possible abuse, neglect, misappropriation of resident□s properties and/or injuries of unknown sources is identified and investigated thoroughly and assure measures are put in place to prevent resident□s abuse before it happened. The process will also assure proper procedure for reporting is followed based on the facility Abuse Policy and Procedures. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. Any negative findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder.

Effective 10/06/2018, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours. Then this review will include completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that inappropriate behaviors documented that may indicate possible abuse, neglect, misappropriation of resident□s properties and/or injuries of unknown sources is identified and investigated thoroughly and ensure measures are put in place to prevent resident□s abuse before it happened. The process will also assure proper procedure for reporting is followed based on the facility Abuse Policy and Procedures. This

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systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the week end supervisor report form and maintained in the daily clinical meeting binder.

Executive Director, Director of Nursing, Certified Dietary Manager, Director of Social Services and/or Staff Development Coordinator conducted re-education for current scheduled staff, full time, part time, and as needed employee for all departments. This education included the facility□s abuse and neglect prohibition policy, including prevention, protection, investigation, and notification. The emphasis of this education will placed on proper notification and time frame. This education will be completed by 10/16/2018, any employee not educated by 10/16/2018 will not be allowed to work until educated on this requirement. Effective 10/16/2018, this education will be added on new hires orientation for all new facility employees. This education will also be provided annually for all staff effective 10/16/2018.

The facility plans to monitor its performance to make sure that solutions are sustained.
Effective 10/16/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with abuse policies and procedures, specifically in the area of reporting through reviewing clinical documentation for the last 24 hours. This

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F 607	Continued From page 27	F 607	review will include, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that inappropriate behaviors documented that may indicate possible abuse, neglect, misappropriation of resident□s properties and/or injuries of unknown sources is identified, and reported per facility abuse policy and procedures. Any issues identified during this monitoring process will be addressed promptly by the DON, ADON, SDC and/or Registered Nurse supervisor. Findings from this monitoring process will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow ups are done. This monitoring process will take place daily (Monday - Friday) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 10/16/2018, Facility Administrator and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. The title of the person responsible for implementing the acceptable plan of	

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F 607	Continued From page 28	F 607	correction Effective 10/16/2018 the facility executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance. Compliance Date 10/16/2018	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 record review, observation, staff, and resident interview the facility failed to provide supervision of 1 (Resident #1) of 3 sampled residents reviewed for wandering behavior resulting in unwanted advancement into the personal space of Resident #2 and the sexually aggressive behavior exhibited toward Resident #3. Immediate Jeopardy began on 5/19/18 and was removed on 10/6/18 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level grid position (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and	F 689	Date: 10/06/2018 Corrective action accomplished for those residents found to have been affected by the deficient practice. On 5/19/2018 at 10:00 pm, Resident #1 was observed in the room by the licensed nurse #1. Resident #1 was attempting to put his hands under resident #2□s cover while resident #2 was in bed. Resident #1 was removed from the room by licensed nurse #1. Head to toe skin assessment for resident #2 completed by licensed nurse #1 on 5/19/2018 no injuries noted. Resident #1 was placed on every 15 minutes watch check for 3 days and was discontinued as resident was noted to	10/20/18

