STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 11/28/2018

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 11/14/18 through 11/16/18. Management review decided that an immediate jeopardy exited and the survey team went back to the facility on 11/27/18 and exited on 11/28/18. Immediate jeopardy was identified at: CFR 483.10 at tag F600 at a scope and severity of J CFR 483.35 at tag F725 at a scope and severity of J Tag F600 constituted Substandard Quality of Care Immediate jeopardy began on 9/26/18 and was removed on 11/28/18. Extended survey was conducted on 11/27/18 through 11/28/18	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	F 600		12/12/18

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

Electronically Signed | 12/07/2018

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F 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff, Physician Assistant (PA) and Geriatric Nurse Practitioner (GNP) interview, the facility failed to protect cognitively impaired residents from physical abuse for 2 of 3 sampled residents reviewed for abuse (Residents #3 & #4). Resident #3 who was cognitively impaired and had repeated aggressive behaviors towards other residents, had beaten Resident #9 (who was cognitively impaired) with a call bell on 9/26/18 and had thrown a chair on Resident #2 (who was cognitively impaired) and had punched her on the shoulder on 10/9/18 causing a red spot on Resident #2's leg. Resident #4 who was cognitively intact and was verbally abusive to other residents pushed Resident # 1 (who was cognitively impaired) with a walker causing Resident #1 to fall and sustained a left hip fracture on 10/28/18. Immediate jeopardy began on 9/26/18 when the facility failed to protect Resident #9 from abuse by Resident #3 and failed to manage Resident #3's behavior causing her to abuse another resident, (Resident #2) on 10/9/18. The facility also failed to protect Resident #1 from abuse by Resident #4 causing Resident #1 to fall and fractured her hip on 10/28/18. Immediate jeopardy was removed on 11/28/18 when the facility provided an acceptable credible allegations. The facility remains out of compliance at a lower scope and severity of D (no harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective.	F 600	Address how corrective action will be accomplished for those resident found to have been affected by the deficient practice; On 9-26-18, Resident #3 was put on Q 15 minute checks. She was monitored by the charge nurse until 9/28/18 for 24 hours/7 days a week due to cursing at her roommate, attempting to hit staff, and hitting roommate with call bell. At that time, roommate was moved out of Resident #3 room, Seroquel 50 mg by mouth at 1pm and Seroquel 150mg by mouth at 7PM were initiated by Psychiatric PA. An order for Ativan 0.5 mg q 6 hours PRN for anxiety/ agitation and Behavioral and Psychological Symptoms of Dementia was initiated if resident was up between 9pm and 2am x 12 days. On 9-27-18, Resident #3 was moved into a private room. On 9/28/18 resident was argumentative with another resident, spit out medications and refused remainder of medications. No noted behaviors until 10-7-18, when resident yelled at another resident and snatched a cup out of resident hand. The residents were separated by staff and redirected. On 10-8-18, new orders for Haldol 0.5mg by mouth at bedtime was ordered due to increasing behaviors due to resident yelling at a resident on 10-7-18. On 10-9-18, at 2:00PM Resident # 3,	

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F 600	Continued From page 2 Findings included: 1. Resident #3 was admitted to the facility on 8/1/18 with multiple diagnoses including Alzheimer's disease and dementia with behavioral disturbances and agitation. The admission Minimum Data Set (MDS) assessment dated 8/8/18 indicated that Resident #3 had severe cognitive impairment and she had physical and verbal behavioral symptoms and wandering. Resident #3 resided in the memory care unit. Resident #3's care plan dated 8/6/18 indicated that Resident #3 had behaviors of yelling, cursing and she had threatened and attempted to hit staff. On 8/10/18, Resident #3 was aggressive and violent with staff and other residents. A one on one sitter was provided from 8/10/18 through 8/14/18. The approaches included to approach the resident calmly and positively, Social Worker (SW) to evaluate and visit the resident as needed, monitor and document resident's behavior as needed and report increase in negative behavior to the physician. Resident # 2 was admitted to the facility on 3/21/18 with multiple diagnoses including Alzheimer's disease. The quarterly MDS assessment dated 9/24/18 indicated that Resident #2 had severe cognitive impairment and had no behaviors. Resident #2 resided in the memory care unit. Resident #2's care plan dated 9/24/18 indicated that she was a wanderer. The approaches included to observe the resident's whereabouts when out of bed and to redirect resident as	F 600	picked up a chair and threw it at Resident # 2, then proceeded to punch Resident #2 in her arm when she got up out of her chair to walk away. Home Health Certified Nursing Assistant witnessed the incident and Resident #3 was immediately separated by the aides and removed by the charge nurse from Resident # 2 and placed Resident # 3 on 1:1 until she was transported to the hospital via facility transport and sitter on 10/10/18. An assessment was done by the Nurse on Resident # 2, and noted a red mark on her leg. Police were called by the DON at 2:20 PM and both residents were interviewed by the officer. Neither resident was able to explain what happened as both Brief Interview for Mental Status scores are 0. Both Responsible Person and Physician were made aware of the incident by the Unit Manager. Skin checks were obtained by the Unit Manager on all residents residing in the memory care unit. No abuse was reported or assessed. Psychiatric Physician Assistant was in house during the time of the incident on 10-9-18. Psychiatric PA reviewed Resident #3's medications and made changes to include discontinuation of Haldol, order for Ativan 0.5 mg every 6 hours as needed, discontinuation of Seroquel 150mg daily at 1pm, start Seroquel 100mg at bedtime. Psychiatric PA noted in note that no incidents since 9-26-18 and the increase of Seroquel. The event occurred due to interventions put in place failed to prevent Resident #3 from having behaviors.	

