STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345541	A. BUILDING _____ B. WING _____	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation (Event ID #KRGX11) was conducted on 11/4/18. Past-noncompliance was identified at: CFR 483.12 (a) (1) F600 J CFR 483.12b at tag F607 J The tags F 600 and F 607 constituted Substandard Quality of Care. Non-noncompliance began 10/16/18. The facility came back in compliance effective 10/25/18. An extended survey was completed on 11/8/18.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews it was determined that the facility failed to protect a resident's right to be free of physical abuse for 1	F 600	Past noncompliance: no plan of correction required.	12/4/18

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

Electronically Signed | 12/04/2018

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of 1 (Resident #1) residents reviewed for abuse. Resident #1, a cognitively impaired resident was slapped by a nursing assistant during the provision of care. Resident #1 was assessed at the facility and found to have no physical injuries from being slapped by the staff member. Findings included:

Resident #1 was admitted to the facility on 8/15/18 with diagnosis including muscle weakness and anxiety disorders. Review of his 14 Day Minimum Data Set (MDS) assessment dated 8/29/18 revealed the residents' speech was unclear. He scored a zero on the brief interview of mental status indicating that he had poor cognition and memory. No behaviors were documented during the assessment period. He required extensive, two-person assistance for bed mobility and was totally dependent for toileting with 2 persons assist. The resident was also dependent on staff for eating, dressing, bathing and personal hygiene. He had no limits with range of motion per the assessment.

Review of the medical record revealed a general note dated 10/16/18 6:49 AM which stated, "Res (Resident) was very combative while doing care, he punched CNA (certified nursing assistant) in the jaw and kicked her, was combative during the entire care."

Review of the medical record revealed a general note dated 10/16/18 10:37 PM written by Nurse #1 which stated "Resident combative during care. This nurse called into room assisted CNAs with changing brief. CNAs stated that resident was hitting and kicking."

Review of a Daily Skilled Nursing Evaluation

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F 600	Continued From page 2	F 600		

dated 10/16/18 (untimed) stated, alert not oriented, memory problem, unclear speech, barely never understands. Behavior hitting others, grabbing other, behaviors unchanged.

Review of the Facility Investigation Time Line of an incident that involved Resident #1 being slapped by nursing assistant (NA) #1 on 10/16/18 that was signed by the Administrator 10/22/18 revealed the following: At approximately 7:15PM- NA #1 went to supervisor and floor nurse and informed them that resident #1 was being combative by way of hitting, kicking, and punching while providing personal care (changing brief and peri-care). Floor nurse then went into room and assisted with personal care until task was completed. Supervisor requested staff statements on the resident being combative from both CNAs present in the room. Statements were turned into the nurse manager approximately 10:45 PM while CNAs were leaving. Upon reviewing the statement, it was noted that in the statement from NA #1, she stated that the resident became very violent and punched the other CNA (NA#2) and herself in the chest and slapped NA #1 in the face, and because it caught her off guard "I slapped him back, not hard enough to leave a mark". After turning her statement in, she left the facility.

Review of an Investigation-employee statement written by NA #2 date signed 10/16/18 7:00PM stated, "I (NA#2) went in Room # with (NA #1) to help her put the brief on (Resident #1) in room #. While we were trying to put the brief on he started kicking, hitting and punching both of us. I tried to hold his hands and feet but was unable to. And then (NA #1) slapped him because he hit her and he started kicking and hitting her so she slapped

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him again. I then told her to go get the nurse and she did."

During interview on 11/4/18 at 3:20 PM with NA #2 she stated that NA #1 needed someone to help (with Resident #1), someone to hold him while we changed him. She was changing him, I was trying to hold his hands, so he wouldn't hit us. He punched me in my breast. He was hitting us and kicking us. He slapped her in the face. She was on the side closest to the window. She had already put the pad underneath him, but she needed help to get the diaper on him. NA #2 stated she then let go of his hand and told NA #1 to go get the nurse. NA #1 went to get the nurse. Resident #1 hit NA #1 before the nurse came in. She slapped him open handed on the face on the left side. He didn't say anything, he was still trying to fight us. She hit him hard, it was more of a reflex. NA #2 stated they got the brief on and that NA #1 hit the resident twice. She slapped him again. That one was not as bad as the first one. NA #2 reported that she went out and told another NA (NA #3), who told her to tell the Assistant Director of Nurses (ADON). The ADON came and talked to her (NA#2) after the incident and told her to slip a note under the door if she could not talk about it. NA #2 stated that she received abuse training after the date of the incident.