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F 689	Continued From page 29 all staff have been in-serviced. Findings included: Resident #1 was admitted to the facility on 1/12/18 and had diagnoses of traumatic brain injury, dementia, dysarthria (slowed or slurred speech), and anarthria (the inability to produce clear speech). The documentation on the most recent quarterly Minimum Data Set (MDS) assessment dated 7/27/18 coded Resident #1 as severely cognitively impaired with trouble concentrating two to six days of the assessment period. Resident #1 was also assessed as having no behaviors and ambulatory with no assistance. Resident #1 was not coded as having wandering behaviors that would affect others. The documentation in the care plan initiated on 1/31/18 for Resident #1 had problem areas for his inability to express emotion, listen and share information due to auditory and verbal deficits. The documentation in a nursing note dated 5/19/18 at 10:25 PM for Resident #1 stated, "Resident observed in another female resident's room on 300 hall. He had gotten in females room and was sitting in her (Resident #2) room in the wheel chair, had his hands under her covers and was attempting to touch her inappropriately without [her] consent. Resident (#2) had yelled out and had turned her call bell on to call for help. Resident (#1) was removed from her room and returned to his room and asked to go to bed for the night." Resident #2 had diagnoses of heart failure,	F 689	show no behaviors of wondering. Resident #1 & #2 attending physician and responsible party notified. On 9/19/18 at 10:15 pm, Resident # 1, was observed in the room of resident # 3. Resident # 1 was leaning over resident #3. Resident #1 observed kissing resident #3 on her mouth by certified nursing assistant #1. Resident #1 right hand was observed in resident #3 brief and left hand was observed putting his P& back in his pants. Two Nurse Aides, #1 and #2, saw resident # 1 and immediately removed him from the room. The CNAs reported it to licensed nurse #1 who completed head to toe skin assessment resident # 3 and found no signs of injury. Charge nurse #1 called the administrator at @11:30pm to inform of the incident. He advised the nurse to move patient #1 to the 100 hall which is away from Resident #3. Resident # 1 was immediately moved to another room and placed on 15 minute checks by licensed nurse #1 to ensure he did not go in any room other than his own, effective 9/19/18 at 10:45 pm for 3 days until 9/22/18 at 7:00am then was reduced to 30 minutes check as resident exhibited no wandering behavior for 3 days. 30 minutes check was continued for 5 days until 9/26/2018 at 3pm when it was reduced to hourly as resident exhibited no wandering behavior for 5 days. On 9/28/18 Resident was observed walking up and down the hall more often than usual. Licensed nurse #2 increased the monitoring to every 30 minutes completed by certified nurse aides on duty continue until 10/1/18 at 7am when resident was	

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seizure disorder, anxiety and depression. The documentation on the most recent quarterly MDS assessment dated 8/31/18 coded Resident #2 as having moderately impaired cognition and requiring extensive assistance of one person with bed mobility.

Resident #2 was interviewed on 10/5/18 at 11:13 AM. Resident #2 revealed Resident #1 came in her room at night and put his hand under her bed covers. She stated she hollered and rang the call bell for help until they came and got Resident #1 out of her room. When asked how this made her feel at that time, she revealed it was "upsetting." She indicated she still saw Resident #1 walking in the halls but he had not come into her room after that incident.

The care plan for Resident #1 was updated on 5/19/18 with the problem area that stated, "I demonstrate inappropriate behavior towards a female resident." The documentation of the approach on the care plan stated, "Place resident in area where constant observation is possible."

Nurse #1, a nursing supervisor, was interviewed on 10/5/18 at 4:12 PM. Nurse #1 revealed that she was the nurse on the hall where Resident #1 resided on the evening of 5/19/18 but she usually worked on the first shift (7:00 AM to 3:00 PM). She indicated Resident #1 was removed from the room of Resident #2, redirected to his own room, and went to sleep on the evening of 5/19/18. She stated she called the facility Administrator to notify him of the incident with Resident #1 and Resident #2. Nurse #1 indicated she was directed by the Administrator to "keep an eye on him (Resident #1)." Nurse #1 revealed Resident #1 was checked on every 15 minutes by the nursing staff noted ambulating more on hallways. Every 15 minutes checks continue until today. Every 15 minute checks will continue until resident #1 is noted to wander safely on the hallway and exhibited no signs of wandering to other residents room. Licensed nurse on duty will monitor to ensure the completion of 15 minutes check. Resident #1 & #3 family members were notified at the time by nurse #1. Both resident□s physicians were notified at the time and no new orders by licensed nurse #1.
Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.
100% of wandering risk assessments for all current residents with wandering behavior completed by the Director of Nursing on 10/6/18 to identify if any resident exhibited wandering behaviors in the past 7 days, no other resident identified with wandering attempt in the last 7 days.
100% interview of all current alert and oriented resident was completed on 10/6/2018 by Assistant Director of Nursing, Director of Social services, Registered nurse supervisor and/or Central Supplies supervisor to identify any resident to include Resident #1 has wandered in their room uninvited and exhibited any inappropriate behavior. No other resident voiced any concern regarding resident #1 or any other resident related to wandering behaviors