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F 600	Continued From page 3 indicated and as needed. The psychiatric notes for Resident #3 were reviewed. The notes dated 8/8/18 revealed that Resident #3 continued to have aggressive and combative behaviors. She was hitting staff and other residents. The plan was to discontinue the Haldol (antipsychotic drug) and to increase Seroquel (antipsychotic drug) and to add Ativan (antianxiety drug) as needed for agitation. The notes dated 9/18/18 revealed that Resident #3 had episode of insomnia along with agitation, complaining about her roommate, telling her to get out of her room. There was an addendum note dated 9/26/18 which indicated that the nurse had called and reported that Resident #3 was up during the night and was agitated with the roommate. Later on she was found beating her roommate with her call bell. The roommate was not injured as she was under her blankets. They were separated and her medications were changed. The dose of her Seroquel was increased. The notes dated 10/9/18 revealed that the GNP had observed Resident #3 sitting at the dining table and was threatening other resident saying that she would kill her if she touched her food. The notes revealed that Resident #3 had several altercations with other residents and one resulting in a minor leg injury. The plan was to increase her Seroquel. There was an addendum note indicating that the of Director of Nursing (DON) had called informing her that Resident #3 required one on one sitter and that the DON wanted to send Resident #3 out to a psychiatric hospital. The GNP had changed Resident #3's Seroquel to Risperdal (antipsychotic drug)) and had increased the Ativan as needed. Resident #3's nurses' notes were reviewed. The	F 600	100% skin assessment of all residents in the secured memory care unit was completed by the Unit Managers on 10-9-18 No concerns were identified. 100% Resident Representative interviews were completed for the locked unit residents by the Social Worker, Unit Managers, Director of Nursing, Medical Records, Maintenance Director, Dietary Manager, Admissions, Business Office, Minimum Data Set Nurse, Activities. No concerns from voiced from interviews. Example of Interview Questions: Do you feel the resident been harmed by another resident in the facility? If yes, was facility made aware? Do you feel resident is safe in the facility? A 100% all staff In-service was initiated on 10-9-18 on abuse Prevention/Intervention by the Director of Nursing. The in service included prevention of resident abuse, and recognizing signs and symptoms of abuse, dementia protocol, behavioral assessment, intervention and monitoring and behavioral management to include updating of plan of care. The In service was completed by 10/11/18. On 10-28-18, Residents #1 and #4 were immediately separated by staff. Resident #4 was immediately placed on a 1:1 sitter secondary to knocking Resident # 1 down. Resident #4 was reassessed for Brief Interview for Mental Status and proper placement in the memory care unit. Resident # 4 was moved to a room out of the memory care unit with a 1:1 sitter in an effort to decrease her agitation and her care plan was updated to reflect changes. Resident # 1 was immediately	

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F 600	Continued From page 4 notes dated 9/26/18 at 8:50 PM revealed that Resident #3 had an episode of agitation and aggressive behavior throughout the shift. She was determined that she didn't want her roommate in her room. She had it in her head the whole room was hers and belonged to her. She was cursing and being disrespectful to her roommate. She became combative with staff. She attempted to hit the nurse aide with her bedside commode. Resident #3 was left alone to calm down. Afterwards, she was reoriented to her room and her roommate (Resident #9). The curtain was pulled to allow Resident #9 to enter the room and go to bed. Nurse 2 instructed Resident #9 to ring the call light if needed. A 15 minute check was conducted to monitor Resident #3. Resident #9 rang the call light at 12:15 AM and Resident #3 was observed standing over Resident #9. Resident #3 had pulled her call bell out of the wall and was striking Resident #9 with it. Resident #3 was removed from the room and was brought to the nurse's station. She stayed up until 3 AM when she became sleepy and was brought back to her bed. A 15 minute check was continued and the psychiatric services was notified. The nurse's notes dated 10/7/18 at 6:25 PM revealed that Resident #3 was yelling at other resident saying that she stole her water pitcher. The other resident was explaining that it was not hers and Resident #3 became agitated yelling at her saying "give me my damn cup back". Resident #3 snatched the cup from other resident's hand and the staff intervened. The notes dated 10/10/18 (addendum from 10/9/18) revealed around 2 PM Resident #3 was in the television/dining room and started accusing another resident (Resident #2) of stealing her purse. Resident #3 picked up a chair and threw it at another resident (Resident #2). As Resident	F 600	assessed and found to be in pain and unable to bear weight. XRAY was ordered for Resident # 1. Resident # 1 was found to have a hip fracture, and transported to the hospital on 10-28-18. 100% skin audit was completed by the unit manager and charge nurse on all residents in the secured memory care unit on 10-28-18, no concerns identified. 100% Resident Representative interviews were completed for the locked unit residents by the Social Worker, Unit Managers, Director of Nursing, Medical Records, Maintenance Director, Dietary Manager, Admissions, Business Office, Minimum Data Set Nurse, Activities. No concerns from voiced from interviews. Example of Interview Questions: Do you feel the resident has been harmed by another resident in the facility? If yes, was facility made aware? Do you feel resident is safe in the facility? The event occurred as staff did not document and report increasing behaviors as reported during the investigation. The staff interviewed during complaint survey on 11/14-11/16 reported Resident #4 with increasing verbal aggression towards others, though the documentation in the resident chart does not reflect any concerns. A 100% all staff In Service was conducted by the Director of Nursing on 10-28-18 to include abuse and neglect, signs and symptoms of abuse and prevention of abuse, proper documentation of problematic behavior to include onset, frequency and precipitating factors. Address how the facility will identify other	