Review of an Investigation-Employee Statement date signed 10/16/18 9:00PM written by NA #1 stated, "At 7 PM after I had cleaned the resident and dressed him for bed. The resident wouldn't allow me to put his brief on so I went to get help from another CNA (Certified Nursing Assistant) NA #2 and when we tried to continue care, (Resident #1) became very violent he punched

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(NA#2) and myself in chest, and slapped me in the face, because it caught me off guard I slapped him back, not hard enough to leave a mark, but I immediately contacted the nurse and informed her of what happened."

Interview with a nursing assistant #1 (NA) at 12:43 PM on 11/4/18 revealed that it was a normal day. She was not told that the resident was taken off all his medication. The resident had a bowel movement and she entered the room to clean him up. She stated that she got another NA to help her because the resident was a tall man, who spoke no English, he weighed 200 pounds and was a 2 person assist. The NA reported that the resident was agitated, and they tried talking to him when he started fighting and kicking he hit her and the other NA in the chest. She stated they stopped providing care and went to the nurse supervisor who told her to get her nurse. The nurse came into the room and was talking to him, she and the other NA were holding him down still trying to clean him up. "I turned my head and he socked me, I mean slapped the fire out of me. I slapped his hand on instinct. I told the nurse supervisor I hit him, and I apologized." She stated that she probably did slap his face, but it wasn't a slap, it was a pop like don't hit me. She reported that she only hit Resident #1 once. She stated that she did not hurt him. He had no bruises and that she did not intend to hurt him. She stated that the resident was calm when the nurse was talking to him and she told them to go ahead and clean him up. He snapped again so the nurse told them (NAs) to leave him alone. NA #1 stated that she had worked with the resident previously and he was calm when he was on medication.

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Review of an Investigation-employee statement written by Nurse #1 dated and signed 10/16/18 at 9:00PM stated, "I was called into the room. (NA #1) told me that resident was being combative and hitting them and they couldn't change him. I went into the room. Res. (Resident) was laying in the bed on his side. I held resident's hands and told him to let them change him. Res. Held legs together at first but did let them change his brief. Did not try to hit or kick."

Telephone interview with Nurse #1 at 2:23 PM on 11/4/18 revealed that the NA #1 came and got her because Resident #1 was being combative, and they needed help. She stated that she held his hands and talked to him and he was calm for her. The resident let them change him. Supervisor said she wanted them to do a witness statement. "At the end of the shift I was going over the witness statements and saw what was written. NA #1 did leave early that day. She looked like she was upset. This was not the first time the resident was combative when being changed."

The resident was observed at 4:39 PM on 11/4/18 laid back in his wheelchair with his feet off the ground.

During interview with the Administrator and Clinical Nurse Consultant on 11/4/18; they reported completing a plan of correction.

The Administrator stated the following corrective action had been completed as of 10/25/18:

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CORRECTIVE ACTION PLAN
F-600

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F 600	Continued From page 6 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION 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. Address How Corrective Action (S) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: Immediately after learning of the incident the following interventions were put into place by the Administrator and Director of Nursing: 1. The employee who admitted to abusing the resident was suspended pending the investigation and then terminated once the investigation was completed. 2. On October 17, 2018 the ADON completed a thorough skin assessment on the resident and there were no noted areas of bruising, discoloration, scratches and or injury. The resident did not appear to have any mental or emotional distress as a result of the incident as he mentally appeared to be at his baseline and did not show any nonverbal signs of mental distress such as crying out or being scared of care givers. 3. The Assistant Director of Nursing/Staff Development conducted In-services with all nurses and CNAs beginning on 10/17/2018 and completed on 10/24/2018 on the following; a. Abuse, what is it; b. Types of abuse; c. What to do if abuse is witnessed;	F 600		