100% interview of all current employees

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F 689	Continued From page 31 for "a couple of days" after the 5/19/18 incident. Nurse #2, a nursing supervisor, was interviewed on 10/6/18 at 8:41 AM. Nurse #2 indicated she worked on the second shift (3:00 PM to 11:00 PM) and sometimes third shift (11:00 PM to 7:00 AM) for the hallway where Resident #1 resided in May 2018. Nurse #2 indicated that the first time Resident #1 demonstrated the concerning behavior of going into female resident rooms was on 5/19/18. She said he did have a tendency to wander but was easily redirected. Nurse #2 revealed the nursing staff kept an "eye on him" for a few days after the 5/19/18 incident but after a while the staff "felt like he was okay." Nurse #2 revealed she did not think he would hurt anybody so the nursing staff were watching him. Documentation in the nursing notes from 5/20/18 to 5/26/18 revealed the resident was not noted to have any inappropriate behaviors at night but did ambulate in the hallways of the facility. There was no documentation in the nursing notes to indicate the resident was wandering into other resident's rooms between 5/20/18 to 5/26/18. Documentation in a nursing note dated 5/27/18 at 10:39 PM stated in part, "Resident has been wandering in and out of residents rooms. Resident has been easily redirected this shift." Documentation in a nursing note dated 5/28/18 at 8:52 AM stated in part, "Resident did have behaviors noted this shift 11PM -7AM. Patient was combative with writer and staff trying to keep him out of ladies bedrooms while asleep. Eventually able to redirect resident to his room and continued to monitor him throughout the shift. Supervisor and management made aware."	F 689	on duty interviewed by the Executive Director, Director of Nursing and/or Director of Social Services on 10/5/2018 and 10/6/2018 to identify if any wandering behaviors for resident #1 was noted to any resident to include residents with cognitive deficit. No other staff member voiced concerns for any additional residents beside, resident #2, and #3. Any staff member not interviewed by 10/6/2018 at 11:59pm will be not be allowed to work until interviewed. Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur. Effective 10/6/2018, and moving forward, licensed nurses will complete Wandering risk assessments for all residents on admission/re-admission, quarterly, with any significant changes of resident□s condition, and/or whenever a resident is noted to exhibit wandering behaviors/attempts. Any noted concerns will be addressed and corrected by licensed nurses immediately; interventions will be implemented and resident□s care plan will be revised and updated immediately by licensed nurses. Direct care staff will be notified of new interventions put forth by a licensed nurse through resident□s care guide which are located in each nursing station. Effective 10/6/2018, the center interdisciplinary team, which includes Director of Nursing, MDS nurse #1, MDS number #2, Registered nurse, Social worker #1, and Activity Coordinator #1,	

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F 689	Continued From page 32 Nurse #3, the nurse who wrote the nursing note dated 5/27/18 at 10:39 PM and 5/28/18 at 8:52 AM, did not respond to requests for an interview. An interview was conducted Nurse #2 (second shift supervisor) on 10/6/18 at 8:41 AM. Nurse #2 revealed she was not aware of the combative behavior and attempts to get into the female residents rooms of Resident #1 on 5/28/18. An interview was conducted with Nurse #1 (first shift supervisor) on 10/6/18 at 9:32 AM. Nurse #1 revealed she was not aware of the combative behavior and attempts to get into the female residents rooms of Resident #1 on 5/28/18. The DON (Director of Nursing) was interviewed on 10/5/18 at 4:15 PM. The DON indicated she was not made aware of the 5/28/18 behavior of Resident #1. An interview was conducted with the DON on 10/6/18 at 11:31 AM. She indicated that after the 5/19/18 wandering behavior of Resident #1 the care plan was updated with the intervention of 15 minute checks as needed. She indicated that after the 5/28/18 behavior of Resident #1 documented in the nursing notes the resident's care plan was updated with the interventions of frequent monitoring as needed and redirection with rest as needed. Review of the medical record for Resident #1 did not reveal any documentation to indicate any behavior or wandering problems in June, July, or August of 2018. Documentation on the care plan for Resident #1 was updated on 8/1/18 for the problem of a risk	F 689	Executive director initiated a process for reviewing any resident who is noted with inappropriate wondering behaviors to identify the root cause of the behavior exhibited and put forth an appropriate intervention to prevent the reoccurrence. Intervention to include but not limited to prompt psychiatric evaluation, social service consultation, one on one care, and/or medication evaluation will be implemented when appropriate. Any identified issues will be addressed promptly and plan of care developed as indicated. This review will take Monday through Friday effective 10/6/18 Effective 10/6/2018, week end RN supervisor and/or designated licensed nurse reviewing any resident who is noted with inappropriate wandering behaviors to identify the root cause of the behavior exhibited and put forth an appropriate intervention to prevent the reoccurrence. Intervention to include but not limited to prompt psychiatric evaluation, social service consultation, one on one care, and/or medication evaluation will be implemented when appropriate. Any identified issues will be addressed promptly and plan of care developed as indicated. This review will take Saturday and Sunday through Friday effective 10/6/18. Executive Director, Director of Nursing, Certified Dietary Manager, Director of Social Services and/or Staff Development Coordinator conducted re-education for current scheduled staff, full time, part time	

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for unsupervised exits from the facility related to cognitive impairment and restlessness. Some of the interventions included encouraging socialization with other peers as appropriate, at risk wandering protocol, and allow to ventilate feelings related to stay at the facility.

