STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 02/08/2019

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PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 2/5/19 through 2/8/19. Immediate Jeopardy was identified at: CFR 483.12 at tag F 600 at a scope and severity J CFR 483.12 at tag F 607 at a scope and severity J Tags F 600 and F607 constituted Substandard Quality of Care Immediate Jeopardy began on 1/9/19 and was removed on 2/8/19. An extended survey was conducted. An amended Statement of Deficiencies was provided to the facility on 04/08/19 because the results of the facility's Informal Dispute Resolution (IDR) deleted two examples from tag F-835 which resulted in the tag's scope and severity being lowered from a "J" level to an "E" level. The information in tag F-0000 was also changed to reflect the results of the facility's IDR. Event ID #2RY011.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose	F 561		3/14/19

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

Electronically Signed | 03/03/2019

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F 561	Continued From page 1 activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to provide showers as scheduled for 1 (Resident #4) of 3 sampled residents reviewed for preferences. The findings included: Resident #4 was admitted 5/16/11 with cumulative diagnoses of Diabetes, Anxiety and Depression. The quarterly Minimum Data Set dated 9/26/18 indicated severe cognitive impairment and she was coded for physical behaviors. Resident #4 was coded for total assistance with bathing and hygiene. Review of Resident #4's care plan last revised 11/21/18 read she required assistance with her	F 561	This plan of correction constitutes a written Allegation of Compliance with federal and state requirements. Preparation and submission of this Allegation of Compliance does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. 1)Processes that lead to the deficiency cited were lack of oversight in requesting preferred bathing method of alert and oriented residents. Corrective Action was	

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F 561	Continued From page 2 ADLs due to functional limitations related the left side hemiplegia and limited range of motion due to contractures. Review of the undated D Hall Bath List indicated Resident #4 was to receive a shower on Tuesday, Thursday and Saturday on second shift. Review of the electronic bath record from 12/21/18 to 2/6/19 revealed Resident #4 had not received a shower at any time. In an observation on 2/6/19 at 11:45 AM, Resident #4 was sitting in a high back wheelchair in the dining room waiting for lunch. She was clean and absent of odors. Resident #4 was pleasant and cooperative. Her legs were observed to be flexed at the knees. In an interview on 2/6/19 at 1:30 PM, Nursing Assistant (NA) #3 stated she was not aware of any shower refusals for Resident #4 but that she did not fit properly in the shower chair because it was uncomfortable due her bilateral leg contractures. NA #3 stated she could not recall if she informed anyone of issues with the shower chair and Resident #4 and stated he had not attempted to give her a shower on second shift. During an observation with the Director of Nursing (DON) on 2/6/19 at 2:10 PM, the shower room on Daisy Lane Hall housed a bariatric padded shower chair and a regular padded shower chair. The DON stated she was aware	F 561	accomplished for affected resident (#4) by the deficient practice by: Occupational Therapy evaluation was conducted on 2/7/19 by the Therapy Outcomes Coordinator (TOC). TOC performed shower evaluation with 3 Certified Nursing Assistants present and provided showering techniques to 3 Certified Nursing Assistants on positioning resident (#4). Proof of evaluation and findings was submitted to Surveyors on 2/7/19 by the Therapy Outcomes Coordinator. The above process corrected the deficiency as it relates to Resident #4 as evidenced by resident #4 has received showers since Therapy evaluation on 2/7/19. 2)The procedure for implementing an acceptable Plan of correction including identification of other potential residents affected for the deficiency and to protect those residents from similar situations related to the choice of shower preferences are as follows: The Director of Health Services (DHS)/Assistant Director of Health Services (ADHS)/Clinical Competency Coordinator (CCC) interviewed Alert and Oriented residents on shower/bath preferences starting 3/1 and will conclude by 3/11/19. Family interviews were conducted by the DHS on those residents deemed not able to be interviewed for shower/bath preferences starting 3/1 and will conclude by 3/11/19. The findings will be entered into Smart Charting by the DHS to ensure communication to Nursing Department with a completion date set for 3/11/19. A reclining shower chair was also	