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F 600	Continued From page 7 d. How to react to combative behavior from residents; how to provide care and services to combative residents to prevent abuse to resident(s) or harm to the care giver; 4. Beginning 10-17-2018 an intervention of two CNAs (and/or one CNA and one nurse) are to always provide care together for this resident due to his history of combative behavior. Address How Corrective Action Will Be Accomplished For Those Residents Having Potential To Be Affected By The Same Deficient Practice: Immediately after learning of the incident the following interventions and corrective actions were put into place by the Administrator and Director of Nursing for residents having the potential to be affected by the alleged deficient practice: 1. Following the incident on October 16, 2018, the Administrator and Director of Nursing reviewed all incident reports for the past three (3) months to determine if there were any bruises or injuries of unknown origin as a sign of a systemic issue with resident abuse. The review of the incident reports completed on 10-18-2018 did not reveal any injuries or bruises of unknown origin for any resident. 2. On October 25, 2018 alert and oriented resident were interviewed by the facility activity director concerning resident abuse as well as violation of any resident rights. A Resident Council Meeting was held on 10/25/18 and further discussion of resident abuse and violation of resident rights took place. No report from alert and oriented residents was lodged concerning	F 600		

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any incident of resident abuse or violation of resident rights.
3. Between the dates of 10/17/2018 and 10/25/18 a Body Audit was completed on all residents by the CNA's and given to the Staff Nurses who in turn reviewed for any signs or symptoms of bruises, impairment of skin or signs of injury of unknown origin. There were no injuries of unknown origin detected.

Address What Measures Will Be Put Into Place Or Systemic Changes Made To Ensure That The Deficient Practice Will Not Recur:

1. For any resident with combative behaviors, only CNAs who have been employed by the facility for greater than three (3) months and have demonstrated the ability to work with combative residents to de-escalate the behaviors and provide care in a manner and way that protects the resident from abuse will be assigned to these residents. The decision to implement this procedure was made on October 17, 2018 by the Director of Nursing who then educated the supervisory nurses, (who make the CNA assignments), about this procedure . The CNA's and Staff Nurses were then educated on this protocol on October 17, 2018 by the DON.
2. All staff nurses and supervisory nurses were informed of the incident and instructed to be hyper vigilant with observation of CNAs to ensure abuse does not occur and to report immediately any concerning CNA behaviors to the Director of Nursing. The decision to implement this procedure was made on October 17, 2018 by the Director of Nursing who then educated the supervisory nurses, (who make the CNA assignments), about this procedure. The CNA's and Staff Nurses were then educated on this

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protocol on October 17, 2018 by the DON.
3. Administrative Staff, following the incident, rounded on the resident care units six (6) times the first week (entering rooms and showers where care was being provided) and four (4) times the following week to ensure that care delivery was being conducted in a way that preserved the resident's privacy, dignity and freedom from abuse. These rounds will continue at four (4) per week (including at least one (1) on the 11-7 shift for the next six (6) months and then two (2) per week for the following six (6) months to ensure that the deficient practice does not reoccur. The Administrative Staff were notified October 17, 2018 by the Administrator who makes the assignments.

Indicate How The Facility Plans To Monitor It's Performance To Make Sure That Solutions Are Sustained. The Facility Must Develop A Plan For Ensuring That Correction Is Achieved And Sustained:

1. The QA Committee, QAPI Committee and the Medical Director have been apprised of this plan and commit their support to assisting the facility with achieving and sustaining compliance with this alleged citation. The QAPI Committee was notified on 10/18/2018.
2. The resident care unit rounds will be presented at weekly QA meetings and monthly to the QAPI Committee for evaluation to determine if the system is adequate and if not to devise and re-implement a system to ensure that the alleged deficient practice does not occur again.