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F 600	Continued From page 5 #2 tried to walk away, Resident #3 balled her fist and hit Resident #2 in her right shoulder. The incident was witnessed and Resident #3 was immediately redirected to her room where one on one sitter was provided. An incident report dated 10/9/18 was reviewed. The report indicated that Resident #3 was noted to be agitated while in the television/dining room. Resident #3 stated "someone took my pocketbook". Resident #3 was observed to take a chair and threw it at another resident (Resident #2). When the other resident (Resident #2) walked away, Resident #3 balled her and hit her in the right arm. Residents #2 and #3 were separated and Resident #3 was taken to her room where one on one sitter was initiated as well as psychiatric services was made aware. The facility's investigation of the incident dated 10/15/18 was reviewed. The investigation revealed that on 10/9/18 at 2:30 PM, Resident #3 threw a chair at another resident (Resident #2). When Resident #2 got up to walk away, Resident #3 punched her in her right arm. Residents #2 and #3 were separated immediately. Both residents resided in the memory care unit. An assessment was completed on Resident #2 with no apparent injury noted. The responsible parties (RP) were made aware of the incident. Skin checks were obtained on all residents residing in the memory care unit with no injuries noted. RPs were called and interviewed and no reports of abuse reported. The psychiatric services was made aware and Resident #3's medications were reviewed and changes were made accordingly. Resident #3 had history of behaviors and had been followed by the psychiatric services with no improvement. Resident #3 was sent for	F 600	residents having the potential to be affected by the same deficient practice; On 11/21/18 100% audit by the unit managers and DON of all current resident notes were reviewed back to 8/01/18 for effectiveness of interventions that were put in place regarding behaviors. Changes in plan of care were made as they were identified during the audit. Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur; An in service on behavior management was initiated on 11/24/18 by the ADON to 100% all nursing staff to include all licensed nurses and certified nursing assistants to include interventions and monitoring residents, and documentation of interventions and behaviors and reporting to the on call nurse and behaviors that show signs of harm to other residents, staff, or self- harm. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: and include dates when corrective action will be completed; Beginning 11/21/18, Utilizing behavior documentation flowsheet audit tool, the Unit Managers, RN Supervisors, ADON, and/or DON reviewed progress notes and 24 hour report sheets during M-F clinical meeting 5 x weekly x 12 weeks to identify reported behaviors of residents that require intervention of services or changes in staffing ratio based on resident needs and behaviors. This will be reviewed daily by the DON, ADON, RN Supervisors, Unit Managers or	

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evaluation at the psychiatric hospital per doctor's order due to ongoing violence towards staff and other residents. Investigation was completed on 10/15/18 and allegation of abuse was substantiated.

The 24 hour report that was sent on 10/9/18 and the 5 day report that was sent on 10/16/18 were reviewed. The allegation of resident abuse on Resident #3 was substantiated.

A written statement from the witness (undated) was reviewed. The statement was written by Nurse Aide (NA) #4 (employed by home health agency) who was a sitter of another resident in the memory care unit. The statement indicated that Resident #3 took a chair on 10/9/18 and threw it at Resident #2 and the chair hit her in the right leg. Then as Resident #2 walked away, Resident #3 punched Resident #2 in the right shoulder.

An interview was conducted with Nurse #1 on 11/14/18 at 11:46 AM. Nurse #1 stated that she worked 7A-7P shift in the memory care unit. She indicated that Resident #3 was very combative, physically and verbally abusive to staff and residents when first admitted. The psychiatric services began working with her and slight improvement on her behavior was noted. On 10/9/18 after lunch, Resident #3 was very agitated. She was in the television/dining room with Resident #2. Nurse #1 stated that she was at the nurse's station when she heard the commotion. She went to the television/dining room and NA #4 informed her that Resident #3 was agitated, picked up a chair and threw it at Resident #2 hitting her right leg. When Resident #2 walked away, Resident #3 punched her on her

Administrator. The results will be presented to the Quality Assurance Committee monthly x 3.

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right shoulder. Nurse #1 stated that she assessed Resident #2 after the incident and she noticed a red spot on her right leg.

An interview with Nurse Aide (NA) # 2 was conducted on 11/14/18 at 12:05 PM. NA #2 stated that she was assigned to work in the memory care unit. She stated that Resident #3 was mean, and she threatened staff and residents saying "I will knock you out". She was verbally abusive to staff and residents. NA #2 stated that she had informed the nurses and had tried to redirect Resident #3 when she was displaying behaviors.

An interview with NA #1 was conducted on 11/14/18 at 1:16 PM. NA #1 was assigned in the memory care unit. She stated that Resident #3 was mean and hateful. She was very combative. NA #1 stated that on 10/9/18, there were 2 NAs in the unit and they were busy passing lunch trays. She heard a commotion in the television/dining room. NA #4 who was in the television/dining room had witnessed Resident #3 picked up a chair and threw it at Resident #2 and then punched her when she tried to walk away. NA #1 stated that the nurses were aware of Resident #3's behavior and when she observed Resident #3 having behaviors, she had tried to calm her down and had to redirect her away from other residents.

An interview with NA #4 was conducted on 11/14/18 at 2:21 PM. NA #4 stated that she was sent by the home health agency to sit with a resident in a memory care unit. She stated that she was sitting in the television/dining room with the resident. She observed Resident #3 agitated looking for her pocket book. Suddenly, she

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picked up a chair and threw it at Resident #2 hitting her right leg and when Resident #2 tried to get up to walk away, Resident #3 punched Resident #2 on her right shoulder. NA #4 stated that there were no staff member present in the television/dining room. The nurse's aides were busy passing the trays on the other hall dining room. She immediately separated Residents #2 and #3 before the staff members came to the room. NA #4 stated that Resident #2 did not provoke Resident #3. Resident #2 was quiet sitting in the dining table.

An interview was conducted with the PA on 11/15/18 at 10:05 AM. The PA indicated that she expected the residents in the memory care unit to be safe.

An interview with the Unit Manager (UM) was conducted on 11/15/18 at 11:56 AM. The UM stated that she was informed by Nurse #1 that there was no contact when the chair was thrown to Resident #2 by Resident #3. She indicated that she didn't know that there was a witness to the incident who observed Resident #3 threw a chair at Resident #2 hitting her right leg.

On 11/15/18 at 2:50 PM, the GNP was interviewed. She stated that she had been following Resident #3 due to her aggressive and combative behaviors. She had made changes to her medications by increasing the dose of the Seroquel and adding Ativan. The GNP further indicated that the staff in the memory care unit were good on non- pharmacological approaches like redirection, keeping them busy, playing music and offering snacks when they were agitated.