There was also no documentation of wandering into residents' rooms in the nursing notes for Resident #1 from 9/7/18 to 9/23/18.

The documentation in an incident report, written by Nurse #1, regarding Resident #1 dated 9/19/18 at 10:15 PM stated, "Resident (#1) was observed in another resident's room (female Resident #3) by 2 staff member, leaning over resident kissing her on the mouth and had his right hand in her (incontinence) brief and his left hand on his penis. When staff entered room, he was removed from her room, placed on another hall and 15 minute checks were started on resident." The documentation on the incident report indicated the family of Resident #1 was notified at 11:30 PM, no injuries were noted as well as notification of the physician, DON, and Administrator.

Resident #3 had diagnoses of aphasia and history of cerebral vascular accident. Documentation in an annual MDS assessment dated 8/6/18 coded Resident #3 as severely cognitively impaired with cognitive decision making skills and she was totally dependent on one or two people for all activities of daily living.

Resident #3 was observed on 10/5/18 at 11:28 AM to be lying on her back in a low bed. The resident made moaning sounds but did not communicate verbally.

and as needed employee for all departments started on 10/5/2016. This education included identifying wandering residents, abuse policy and procedures, proper reporting, appropriate actions to be taken for residents with wandering behaviors, wandering assessment completion requirements per protocol and provision of safety for all residents. This education will be completed by 10/6/2018, any employee not educated by 10/6/18 will not be allowed to work until educated on this requirement. Effective 10/6/2018. This education will be added on new hires orientation education for all new facility employees. This education will also be provided annually for all staff.

The facility plans to monitor its performance to make sure that solutions are sustained.
Effective 10/07/2018 the Director of Nursing, Assistant Director or Nursing, RN supervisors will review daily documentation and 24 hours reports to identify any indication of wandering behaviors. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow ups are done. This monitoring process will take place daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.
Effective 10/6/2018, Executive Director and/or Director of Nursing will report

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F 689	Continued From page 34 The documentation in an incident report regarding Resident #3 dated 9/19/18 at 10:15 PM stated, "Resident (#3) was observed lying in her bed, another resident was standing over her kissing her in the mouth and had his hand in her brief. Resident was not yelling out for help, was lying there calmly." The documentation in the incident report indicated there were no injuries noted as well as notification of the physician, DON and Administrator. Nurse #1, a nursing supervisor, was interviewed on 10/5/18 at 4:12 PM. Nurse #1 confirmed she was the nurse on the hall when Resident #1 was found in the room of Resident #3 on 9/19/18. Nurse #1 indicated she was notified by two nurse aides that Resident #1 was inappropriately touching Resident #3. She said Resident #1 was immediately returned to his room, Resident #3 was assessed for any injuries, and the Administrator was notified of the incident. Nurse #1 revealed the Administrator instructed her to move Resident #1 to another room on another hallway. Nurse #1 revealed she moved the resident to another hallway immediately and 15 minute checks were initiated for Resident #1. Nurse #1 stated she asked the two nurse aides on the hall to write statements regarding the incident. Nurse #1 stated the facility social worker was notified the next day of the events on the evening of 9/19/18. The documentation of the incident from NA (Nurse Aide) #1 stated, "At 10:15 PM call light was on in Room [Number] and noticed there was a wheelchair by bed A. As I entered the room [I] saw [Resident #1] bent over kissing [Resident #3] in her mouth, his right hand was in her brief, his	F 689	findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. The title of the person responsible for implementing the acceptable plan of correction Effective 10/06/2018 the facility executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	

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left hand was putting his private part back in his pants, after asked him what he was doing, I called for the nurse he then exited the room."