3. Incident Reports will be reviewed Monday through Friday in morning meetings for any unusual incident to include bruises, skin tears and

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injuries of unknown origin. An immediate investigation will be started for all bruises or unknown origin, skin tears of unknown origin or any other incident or injury of unknown origin and any occurrence that is suspected abuse will be reported immediately to the Huntersville Police Department and the North Carolina Health Care Personnel Registry.
4. The incident reports are completed electronically by the staff nurses and the nurse supervisors are responsible to print the incident report(s) for their unit before the morning meeting and are responsible to bring them to the morning meeting. In the event the nursing supervisor is absent the responsibility of printing the incident reports is assigned to the ADON and then to the DON.
5. All incident reports will be reviewed monthly at the QAPI Committee Meeting for any bruises, skin tears and injury of unknown origin and investigations of incidents of unknown origin to determine if any patterns or practices exist that may be considered abuse. If any patterns or practices are noted, the QAPI Committee will begin an immediate investigation to ensure that solutions are put into place to ensure corrective action is achieved and sustained. ·

Date of Compliance: 10-25-2018

Validation Information: An interview with the Administrator and Director of Nursing on 11/8/18 at 4:14 PM revealed they expected the nursing staff to follow the facility's abuse policy and to immediately report to administration any concerns with abuse. The Administrator stated the following corrective action had been completed as of 10/25/18.

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Quality Assurance Performance Improvement (QAPI) Committee met and developed a plan
All staff were in-serviced on identifying and reporting abuse; any prn (as needed) staff could not work until they were re-educated and only trained nurse aides employed at least 3 months would be assigned to work with residents identified with aggressive behaviors.
Body audits were completed on 100% of the residents, residents were interviewed regarding abuse and a Resident Council meeting was held to discuss any concerns related to abuse that residents had
Resident care plans were audited/updated regarding residents with aggressive behaviors
Incident reports for the prior 3 months were reviewed to identify any concerns related to injuries of unknown origin
Administrative staff monitored resident: staff interactions during nursing care and were currently monitoring 4 residents each week to ensure staff/residents were aware of the procedure for reporting abuse, and that abuse was not occurring
Staff reviewed orientation packets to make sure it contained up-to-date information regarding identifying/reporting abuse
The facility continued to monitor/audit for ongoing compliance

The facility provided documentation of training for all staff regarding abuse, documentation of all body audits, revised care plans, minutes from Resident Council, resident interviews and QAPI monitoring for corrective action as of 10/25/18. At the time of the survey, sampled residents were observed to receive nursing care without concerns related to abuse. Interviews with alert/oriented residents revealed they were they

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F 600	Continued From page 12 felt safe. Interviews with staff revealed they were aware of the facility's revised policy/procedures for preventing/reporting abuse. The facility's date of compliance was validated as 10/25/18.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility to implement their policy and procedure in the areas of reporting and protection by not immediately reporting staff to resident abuse to administration for 1 of 1 Residents (Resident #1) reviewed for abuse. Facility staff failed to immediately report staff to resident abuse for 1 of 1 cognitively impaired residents (Resident #1) who was slapped by a nursing assistant. Findings included: Review of the facility Abuse Policy and Procedures Reporting/Response on 11/4/18 revealed the following, "Any suspected incident of abuse, neglect or misappropriation of resident property is to be reported immediately to a supervisor or a member of administration." The	F 607	Past noncompliance: no plan of correction required.	12/4/18

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OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

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facility Investigation/Protection Policy stated, "(Facility) will review all incidents to determine, if possible, the cause of the incident and injury that may have been inflicted. 1) a complete and through follow up will be conducted to identify the cause of all injuries. 2) Needed investigations will be conducted with the resident's safety as the foremost concern in order to protect the resident from future harm. 3) If abuse or neglect is suspected, the individual suspected of abusing or neglecting the resident will be placed on suspension pending the outcome of the investigation."