On 11/16/18 at 10:24 AM, the DON was

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interviewed. The DON stated that her expectation in the memory care unit was to keep the residents safe.

On 11/27/18 at 12:53 PM, Nurse #2 was interviewed. Nurse #2 stated that she worked 7P - 7A in the memory care unit. She was assigned to Resident #3 on 9/26/18. Resident #3 was agitated that evening when she came to work at 7 PM. Resident #3 was confused and she didn't recognize her roommate (Resident #9). Nurse indicated that she had placed Resident #9 to bed, placed her call bell within reach and instructed her to call when needed. Nurse #2 further stated that when the call light came on, she came to the room of Resident #3 and #9, and found Resident #3 standing over Resident 9 who was in bed covered up with a blanket. Resident #3 had a call bell in her hand and was beating Resident #9. Nurse #2 reported that she took Resident #3 out of the room into the nurse's station until she became sleepy and then she was placed back in bed. Nurse #2 stated that the Unit Manager was aware of Resident #3's behavior

2. Resident #4 was admitted to the facility on 7/25/16 with multiple diagnoses including dementia without behavioral disturbances, agitation and delusional disorder. The quarterly MDS assessment dated 9/4/18 revealed that Resident #4's cognition was intact and had no behavior. Resident #4 resided in the memory care unit.

Resident # 1 was admitted to the facility on 10/25/18 with multiple diagnoses including Alzheimer's disease. There was no admission Minimum Data Set (MDS) assessment completed

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yet. Resident #1 resided in the memory care unit.

The interim care plan dated 10/25/18 revealed that Resident #1 was a wanderer. The approaches included to monitor resident's whereabouts frequently and to intervene and redirect for safety as needed.

Resident #1's nurse's notes were reviewed. The notes dated 10/25/18 at 6:23 PM revealed that Resident #1 was alert to self only. The notes dated 10/27/18 at 4:00 PM revealed that Resident #1 was able to ambulate independently within the locked unit. The notes dated 10/28/18 at 7:42 PM revealed that Resident #1 entered the room of another resident (Resident #4). Resident #4 pushed Resident #1 causing her to fall. Resident #1 hit her left shoulder on the door jam and then fell onto her left side. Resident #1 was unable to extend her leg and she screamed in pain with range of motion. The staff attempted to assist Resident #1 to stand but the resident was unable to bear weight on her left leg. Resident #1 had complained of pain on her left leg/hip. The doctor was notified and he ordered x-ray of the femur/hip. The result of the x-ray showed fracture of left femur. Resident #1 was discharged to the hospital on 10/28/18.

Resident #4's nurse's notes dated 10/28/18 at 7:58 PM revealed that Resident #4 was in her room when Resident #1 entered her doorway. Resident #4 pushed Resident #2 with her walker causing Resident #2 to fall. Resident #4 denied pushing Resident #2 stating that she saw resident #2 on the floor and she shut the door because she didn't want to be involved with her.

The incident report dated 10/28/18 was reviewed.

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The report revealed that Resident #1 entered the doorway of another resident's room (Resident #4). Resident #4 pushed Resident #1 causing her to fall. Resident #1 complained of pain on her left leg/hip.

The hospital discharge summary dated 10/29/18 was reviewed. The discharge summary revealed that Resident #1 had severe dementia and was brought to the emergency room from a nursing home following a fall. Resident #1 complained of pain in her left hip and had difficulty ambulating. Left hip x-ray was done at the facility showing a left femoral fracture. Resident #1 was admitted and she underwent left hip surgery.

The psychiatric notes of Resident #4 dated 10/30/18 were reviewed. The notes revealed that Resident #4 had dementia and delusions and she continued to have delusions of her doll being a live person. The notes indicated that the staff had requested a psychiatric visit as Resident #4 had pushed her walker purposely into another resident causing the resident to fall and to break her hip. Resident #4 reported no recall of the incident. The Staff reported that Resident #4 could be bossy and pushy at times with other residents but has never been physical before. Resident #4 was also noted not to like "b .... people" and had been verbally abusive to other residents and staff.

The facility's investigation report dated 11/2/18 was reviewed. The report revealed that the Director of Nursing (DON) was called on 10/28/18 at approximately 4:30 PM to report that Resident #4 had pushed Resident #1 to the floor. Nurse #1 had witnessed Resident #1 attempting to enter Resident #4's room. Resident #1 was standing in

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the front of Resident #4's doorway, when Resident #4 took her walker and pushed it into Resident #1, causing Resident #1 to fall. The report revealed that Resident #1 hit her left shoulder on the door jam and falling on her left side. Resident #1 and #4 were separated immediately. Resident #1 was assessed and found to be in pain and unable to bear weight. The attending physician and the responsible party (RP) were contacted. The physician had ordered for an x-ray to left femur/hip on Resident #1. The x-ray result revealed a fracture to the left femur. Resident #1 was sent to the hospital at 8:10 PM. The psychiatric services was contacted and updated on the incident with Resident #4. All RPs were contacted and interviewed and there were no abuse allegations reported. Hundred percent (100%) skin assessment was conducted to all residents residing in the memory care unit. When interviewed, Resident #4 denied pushing Resident #1 stating that she was not involved at all but the incident was witnessed by Nurse #1. Resident #4 had history of becoming aggravated with other residents and she had history of wandering. A 24 hour sitter was assigned to Resident #4 and she was moved out of the memory care unit with wander guard on 10/28/18. The investigation was completed on 11/2/18 and the incident was substantiated.

The 24 hour report that was sent on 10/28/18 and the 5 day report that was sent on 11/2/18 were reviewed and the allegation for abuse on Resident #4 was substantiated.

An interview with NA #2 was conducted on 11/14/18 at 12:05 PM. Nurse Aide (NA) #2 stated that Resident #4 was verbally abusive to staff and residents. She had witnessed Resident #4

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threatening other residents when they tried to enter her room. NA #2 stated that the nurses were informed and were aware of Resident #4's behavior.