The documentation of the incident from NA #2 stated, "I was in hallway after CNA (certified nursing assistant) asked [Resident #3 what he was doing.] He was over [Resident #3's] bed and he had his private part out and then he put [it] back in his pants."

An interview was conducted with the social worker on 10/5/18 at 4:56 PM. The social worker indicated that she was notified of the behavior of Resident #1 on the morning of 9/20/18. The social worker indicated the nursing staff were assessing the well-being of Resident #3 and that she did not assess Resident #3 on 9/20/18.

Nurse #2, the second shift nursing supervisor, was interviewed on 10/6/18 at 8:41 AM. She stated the behavior on the evening of 9/19/18 was not the usual behavior for Resident #1. She indicated he did not usually have problematic behavior but would wander in the hallways.

The DON was interviewed on 10/5/18 at 4:15 PM. The DON indicated she was notified of the behavior of Resident #1 on the morning of 9/20/18. She stated that the intervention put in place after the incident was the removal of the resident to another hallway, every 15 minutes a documented check of the resident, a mental health consult, checking of the urine for possible urinary tract infections as needed, redirection, and the encouragement of facility activities. The DON provided documentation of the 15 minute monitoring of the resident initiated on 9/19/18 and indicated that the monitoring time interval varied

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as the concern for the behavior of Resident #1 varied. The DON indicated the nurses staff varied the monitoring interval for the resident based on the amount of wandering he was doing. The DON stated if Resident #1 was walking around more the interval was every 15 minutes to check on him.

A review of the documentation on the location and behavior monitoring for Resident #1 indicated that various time intervals were used to monitor the resident. The documentation shows that on 9/19/18 beginning at 10:15 PM Resident #1 was monitored every 15 minutes until 6:45 AM on 9/20/18.

There was no location/behavior log documentation for 9/20/18 from 7:00 AM to 9/21/18 at 2:30 PM.

An interview was conducted with NA #3 on 10/6/18 at 8:04 AM. NA #3 stated that on 9/20/18 -9/21/18 she was assigned to Resident #1 on the first shift and part of the second shift. NA #3 indicated she monitored the resident every 15 minutes or 30 minutes depending what was on written on the behavior log on the clip board. NA# 3 indicted the nursing assistants did not determine the monitoring interval for Resident #1. NA #3 stated Resident #1 has been monitored every day since he arrived on the hallway. NA #3 stated she was told Resident #1 had been in a ladies room, had done something inappropriate and had to be moved to another hall. NA#1 stated that Resident #1 was being monitored so he did not go into female resident rooms.

An interview was conducted with NA #4 on 10/6/18 at 7:45 AM. NA #4 indicated she was

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assigned to Resident #1 on 9/20/18 on the second shift and monitored the resident every 15 minutes.

NA #5 was interviewed on 10/6/18 at 8:10 AM. NA #5 indicated Resident #1 was being monitored so he did not go into other people's rooms. NA #5 indicated she would monitor the resident every 15 to 30 minutes based on what was on the monitoring sheet at the nurses station. NA #5 indicated she was assigned to Resident #1 on 9/20/18-9/21/18 for the third shift. She stated she monitored the resident every 15 or 30 minutes on 9/20/18. NA #5 stated once or twice Resident #1 got up to use the bathroom but the majority of the time she went in to check on him he was still sleeping.

The documentation on the location and behavior monitoring for Resident #1 for 9/21/18-9/25/18 indicated the resident was monitored every half hour. The documentation for the location and behavior monitoring for Resident #1 for 9/26/18-9/27/18 changed to every hour. Documentation indicated on 9/28/18 Resident #1 was monitored every half hour. There was no documentation for monitoring of Resident #1 for 9/29/18-9/30/18. The documentation indicated the behavior monitoring resumed for every 15 minutes from 10/1/18 to 10/6/18.

Documentation in a physician's progress note dated 10/1/18 stated, "[Patient] has been moved to 100 Hall because he was caught sexually molesting another resident. Because adequate communication with him is impossible, we felt that the only way to help was to remove him from the hall he was on. There have been no incidents since then."

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The physician was interviewed on 10/6/18 at 10:45 AM. The physician indicated Resident #1 can't communicate due to a traumatic brain injury which left him unable to hear and speak clearly. He stated he was notified of both the incident Resident #1 had with Resident #2 and Resident #3. He stated Resident #2 was scared a little bit by Resident #1 coming in her room but he did not touch her. He stated he was not aware of any other additional incidents since Resident #1 was moved to another hallway.