Resident #1 was admitted to the facility on 8/15/18 with diagnosis including muscle weakness and anxiety disorders. Review of his 14 day Minimum Data Set Assessment (MDS) dated 8/29/18 revealed the residents' speech was unclear. He scored a zero on the brief interview of mental status indicating that he had poor cognition and memory. No behaviors were documented during the assessment period. He required extensive, two-person assistance for bed mobility and was totally dependent for toileting with 2 persons assist. The resident was also dependent on staff for eating, dressing, bathing and personal hygiene. He had no limits with range of motion per the assessment.

Review of the medical record revealed a general note dated 10/16/18 at 10:37 PM which stated "Resident combative during care. This nurse called into room assisted CNAs (certified nursing assistants) with changing brief. CNAs stated that resident was hitting and kicking."

Review of an Investigation-employee statement written by Nursing Assistant (NA) #2 dated and

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signed 10/16/18 at 7:00 PM stated, "I (NA#2) went in Room # with (NA #1) to help her put the brief on (Resident #1) in room #. While we were trying to put the brief on he started kicking, hitting and punching both of us. I tried to hold his hands and feet but was unable to. And then (NA #1) slapped him because he hit her and he started kicking and hitting her so she slapped him again. I then told her to go get the nurse and she did."

During interview on 11/4/18 at 3:20 PM with NA #2 she stated that NA #1 needed someone to help (with resident #1), someone to hold him while we changed him. She was changing him, I was trying to hold his hands, so he wouldn't hit us. He punched me in my breast. He was hitting us and kicking us. He slapped her in the face. She was on the side closest to the window. She had already put the pad underneath him, but she needed help to get the diaper on him. NA #2 stated she then let go of his hand and told NA #1 to go get the nurse. NA #1 went to get the nurse. Resident #1 hit NA #1 before the nurse came in. She slapped him open hand on the face on the left side. He didn't say anything, he was still trying to fight us. She hit him hard, it was more of a reflex. NA #2 stated they got the brief on and that NA #1 hit the resident twice. She slapped him again. That one was not as bad as the first one. NA #2 reported that she went out and told another NA (NA #3), who told her to tell the Assistant Director of Nurses (ADON). The ADON came and talked to her (NA#2) to her after the incident and told her to slip a note under the door if she could not talk about it.

Interview with the ADON on 11/4/18 at approximately 5:40 PM revealed that she was present in the facility on 11/16/18. She told NA #2

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to put a note under her door because NA#2 was visibly upset and crying.

Review of an Investigation-Employee Statement dated and signed 10/16/18 at 9:00 PM written by NA #1 stated, "At 7 PM after I had cleaned the resident and dressed him for bed. The resident wouldn't allow me to put his brief on so I went to get help from another CNA (Certified Nursing Assistant) NA #2 and when we tried to continue care, (Resident #1) became very violent he punched (NA#2) and myself in chest, and slapped me in the face, because it caught me off guard I slapped him back, not hard enough to leave a mark, but I immediately contacted the nurse and informed her of what happened."

Interview with NA #1 at 12:43 PM on 11/4/18 revealed that it was a normal day. She was not told that the resident was taken off of all his medication. The resident had a bowel movement and she entered the room to clean him up. She stated that she got another NA to help her because the resident was a tall man, who spoke no English, he weighed 200 pounds and was a 2 person assist. The NA reported that the resident was agitated, and they tried talking to him when he started fighting and kicking he hit her and the other NA in the chest. She stated they stopped providing care and went to the nurse supervisor who told her to get her nurse. The nurse came into the room and was talking to him, she and the other NA were holding him down still trying to clean him up. "I turned my head and he socked me, I mean slapped the fire out of me. I slapped his hand on instinct. I told the nurse supervisor I hit him, and I apologized." She stated that she probably did slap his face, but it wasn't a slap slap, it was a pop like don't hit me. She reported

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that she only hit Resident #1 once. She stated that she did not hurt him. He had no bruises and that she did not intend to hurt him. She stated that the resident was calm when the nurse was talking to him and she told them to go ahead and clean him up. He "snapped" (became combative) again so the nurse told them (NAs) to leave him alone. NA #1 stated that she had worked with the resident previously and he was calm when he was on medication. NA #1 stated that she followed protocol to the letter.