An interview was conducted on 11/14/18 at 1:16 PM with NA #1. NA #1 was assigned in the memory care unit (MCU). She stated that she normally was scheduled to work 7-3 shift but on 10/28/18 she was asked to stay over to help. NA #1 indicated that Resident #1 was confused and she wandered. Resident #4 was alert and oriented with some confusion and verbally abusive to staff and residents. Resident #4 didn't want anybody on her space and occasionally, she wound have arguments with her roommate. NA #1 stated that she tried to redirect other residents away from Resident #4's room.

An interview was conducted on 11/14/18 at 3:15 PM with Nurse #1, assigned to Resident #1. She stated that Resident #1 had memory problems and was a wanderer. Resident #4 was alert and oriented, she didn't want anybody in her room or near her room. She was verbally abusive to staff and other residents. She stated that she had witnessed Resident #4 had threatened and had pushed other residents in the past but did not cause them injuries or to fall. Nurse #1 indicated that on 10/28/18 at 4:30 PM, she had witnessed Resident #1 standing at the doorway of Resident #4, when Resident #4 with her walker pushed Resident #1. Resident #1 hit her left shoulder on the door frame and then she landed on the floor. When Resident #1 was on the floor, Resident #4 was observed pushing the door against Resident #1 trying to close the door. The nurse indicated that when she interviewed Resident #4, Resident #4 denied pushing Resident #1 but she admitted

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that she was trying to close the door because she didn't want to be involved with Resident #1. Nurse #1 stated that she was standing at the nurse's station when the incident happened and could see the doorway of Resident #4. Nurse #1 further indicated that Resident #4 was being followed by the psychiatric services for management of her behaviors and medications. The Nurse stated that the staff members were trying to redirect other residents away from her room.

On 11/14/18 at 4:23 PM, Resident #4 was observed in bed and was interviewed. She stated that Resident #1 was coming into her room and she told her "no". Resident #4 then said "I shut the door on her face" because she didn't want anybody in her room.

On 11/15/18 at 10:05 AM, the PA was interviewed. She stated that she was informed of the incident that occurred with Residents #1 and #4. The PA indicated that she expected the residents in the memory care unit to be safe.

On 11/15/18 at 11:15 AM, the Social Worker (SW) was interviewed. She stated that she was responsible for assessing the resident's cognition on the MDS assessments. The SW indicated that Resident #4's cognition was intact and she had a Brief Interview for Mental Status (BIMS) score of 14. The SW indicated that Resident #4 was alert and oriented to person, place and time but was delusional. She added that Resident #4 had exhibited some behaviors lately and these behaviors might be due to the passing of her sister about 2 weeks ago.

On 11/15/18 at 11:40 AM, NA #3 was interviewed.

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NA #3 stated that Resident #4 could be verbally abusive to staff and other residents. She had witnessed her telling other residents "get out of my room or else ..." NA #3 indicated that she tried to redirect other residents away from Resident #4's room.

On 11/15 at 10:05 AM and 1:30 PM, Resident #4 was observed in bed (outside the memory care unit) with a sitter at bedside.

On 11/15/18 at 2:50 PM, the GNP was interviewed. She stated that she had been following Resident #4 due to her delusional disorder with wandering. The GNP indicated that Resident #4 was a pleasant, calm and sweet lady and she did not have any behaviors until one day she had pushed another resident. She stated that she made changes to her medications and for the staff to continue the monitoring. The GNP further indicated that the staff in the memory care unit were good on non- pharmacological approaches like redirection, keeping them busy, playing music and offering snacks when they were agitated.

On 11/16/18 at 10:24 AM, the DON was interviewed. The DON stated that her expectation in the memory care unit was to keep the residents safe.

The Administrator and the Director of Nursing were notified of the immediate jeopardy on 11/27/18 at 8:55 AM.

On 11/28/18 at 5:07 PM, the facility provided the following credible allegation of immediate jeopardy removal:

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Address how corrective action will be accomplished for those resident found to have been affected by the deficient practice;

On 9-26-18, Resident #3 was put on Q 15 minute checks. She was monitored by the charge nurse until 9/28/18 for 24 hours/7 days a week due to cursing at her roommate, attempting to hit staff, and hitting roommate with call bell. At that time, roommate was moved out of Resident #3 room, Seroquel 50 mg by mouth at 1pm and Seroquel 150mg by mouth at 7PM were initiated by Psychiatric PA. An order for Ativan 0.5 mg q 6 hours PRN for anxiety/ agitation and Behavioral and Psychological Symptoms of Dementia was initiated if resident was up between 9pm and 2am x 12 days. On 9-27-18, Resident #3 was moved into a private room. On 9/28/18 resident was argumentative with another resident, spit out medications and refused remainder of medications.
No noted behaviors until 10-7-18, when resident yelled at another resident and snatched a cup out of resident hand. The residents were separated by staff and redirected. On 10-8-18, new orders for Haldol 0.5mg by mouth at bedtime was ordered due to increasing behaviors due to resident yelling at a resident on 10-7-18.
On 10-9-18, at 2:00PM Resident # 3, picked up a chair and threw it at Resident # 2, then proceeded to punch Resident #2 in her arm when she got up out of her chair to walk away. Home Health Certified Nursing Assistant witnessed the incident and Resident #3 was immediately separated by the aides and removed by the charge nurse from Resident # 2 and placed Resident # 3 on 1:1 until she was transported to the hospital via facility transport and sitter on 10/10/18. An assessment was done by the Nurse