The Administrator was interviewed on 10/5/18 at 4:15 PM. The Administrator confirmed he was notified of the 9/19/18 incident by a phone call from Nurse #1 late that night. He stated he did not recall sending a report to the state regarding the 9/19/18 incident with Resident #1 and acknowledged it was the facility policy to do so.

The DON was interviewed on 10/6/18 at 4:24 PM. She indicated it was her expectations that for the safety of the residents Resident #1 should have been and was removed from the situation. The DON said the priority was to keep the residents safe. She stated it was her expectation that residents be assessed, family notified, proper reporting, care planning, staff in-services as needed, and incident reports filled out after an allegation of sexual misconduct by a resident.

On 10/6/18 at 12:27 PM the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation of compliance on 10/7/18 at 8:27 AM.

The credible allegation of compliance indicated:

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F 689	Continued From page 39 Credible Allegation of Compliance: The creation of this Letter of Credible allegation constitutes a written allegation of compliance. Preparation and submission of this letter does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth by the surveyor agency. This letter is solely prepared because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Date: 10/06/2018 Corrective action accomplished for those residents found to have been affected by the deficient practice. On 5/19/2018 at 10:00 pm, Resident #1 was observed in the room by the licensed nurse #1. Resident #1 was attempting to put his hands under resident #2's cover while resident #2 was in bed. Resident #1 was removed from the room by licensed nurse #1. Head to toe skin assessment for resident #2 completed by licensed nurse #1 on 5/19/2018 no injuries noted. Resident #1 was placed on every 15 minutes watch check for 3 days and was discontinued as resident was noted to show no behaviors of wondering. Resident #1 & #2 attending physician and responsible party notified. On 9/19/18 at 10:15 pm, Resident # 1, was observed in the room of resident # 3. Resident # 1 was leaning over resident #3. Resident #1 observed kissing resident #3 on her mouth by certified nursing assistant #1. Resident #1 right	F 689		

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hand was observed in resident #3 brief and left hand was observed putting his P ... back in his pants. Two Nurse Aides, #1 and #2, saw resident # 1 and immediately removed him from the room. The CNAs reported it to licensed nurse #1 who completed head to toe skin assessment resident # 3 and found no signs of injury. Charge nurse #1 called the administrator at @11:30pm to inform of the incident. He advised the nurse to move patient #1 to the 100 hall which is away from Resident #3. Resident # 1 was immediately moved to another room and placed on 15 minute checks by licensed nurse #1 to ensure he did not go in any room other than his own, effective 9/19/18 at 10:45 pm for 3 days until 9/22/18 at 7:00am then was reduced to 30 minutes check as resident exhibited no wandering behavior for 3 days. 30 minutes check was continued for 5 days until 9/26/2018 at 3pm when it was reduced to hourly as resident exhibited no wandering behavior for 5 days. On 9/28/18 Resident was observed walking up and down the hall more often than usual. Licensed nurse #2 increased the monitoring to every 30 minutes completed by certified nurse aides on duty continue until 10/1/18 at 7am when resident was noted ambulating more on hallways. Every 15 minutes checks continue until today. Every 15 minute checks will continue until resident #1 is noted to wander safely on the hallway and exhibited no signs of wandering to other residents' rooms. Licensed nurse on duty will monitor to ensure the completion of 15 minutes check. Resident #1 & #3 family members were notified at the time by nurse #1. Both resident's physicians were notified at the time and no new orders by licensed nurse #1.

Address how corrective action will be

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accomplished for those residents having the potential to be affected by the same deficient practice.

100% of wandering risk assessments for all current residents with wandering behavior completed by the Director of Nursing on 10/6/18 to identify if any resident exhibited wandering behaviors in the past 7 days, no other resident identified with wandering attempt in the last 7 days.

100% interview of all current alert and oriented resident was completed on 10/6/2018 by Assistant Director of Nursing, Director of Social services, Registered nurse supervisor and/or Central Supplies supervisor to identify any resident to include Resident #1 has wandered in their room uninvited and exhibited any inappropriate behavior. No other resident voiced any concern regarding resident #1 or any other resident related to wandering behaviors

100% interview of all current employees on duty interviewed by the Executive Director, Director of Nursing and/or Director of Social Services on 10/5/2018 and 10/6/2018 to identify if any wandering behaviors for resident #1 was noted to any resident to include residents with cognitive deficit. No other staff member voiced concerns for any additional residents beside, resident #2, and #3. Any staff member not interviewed by 10/6/2018 at 11:59pm will be not be allowed to work until interviewed.

Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur.
Effective 10/6/2018, and moving forward,

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licensed nurses will complete Wandering risk assessments for all residents on admission/re-admission, quarterly, with any significant changes of resident's condition, and/or whenever a resident is noted to exhibit wandering behaviors/attempts. Any noted concerns will be addressed and corrected by licensed nurses immediately; interventions will be implemented and resident's care plan will be revised and updated immediately by licensed nurses. Direct care staff will be notified of new interventions put forth by a licensed nurse through resident's care guide which are located in each nursing station.

Effective 10/6/2018, the center interdisciplinary team, which includes Director of Nursing, MDS nurse #1, MDS number #2, Registered nurse, Social worker #1, and Activity Coordinator #1, Executive director initiated a process for reviewing any resident who is noted with inappropriate wondering behaviors to identify the root cause of the behavior exhibited and put forth an appropriate intervention to prevent the reoccurrence. Intervention to include but not limited to prompt psychiatric evaluation, social service consultation, one on one care, and/or medication evaluation will be implemented when appropriate. Any identified issues will be addressed promptly and plan of care developed as indicated. This review will take Monday through Friday effective 10/6/18

Effective 10/6/2018, week end RN supervisor and/or designated licensed nurse reviewing any resident who is noted with inappropriate wandering behaviors to identify the root cause of the behavior exhibited and put forth an appropriate intervention to prevent the reoccurrence. Intervention to include but not

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limited to prompt psychiatric evaluation, social service consultation, one on one care, and/or medication evaluation will be implemented when appropriate. Any identified issues will be addressed promptly and plan of care developed as indicated. This review will take Saturday and Sunday through Friday effective 10/6/18.

Executive Director, Director of Nursing, Certified Dietary Manager, Director of Social Services and/or Staff Development Coordinator conducted re-education for current scheduled staff, full time, part time and as needed employee for all departments started on 10/5/2016. This education included identifying wandering residents, abuse policy and procedures, proper reporting, appropriate actions to be taken for residents with wandering behaviors, wandering assessment completion requirements per protocol and provision of safety for all residents. This education will be completed by 10/6/2018, any employee not educated by 10/6/18 will not be allowed to work until educated on this requirement. Effective 10/6/2018. This education will be added on new hires orientation education for all new facility employees. This education will also be provided annually for all staff.

The facility plans to monitor its performance to make sure that solutions are sustained.

Effective 10/07/2018 the Director of Nursing, Assistant Director or Nursing, RN supervisors will review daily documentation and 24 hours reports to identify any indication of wandering behaviors. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a daily clinical report form and filed in clinical

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 44	F 689		

meeting binder after proper follow ups are done. This monitoring process will take place daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.

Effective 10/6/2018, Executive Director and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.

The title of the person responsible for implementing the acceptable plan of correction Effective 10/06/2018 the facility executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.

Compliance Date 10/06/2018

The credible allegation was verified on 10/7/18 at 10:00 AM as evidenced by record review, observation, staff and resident interviews.

Interviews were conducted with a sample of staff members from all three shifts to verify re-education was conducted for all employees regarding identifying wandering residents, abuse policies and procedures, proper reporting, appropriate actions to be taken for residents with wandering behaviors, wandering assessment completion requirements per protocol and

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	345291	A. BUILDING _____ B. WING _____	C 10/18/2018

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F 689	Continued From page 45 provision of safety for all residents. The same sample of staff members were interviewed to assure the facility interviewed them regarding additional residents effected by the wandering behavior of Resident #1. Interviews were conducted with a sample of alert and oriented residents on all of the halls of the facility to verify they had been interviewed regarding wandering residents coming in their room uninvited and exhibiting inappropriate behavior. Observations were made to confirm the wandering residents were doing so safely. Documentation of wandering risk assessments, in-service records, and the current behavior/wandering log for Resident #1 were reviewed. All of the evidence indicated the facility had completed the corrective action by 10/6/18.	F 689		
F 711 SS=B	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the	F 711		10/20/18