Review of an Investigation-employee statement written by Nurse #1 dated and signed 10/16/18 at 9:00 PM stated, "I was called into the room. (NA #1) told me that resident was being combative and hitting them and they couldn't change him. I went into the room. Res. (Resident) was laying in the bed on his side. I held resident's hands and told him to let them change him. Res. Held legs together at first but did let them change his brief. Did not try to hit or kick."

Telephone interview with Nurse #1 at 2:23 PM on 11/4/18 revealed that the NA came and got her because Resident #1 was being combative, and they needed help. She stated that she held his hands and talked to him and he was calm for her. The resident let them change him. "Supervisor said she wanted them to do a witness statement. At the end of the shift I was going over the witness statements and saw what was written. NA#1 did leave early that day. She looked like she was upset. This was not the first time the resident was combative when being changed."

Review of the Facility Investigation Time Line signed by the Administrator on 10/22/18 revealed the following:

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10/16/18, At approximately 7:15PM- NA #1 went to supervisor and floor nurse and informed them that resident #1 was being combative by way of hitting, kicking, and punching while providing personal care (changing brief and peri-care). Floor nurse then went into room and assisted with personal care until task was completed. Supervisor requested staff statements on the resident being combative from both CNAs present in the room. Statements were turned into the nurse manager approximately 10:45 PM while CNAs were leaving. Upon reviewing the statement, it was noted that in the statement from NA #1, she stated that the resident became very violent and punched the other CNA (NA#2) and herself in the chest and slapped NA #1 in the face, and because it caught her off guard "I slapped him back, not hard enough to leave a mark". After turning her statement in, she left the facility.

·10/17/18 11:20 AM- "Received call back from 3-11 supervisor (Name), questioned her in regards to the situation the previous evening. She stated that she was informed around 8:00 PM in regards to the resident becoming combative and the CNA (NA#1) responding to the resident with a slap. Supervisor stated that she informed the CNAs to let their charge nurse (Nurse #1) know about what happened and to write statements. This writer then spoke to Nurse #1, floor nurse and was informed that she did not find out about the slapping of the resident until the end of the shift as the CNA was leaving and turned in her statement. It was confirmed by supervisor and CNA, that from time of incident to the end of shift the CNA #1, did not attend to Resident #1; the floor nurse, nurse #1 took over care for him due to his aggression towards the

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CNAs.

Interview with the Clinical Nurse Consultant at 4:01 PM on 11/4/18 revealed that the nurse supervisor on duty told her that she was informed that Resident #1 was combative, and that NA #1 had responded with a slap back around 8 PM on the day of the incident. The nurse supervisor said she did not make a report because she was busy. The Clinical Nurse Consultant stated she and facility management had a phone interview with the nurse supervisor (10/17/18) and met with her in person.

The resident was observed at 4:39 PM on 11/4/18 laid back in his wheelchair.. He did not appear to be in distress.

During interview with the Director of Nurses (DON) during the evening of 11/4/18, the DON stated that she was informed of the incident the following day by the Clinical Nurse Consultant. She stated we all (referring to management) found out that morning that the resident was aggressive, and staff slapped the resident. The DON reported that the statements were already written and that interviews were continued. She further stated that per the nurse supervisor on duty she was in the middle of handling another emergency and that's why she did not report the incident immediately. The DON stated the staff were properly in-serviced after the incident regarding immediate notification. The DON said she would have expected to be notified by the supervisor.

An interview with the Administrator and Director of Nursing on 11/8/18 at 4:14 PM revealed they expected the nursing staff to follow the facility's

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abuse policy and to immediately report to administration any concerns with abuse. The administrator stated the following corrective action had been completed as of 10/25/18:

CORRECTIVE ACTION PLAN F- 607

Facility must develop and implement written policies and procedures that; Prohibit and prevent abuse, neglect and exploitations of residents and misappropriation of resident property, Establish policies and procedures to investigate any such allegations, and Include training as required.