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on Resident # 2, and noted a red mark on her leg. Police were called by the DON at 2:20 PM and both residents were interviewed by the officer. Neither resident was able to explain what happened as both Brief Interview for Mental Status scores are 0. Both Responsible Person and Physician were made aware of the incident by the Unit Manager. Skin checks were obtained by the Unit Manager on all residents residing in the memory care unit. No abuse was reported or assessed.
Psychiatric Physician Assistant was in house during the time of the incident on 10-9-18. Psychiatric PA reviewed Resident #3's medications and made changes to include discontinuation of Haldol, order for Ativan 0.5 mg every 6 hours as needed, discontinuation of Seroquel 150mg daily at 1pm, start Seroquel 100mg at bedtime. Psychiatric PA noted in note that no incidents since 9-26-18 and the increase of Seroquel.
The event occurred due to interventions put in place failed to prevent Resident #3 from having behaviors.
100% skin assessment of all residents in the secured memory care unit was completed by the Unit Managers on 10-9-18 No concerns were identified. 100% Resident Representative Interviews were completed for the locked unit residents by the Social Worker, Unit Managers, Director of Nursing, Medical Records, Maintenance Director, Dietary Manager, Admissions, Business Office, Minimum Data Set Nurse, Activities. No concerns from voiced from interviews. Example of Interview Questions: Do you feel the resident been harmed by another resident in the facility? If yes, was facility made aware? Do you feel resident is safe in the facility?

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A 100% all staff In-service was initiated on 10-9-18 on abuse Prevention/Intervention by the Director of Nursing. The in service included prevention of resident abuse, and recognizing signs and symptoms of abuse, dementia protocol, behavioral assessment, intervention and monitoring and behavioral management to include updating of plan of care. The In service was completed by 10/11/18.

On 10-28-18, Residents #1 and #4 were immediately separated by staff. Resident #4 was immediately placed on a 1:1 sitter secondary to knocking Resident # 1 down. Resident #4 was reassessed for Brief Interview for Mental Status and proper placement in the memory care unit. Resident # 4 was moved to a room out of the memory care unit with a 1:1 sitter in an effort to decrease her agitation and her care plan was updated to reflect changes. Resident # 1 was immediately assessed and found to be in pain and unable to bear weight. XRAY was ordered for Resident # 1. Resident # 1 was found to have a hip fracture, and transported to the hospital on 10-28-18.

100% skin audit was completed by the unit manager and charge nurse on all residents in the secured memory care unit on 10-28-18, no concerns identified. 100% Resident Representative Interviews were completed for the locked unit residents by the Social Worker, Unit Managers, Director of Nursing, Medical Records, Maintenance Director, Dietary Manager, Admissions, Business Office, Minimum Data Set Nurse, Activities. No concerns from voiced from interviews. Example of Interview Questions: Do you feel the resident has been harmed by another resident in the facility? If yes, was facility made aware? Do you feel resident is safe in the facility?

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The event occurred as staff did not document and report increasing behaviors as reported during the investigation. The staff interviewed during complaint survey on 11/14-11/16 reported Resident #4 with increasing verbal aggression towards others, though the documentation in the resident chart does not reflect any concerns.
A 100% all staff In Service was conducted by the Director of Nursing on 10-28-18 to include abuse and neglect, signs and symptoms of abuse and prevention of abuse, proper documentation of problematic behavior to include onset, frequency and precipitating factors.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

On 11/21/18 100% audit by the unit managers and DON of all current resident notes were reviewed back to 8/01/18 for effectiveness of interventions that were put in place regarding behaviors. Changes in plan of care were made as they were identified during the audit.

Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur;

An in service on behavior management was initiated on 11/24/18 by the ADON to 100% all nursing staff to include all licensed nurses and certified nursing assistants to include interventions and monitoring residents, and documentation of interventions and behaviors and reporting to the on call nurse and behaviors that show signs of harm to other residents, staff, or self- harm.

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F 600	Continued From page 20 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: and include dates when corrective action will be completed; Beginning 11/21/18, Utilizing behavior documentation flowsheet audit tool, the Unit Managers, RN Supervisors, ADON, and/or DON reviewed progress notes and 24 hour report sheets during M-F clinical meeting 5 x weekly x 12 weeks to identify reported behaviors of residents that require intervention of services or changes in staffing ratio based on resident needs and behaviors. This will be reviewed daily by the DON, ADON, RN Supervisors, Unit Managers or Administrator. The results will be presented to the Quality Assurance Committee monthly x 3. The credible allegation was verified on 11/28/18 as evidenced by interview of licensed and unlicensed staff on in-service training on abuse policy and procedure and signs and symptoms of abuse and abuse prevention. Nursing staff were interviewed and they verified that they received an in-service on behavior management, documentation of behavior and reporting of behavior to the on-call nurse supervisor. The Unit Managers and the Assistant Director of Nursing were interviewed and they verified that the audit was started on 11/21/18. The behavior documentation flowsheet audit tool was reviewed and the audit of the progress notes and the 24 hour report was started on 11/21/18.	F 600		
F 725 SS=J	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff.	F 725		12/12/18

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F 725	Continued From page 21 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide sufficient nursing staff to protect residents from physical abuse for 2 of 3 sampled residents reviewed for abuse (Residents #3 & #4). Resident #3 had beaten Resident #9 with a call bell on 9/26/18 and had thrown a chair on Resident #2 and had punched her on the shoulder on 10/9/18 causing a red spot on Resident #2's leg. Resident #4 had pushed Resident # 1 with a walker causing Resident #1 to fall and sustained a left hip	F 725	On 10-9-18 and 10-28-18, Resident #3 and Resident #4, showed behaviors towards other residents. Both residents were placed on 1:1 for continuation of monitoring of behaviors and aggression to others. Based on interviews of RP's for non alert and oriented, staff and skin assessments, no other residents had an increased monitoring need to adjust for increased staffing. On 10-9-18 the incident was not	