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F 711	Continued From page 46 exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to obtain physician signatures on monthly orders for September 2018 for 4 (Resident's #8, #9, #10, and #12) of 5 residents records reviewed for physician signatures on orders. Findings included: 1. Resident #8 was admitted to the facility on 8/24/04 and had diagnoses of heart failure, dementia, and hypertension. Review of the medical record for Resident #8 on 10/6/18 revealed the September 2018 physician orders were not a part of the record. An interview was conducted with the medical records employee on 10/6/18 at 12:45 PM. The medical records employee indicated that the physician for Resident #8 requested the physician orders for his patients be put in a folder and put in a box on the wall near the 500 Hall nurses station. The medical records employee stated the September orders for Resident #8 were in a folder awaiting the signature of the physician. An interview with Nurse #6 on 10/6/18 at 12:47 PM revealed the physician was in the building frequently and was last in the building on 10/4/18. An interview was conducted with the Administrator on 10/6/18 at 4:24 PM. The Administrator indicated that it was his expectation the physicians sign the monthly orders and it was	F 711	F711 Monthly Physician orders not signed timely. The identified resident□s physician orders were signed immediately after the MD was contacted by the medical records clerk. The Medical director was actually in the facility at the time reported and immediately signed orders for his residents. There was a 100% audit completed by the medical records clerk for missing MD signatures, notes or placement on charts. This was completed on 10/8/18. Any record found to be deficient was provided for the physician□s immediate signature. Medical Records was in-serviced by the DON on the importance of adhering to the policy on maintaining records and to report any issues as needed for follow-up by the DON on 10/8/18. The Administrator, Medical Records clerk and the DON spoke with all MD on staff on the importance of timely visits and signing of their patient□s medical record in the required time frames. This was accomplished on 10/9/18. After reviewing Physician orders, on the first of each month, they will be provided to the physician on a timely basis for their	

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F 711	Continued From page 47 a problem the facility needed to fix. 2. Resident #9 was admitted to the facility on 8/8/17 and had diagnoses of Type 2 diabetes mellitus, hypertension, and chronic obstructive pulmonary disease. Review of the medical record for Resident #9 on 10/6/18 revealed the September 2018 monthly physician orders were not a part of the medical record. An interview was conducted with the medical records employee on 10/6/18 at 1:00 PM. The medical records employee indicated that the physician for Resident #9 requested that all monthly physician orders be put in the charts of his patients for his review and signature. The medical records employee stated that the September 2018 monthly orders were in a folder and needed to be put in the chart of Resident #9 so her physician could sign them. An interview was conducted with the Administrator on 10/6/18 at 4:24 PM. The Administrator indicated that it was his expectation the physicians sign the monthly orders and it was a problem the facility needed to fix. 3. Resident #10 was admitted to the facility on 12/13/16 and had diagnoses of hypertension, chronic kidney disease, and heart failure. Review of the medical record for Resident #10 on 10/6/18 revealed the September 2018 monthly physician orders were not in the medical record. An interview was conducted with the medical records employee on 10/6/18 at 1:15 PM. The	F 711	signature as per guidelines.. Medical records will audit charts weekly for 4 weeks then monthly thereafter for compliance. Any trends or issues will be discussed with the Quality Assurance committee monthly for three months then every quarter for 1 year.	

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medical records employee indicated the physician for Resident #10 requested that all the monthly orders be transported to his office in a folder, he signed them, transportation picked them up at the office and returned the orders to the facility. The medical records employee indicated the orders were in the physician's office.

An interview was conducted with the Administrator on 10/6/18 at 4:24 PM. The Administrator indicated that it was his expectation the physicians sign the monthly orders and it was a problem the facility needed to fix.

4. Resident #12 was admitted to the facility on 2/26/18 and had diagnoses of hypertension, hyperlipidemia, dementia, and chronic obstructive pulmonary disease.

Review of the medical record for Resident #12 on 10/6/18 revealed the September 2018 monthly physician orders were in the medical record but were not signed by the physician for Resident #12.

An interview was conducted with the medical records employee on 10/6/18 at 1:30 PM. The medical records employee indicated the physician for Resident #9 requested that all monthly physician orders be put in the charts of his patients for his review and signature. The medical record employee indicated the physician for Resident #12 was in the building daily and would sign the September orders on 10/7/18.

An interview was conducted with the Administrator on 10/6/18 at 4:24 PM. The Administrator indicated that it was his expectation the physicians sign the monthly orders and it was

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F 711	Continued From page 49 a problem the facility needed to fix.	F 711		