Address How Corrective Action (S) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:

1. For Resident MR# 2129 the CNA having committed the abuse was suspended during the investigation and then terminated.

2. All staff was in-serviced by the ADON/Staff Development on the facilities abuse, neglect, exploitation and misappropriation policies, procedures and protocols including the facilities zero tolerance of abuse, how to provide care for dementia residents, and reporting any abuse, neglect, exploitation and/or misappropriation IMMEDIATELY to the facility Director of Nursing and Administrator. The in-services concluded on 10-24-2018.

3. For Resident MR# 2129, his care plan has been updated on 10/18/2018 by the MOS Nurse to reflect how to approach him when providing care and services to minimize his behaviors and to gain his cooperation; to always have two staff members when providing his care; to explain in a

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calm voice what is going to be done to the resident before starting care (Resident #2129 spoke English, German and Dutch before his onset of Alzheimer's Disease but now does not respond to either of the languages, even to his wife/partner) and to stop care if resident becomes combative and to re-approach after he has become calm and cooperative to finish care.

4. For Resident MR# 2129, only CNAs that have been with the facility for greater than three (3) months and have demonstrated ability to provide care to combative residents with appropriate responses to their combativeness (how to calm and soothe combative residents) will be assigned to him. The Director of Nursing educated the supervisory nurses, (who make the CNA assignments,)about his procedure and implemented it on October 17, 2018. . The CNA's and Staff Nurses were then educated on this protocol on October 17, 2018 by the DON.

5. For Resident MR# 2129 a full investigation was completed and a report was made to the North Carolina Health Care Personnel Registry and the Police Department on 10-17-2018. (24 hour report filed on 10/17/2018 by DON and 5 day report filed on 10/22/2018 by DON) and to the police department on 10/17/2018 by Corporate Compliance Nurse.

6. On October 17, 2018 the ADON completed a thorough skin assessment on the resident and there were no noted areas of bruising, discoloration, scratches and or injury. The resident did not appear to have any mental or emotional distress as a result of the incident as he mentally appeared to be at his baseline and did not show any nonverbal signs of mental

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F 607	Continued From page 21 distress such as crying out or being scared of care givers. Address How Corrective Action Will Be Accomplished For Those Residents Having Potential To Be Affected By The Same Deficient Practice: 1. The facility already has developed and implemented written policies and procedures that prohibit and prevent abuse, neglect and exploitations of residents and misappropriation of resident property. The facility also has established policies and procedures to investigate any such allegations, and include training as required. All employees are screened upon employment for any history of abuse, neglect, exploitations of residents and misappropriation of resident property. This includes criminal background check, contacting previous employers and checking the licensing boards and registries. 2. Between the dates of 10/17/2018 and 10/25/18 a Body Audit was completed on all residents by the CNA's and given to the Staff Nurses who in turn reviewed for any signs or symptoms of bruises, impairment of skin or signs of injury of unknown origin. There were no injuries of unknown origin detected. 3. This is a one (1) time incident that occurred by a newly hired employee, who readily admitted that she reflectively struck back at the resident after being hit by the combative resident. The breakdown in employees not following the abuse policy occurred when supervisory staff did not immediately remove the CNA from all care giving duties and sent home pending the investigation. As well as supervisory staff did not immediately notify the DON and the Administrator of the	F 607		

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occurrence.
4. The CNA committing the abuse was suspended on 10-17-2018 and terminated on 10-22-2018. The CNA and the Nurses aware of the abuse that occurred were disciplined because they failed to report the abuse immediately to the Administrator and Director of Nursing.
5. The facility has always provided and continues to provide supervision of staff to assure that its policies and procedures are followed.
Immediately after learning of the incident the following interventions were put into place by the Administrator and Director of Nursing:
A. The employee who admitted to abusing the resident was suspended pending the investigation and then terminated once the investigation was completed. She was reported on 10-17-2018 to the Health Care Personnel Registry and the Huntersville Police Department.
B. The staff involved in the incident who did not report the incident to the Director of Nursing and/or Administrator timely were re-educated on Abuse, Proper Reporting to include timing of the report and prevention. They also received disciplinary actions by the Director of Nursing. This was completed on October 17, 2018.
C. The Assistant Director of Nursing/Staff Development conducted In-services with all staff beginning on 10/17/2018 and completed on 10/24/2018 on the following;
1. Abuse, what is it;
2. Types of abuse;
3. What to do if abuse is witnessed;
4. How to react to combative behavior from residents.
5. Reporting abuse timely and how to report abuse