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F 725	Continued From page 22 fracture on 10/28/18. Immediate jeopardy began on 9/26/18 when the facility failed to have sufficient nursing staff to monitor and to protect Residents # 9 and #2 from abuse by Resident #3. Resident #3 had beaten Resident #9 with a call bell on 9/26/18 and had thrown a chair and punched Resident #2 causing a red spot on her leg on 10/9/18. The facility also failed to have sufficient nursing staff to monitor and to protect Resident #1 from abuse by Resident #4 by pushing Resident #1 with a walker causing Resident #1 to fall and to fracture her hip on 10/28/18. Immediate jeopardy was removed on 11/28/18 when the facility provided an acceptable credible allegations. The facility remains out of compliance at a lower scope and severity of D (no harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Findings included: This tag is crossed referred to: F 600 - Based on record review, observation and staff, Physician Assistant (PA) and Geriatric Nurse Practitioner (GNP) interview, the facility failed to protect cognitively impaired residents from physical abuse for 2 of 3 sampled residents reviewed for abuse (Residents #3 & #4). Resident #3 who was cognitively impaired and had repeated aggressive behaviors towards other residents, had beaten Resident #9 (who was cognitively impaired) with a call bell on 9/26/18 and had thrown a chair on Resident #2 (who was cognitively impaired) and had punched her on the shoulder on 10/9/18 causing a red spot on	F 725	witnessed by facility staff. The 10-28-18 incident was witness by a staff member, but the staff member was unable to intervene timely. The nurse was standing at her cart and saw resident #1 walking down the hall approximately 75 to 100 feet from her. She then saw resident #4 push her walker into resident #1 causing resident #1 to fall. On 10-7-18, Resident #3 showed aggressive behaviors toward another resident and residents were separated. On 10-8-18, Haldol every 6 hours as needed was ordered. On 10/9/18, Resident #3 and Resident #2 were separated after resident # 3 threw a chair at resident #2 and then hit her arm as she stood from her chair to walk away. Resident #3 was placed on a 1:1. Resident #3 was seen by the Psychiatric PA on 10-9-18, with medication changes. On 10-10-18, Resident #3 showed increased aggressive behaviors to staff and residents, and was discharged to the hospital for evaluation and treatment. Resident #2 was assessed and denied pain and was taken to activities. On 10-28-18, Resident #4 was placed on a 1:1 sitter secondary to knocking Resident # 1 down. Residents were immediately separated, to include placing Resident #4 on 1:1 sitter. Resident #1 was transported to the hospital secondary to a hip fracture. On 10-28-18, a 100% staff in service was provided by the Director of Nursing to include Abuse and prevention of abuse, signs and symptoms of abuse, proper documentation and reporting of	

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Resident #2's leg. Resident #4 who was cognitively intact and was verbally abusive to other residents pushed Resident # 1 (who was cognitively impaired) with a walker causing Resident #1 to fall and sustained a left hip fracture on 10/28/18.

An interview with Nurse #1 was conducted on 11/14/18 at 11:46 AM and at 3:15 PM. Nurse #1 stated that she had worked 7A-7P in the memory care unit. She indicated that the residents needed constant monitoring especially Resident #3. Resident #3 was very combative, physically and verbally abusive to staff and residents and she needed constant redirection. Resident #4 was verbally abusive and she didn't want anybody in her room or near her room so other residents needed to be redirected away from her room. Nurse #2 stated that two Nurse Aides (NAs) were not enough to take care of resident's needs and to monitor the residents in the unit. She indicated that when the 2 NAs were in the resident's rooms providing care and she was passing medications, there were no staff members on the hall to keep an eye on these residents.

An interview with NA #2 was conducted on 11/14/18 at 12:05 PM. NA #2 stated that she worked in the memory care unit. She stated that the residents in the unit had behaviors and they needed to be redirected. She indicated that their behaviors were unpredictable and they could hurt other residents. NA #2 stated that two NAs on the hall were not enough to monitor the residents and at the same time to provide care.

An interview with NA #1 was conducted on 11/14/18 at 1:16 PM. NA #1 stated that she had worked in the memory care unit. She stated that

problematic behavior to include onset, frequency and precipitating factors. This was completed on 10/31/18.
An in service was initiated on 11-24-18 by the Director of Nursing and the Assistant Director of Nursing, and completed on 11/26/18 to include monitoring of behavior and behavioral interventions to all licensed nurses by the Director of Nursing and the Assistant Director of Nursing.
The in service also covered notification of the on call nurse immediately for resident behaviors that show signs of aggression, harm to others or harm to self to accommodate for resident needs and staffing changes.
On 11-21-18 an audit was conducted by the Unit Managers to evaluate residents for behaviors that require additional services or change of staffing need to accommodate the residents. The audit was conducted on progress notes and 24 hour reports dating back to August 1, 2018 to present. Based on the evaluations, one resident was identified as having an increased need, and resident was put on Q15 mins behavior checks, Based on the resident needs and behaviors, resident monitoring by staff will be adjusted accordingly in order to provide adequate supervision to the changing needs of the resident behaviors.
The QA process began on 11-21-18 by utilizing the review of progress notes and verbal report in the M-F clinical meeting and from the on call nurse to assist in the determining residents that may need increased monitoring by staff. The DON, ADON, RN Supervisors, Wound Nurse or

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F 725	Continued From page 24 Resident #3 was very combative, mean and hateful. She needed to be redirected all the time away from other residents. NA #1 indicated that Resident #4 didn't want anybody on her space so other residents had to be redirected away from her room. NA #1 reported that the facility was short of staff especially nurse aides. At times, there were three NAs assigned but when another NA had called out in the other hall, the NA in the unit was the first one they had to pull out leaving the unit with just two NAs. With two NAs in the unit was very hard. She tried her best to provide the care but she didn't have the time to monitor the residents. An interview with the Director of Nursing (DON) was conducted on 11/16/18 at 10:24 AM. The DON stated that she assigned nursing staff in the unit depending on the resident's needs and the behaviors. She would like three NAs assigned at all times but that varies depending on the resident's needs. The DON also reported that the facility was short of NAs especially on the second shift and they had tried hiring more NAs. The DON stated that her expectation in the memory care unit was to keep the residents safe. An interview with Nurse #3 was conducted on 11/27/18 at 4:30 PM. Nurse #3 stated that she had worked in the memory care unit. She indicated that residents in the unit had behaviors that needed to be monitored. She indicated that with two NAs assigned in the hall was not enough to take care of the residents and to keep an eye on them. She added that the unit was short staff and was really bad couple of months now. On 11/27/18 at 4:35 PM, the memory care unit was observed. There were no NAs observed on	F 725	Unit Managers will use the behavior staffing monitoring tool to document residents with behaviors. The QA team will review the results of the behaviors documentation weekly to ensure interventions are appropriate and effective weekly x 12 weeks beginning 11/21/18. The Director of Nursing will bring the results of the audits to the Quality Assurance Committee Meeting Monthly x 3. This in service will be added to the new nurse hire orientation.	

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the hall. When interviewed, Nurse #3 stated that one NA was giving a shower and the other NA was taking a resident to smoke. She also stated that the third NA was pulled to work on the other hall but she was told that another NA was coming to replace. The Unit Manager and the Social Worker were observed in the unit but they were in their offices.

An interview with NA #5 was conducted on 11/28/18 at 8:50 AM. She stated that she had worked in the memory care unit. She stated that at times she was asked to stay over due to short staff. NA #5 indicated that two NAs in the unit was rough, a lot of residents with behaviors and they needed to be monitored. If the two NAs were in the resident ' s room, there were no NA on the hall to monitor the residents.

An interview with Scheduler #1 and #2 was conducted on 11/28/18 at 10:05 AM. Scheduler #1 stated that she tried to schedule 2-3 NAs in the unit depending on the census. She stated that the facility was short of NAs and they were trying to hire more NAs but most of them would not stay. When there were call outs, she tried to call other NAs to come in or she would request other NAs to stay over. Scheduler #2 stated that the facility had staffing issues but they had tried to hire more staff especially NAs.

The Administrator and the Director of Nursing were notified of the immediate jeopardy on 11/27/18 at 8:55 AM.

On 11/28/18 at 5:07 PM, the facility provided the following credible allegation of immediate jeopardy removal:

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Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

On 10-9-18 and 10-28-18, Resident #3 and Resident #4, showed behaviors towards other residents. Both residents were placed on 1:1 for continuation of monitoring of behaviors and aggression to others. Based on interviews of RP ' s for non-alert and oriented, staff and skin assessments, no other residents had an increased monitoring need to adjust for increased staffing.
On 10-9-18 the incident was not witnessed by facility staff.
The 10-28-18 incident was witness by a staff member, but the staff member was unable to intervene timely. The nurse was standing at her cart and saw resident #1 walking down the hall approximately 75 to 100 feet from her. She then saw resident #4 push her walker into resident #1 causing resident #1 to fall.
On 10-7-18, Resident #3 showed aggressive behaviors toward another resident and residents were separated. On 10-8-18, Haldol every 6 hours as needed was ordered. On 10/9/18, Resident #3 and Resident #2 were separated after resident # 3 threw a chair at resident #2 and then hit her arm as she stood from her chair to walk away. Resident #3 was placed on a 1:1. Resident #3 was seen by the Psychiatric PA on 10-9-18, with medication changes. On 10-10-18, Resident #3 showed increased aggressive behaviors to staff and residents, and was discharged to the hospital for evaluation and treatment. Resident #2 was assessed and denied pain and was taken to activities.
On 10-28-18, Resident #4 was placed on a 1:1 sitter secondary to knocking Resident # 1 down.

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Residents were immediately separated, to include placing Resident #4 on 1:1 sitter. Resident #1 was transported to the hospital secondary to a hip fracture.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

On 11-21-18 an audit was conducted by the Unit Managers to evaluate residents for behaviors that require additional services or change of staffing need to accommodate the residents. The audit was conducted on progress notes and 24 hour reports dating back to August 1, 2018 to present. Based on the evaluations, one resident was identified as having an increased need, and resident was put on Q15 mins behavior checks,

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

On 10-28-18, a 100% staff in service was provided by the Director of Nursing to include Abuse and prevention of abuse, signs and symptoms of abuse, proper documentation and reporting of problematic behavior to include onset, frequency and precipitating factors. This was completed on 10/31/18.
An in service was initiated on 11-24-18 by the Director of Nursing and the Assistant Director of Nursing, and completed on 11/26/18 to include monitoring of behavior and behavioral interventions to all licensed nurses by the Director of Nursing and the Assistant Director of Nursing. The in service also covered notification of the on call nurse immediately for resident behaviors that show signs of aggression, harm to others or harm

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to self to accommodate for resident needs and staffing changes.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.

Based on the resident needs and behaviors, resident monitoring by staff will be adjusted accordingly in order to provide adequate supervision to the changing needs of the resident behaviors. The QA process began on 11-21-18 by utilizing the review of progress notes and verbal report in the M-F clinical meeting and from the on call nurse to assist in the determining residents that may need increased monitoring by staff. The DON, ADON, RN Supervisors, Wound Nurse or Unit Managers will use the behavior staffing monitoring tool to document residents with behaviors. The QA team will review the results of the behaviors documentation weekly to ensure interventions are appropriate and effective weekly x 12 weeks beginning 11/21/18. The Director of Nursing will bring the results of the audits to the Quality Assurance Committee Meeting Monthly x 3. This in service will be added to the new nurse hire orientation.

The credible allegation was verified on 11/28/18 as evidenced by interview of licensed and unlicensed staff on in-service training on abuse policy and procedure and signs and symptoms of abuse and abuse prevention. Nursing staff were interviewed and they verified that they received an in-service on behavior management, documentation of behavior and reporting of behavior to the on-call nurse supervisor. The Unit Managers and the Assistant Director of

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F 725	Continued From page 29 Nursing were interviewed and they verified that the audit was started on 11/21/18. The behavior documentation flowsheet audit tool and the behavior staffing monitoring tool were reviewed and the audit of the progress notes and the 24 hour report was started on 11/21/18.	F 725		