Address What Measures Will Be Put Into Place

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F 607	Continued From page 23 Or Systemic Changes Made To Ensure That The Deficient Practice Will Not Recur: 1. All abuse policies, practices, procedures and protocols were reviewed with all staff by October 24, 2018 to ensure that residents are free from abuse, neglect and exploitations or misappropriation of their property. 2. Administrative Staff will round on the resident care units six (6) times a week the week following the incident entering rooms and showers were resident care is being provided, then four (4) times a week for the next six (6) months and two (2) times a week for the following six (6) months with at least one (1) round per week occurring on the 11-7 shift to ensure that care is being provided in a way that protects residents from abuse. The Administrative Staff were notified 10/17/2018 by the Administrator who makes the assignments. Indicate How The Facility Plans To Monitor It's Performance To Make Sure That Solutions Are Sustained. The Facility Must Develop A Plan For Ensuring That Correction Is Achieved And Sustained: 1. Administrative Rounds will be presented to the QAPI Committee monthly to review and evaluate that solutions are achieved and sustained to prevent reoccurrence. 2. All incident reports will be reviewed by the QAPI Committee monthly to evaluate any patterns or practices that may potentially be indicative of abuse or abusive patterns. Any patterns or practices identified by the QAPI Committee will immediately be investigated by the QAPI Committee to determine if abuse is an	F 607		

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issue and to ensure that solutions are achieved and sustained to prevent reoccurrence.

3. All policies, procedures, protocols and practices pertaining to abuse will be reviewed quarterly by the QAPI Committee for the next two quarters and annually thereafter for appropriateness in preventing abuse as outlined in the facilities policies.

4. The QA Committee, QAPI Committee and the Medical Director were apprised of the problem and corrective action plan on 10-18-2018 and commit their support to assisting the facility with achieving and sustaining compliance.

Date of Compliance: 10-25-2018

Validation Information: An interview with the Administrator and Director of Nursing on 11/8/18 at 4:14 PM revealed they expected the nursing staff to follow the facility's abuse policy and to immediately report to administration any concerns with abuse. The administrator stated the following corrective action had been completed as of 10/25/18.

Quality Assurance Performance Improvement (QAPI) Committee met and developed a plan
All staff were in-serviced on identifying and reporting abuse; any prn (as needed) staff could not work until they were re-educated and only trained nurse aides employed at least 3 months would be assigned to work with residents identified with aggressive behaviors.
Body audits were completed on 100% of the residents, residents were interviewed regarding abuse and a Resident Council meeting was held to discuss any concerns related to abuse that

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F 607	Continued From page 25 residents had Resident care plans were audited/updated regarding residents with aggressive behaviors Incident reports for the prior 3 months were reviewed to identify any concerns related to injuries of unknown origin Administrative staff monitored resident: staff interactions during nursing care and were currently monitoring 4 residents each week to ensure staff/residents were aware of the procedure for reporting abuse, and that abuse was not occurring Staff reviewed orientation packets to make sure it contained up-to-date information regarding identifying/reporting abuse The facility continued to monitor/audit for ongoing compliance The facility provided documentation of training for all staff regarding abuse, documentation of all body audits, revised care plans, minutes from Resident Council, resident interviews and QAPI monitoring for corrective action as of 10/25/18. At the time of the survey, sampled residents were observed to receive nursing care without concerns related to abuse. Interviews with alert/oriented residents revealed they were they felt safe. Interviews with staff revealed they were aware of the facility's revised policy/procedures for preventing/reporting abuse. The facility's date of compliance was validated as 10/25/18.	F 607		