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F 561	Continued From page 3 that Resident #4 was not receiving her showers as scheduled but was receiving bed baths. She stated this was probably due to her limited range of motion in her legs and that it would likely be uncomfortable for her in the shower chair. The DON stated she was not aware of any refusals of showers, but that Resident #4 could tell the staff what she wanted and did not want. She stated staff had not reported any shower chair positioning issues to her and that she just assumed that was why they weren't giving her showers. In an interview on 2/6/19 at 2:45 PM, the Rehabilitation Manager (RM) stated Resident #4 was last seen in April 2018 but that was due to eating issues. She stated Resident #4 had received no physical or occupational therapy since 2015 and she had not received any referrals for positioning concerns related to the use of her wheelchair or the use of the shower chair. The RM stated she would follow up with the DON to determine Resident #4's safety in the shower chair to receive her showers. In an interview on 2/6/19 at 5:20 PM, NA #4 stated he had not attempted to give Resident #4 a shower since he had been working on second shift in over a year. He stated Resident #4 "bobbles" and leans to one side when she was sitting up in her wheelchair. He stated he had not reported any concerns related to Resident #4's wheelchair or shower chair positioning. NA #4 stated it would take two staff members to give Resident #4 a shower and that there was not another person on second shift available so that was why she was only receiving bed baths.	F 561	obtained by Central Supply on 2/19/19 for residents unable to maintain an upright position. 3)The procedure for implementing an acceptable Plan of correction including identification of other potential residents affected for the deficiency cited is as follows: Nursing Staff (Full Time, Part time, and as needed staff) received education on F561 on 2/18/19 by the DHS and Administrator. This education was also provided to staff on 2/19/19 by the Clinical Competency Coordinator (CCC). FT/PT/ and as needed Nursing staff will not be allowed to work until receiving this education. New hires to the facility will receive education on F561 by the CCC during orientation. 4)To ensure solutions are sustained the facility will implement the following procedures to monitor performance: New admissions to facility will be interviewed by the Admitting Nurse for bath/shower preferences. Family input will be obtained by the Admitting Nurse for those residents deemed not able to be interviewed. Preferences will be noted on admission observation form and entered into Smart charting by the DHS/ADHS/CCC within 24 hours to ensure communication. DHS/ADHS/CCC will audit 10 residents via Smart Charting daily for 7 days, weekly for 3 weeks, then monthly ensure showers/baths are documented per resident preference. Results of the audits will be reviewed during facility Quality Assurance Performance Improvement	

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F 561	Continued From page 4 During another observation on 2/7/19 at 9:41 AM, Resident #4 was sitting up in her wheelchair. She was not observed leaning and was sitting straight up in her high back wheelchair. Her knees were bent and there was no observed evidence of lower extremity contractures. Resident #4 was unable to straighten her legs on request stating her legs were "stuck." In an interview on 2/7/19 at 11:45 AM, the RM stated she performed an evaluation early on 2/7/19 and there was no safety or positioning issues with Resident #4 in the shower chair. She stated she loved getting a shower and it was safe for Resident #4 to sit in the shower chair for the aides. In another interview on 2/7/19 at 11:50 AM, the DON stated it was her expectation that Resident #4 receive her showers as scheduled.	F 561	Committee monthly to ensure compliance with above plan of correction. The DHS/ADHS will present finding in Quality Assurance. 5) Compliance Date 3/14/2019	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		3/14/19

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F 584	Continued From page 5 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to maintain the roof in good repair with evidence of multiple leaks in the facility's ceiling. This was observed in 1 resident room, on the hallways, the multi-purpose room and the dining room. The facility also failed to maintain resident privacy curtains clean and off the floor in 9 resident rooms observed for environmental cleanliness.	F 584	1)A. Processes that lead to the deficiency cited were flat top roof on facility is in need of replacement. Facility roof approved for replacement on 2/22/2019 and scheduled for replacement to start on 3/14/2019. (1) a. Hallway ceiling vents on B hall outside of rooms 125 and 126 will have roof sealed to prevent future moisture damage and repair of current	

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F 584	Continued From page 6 The findings included: 1. Observations of the facility's environment revealed the following ceiling areas had water or moisture damage: a. On 2/5/19 at 10:30 AM the hallway ceiling vents on B hall outside rooms 125 and 126 had moisture damage. b. On 2/5/19 at 10:35 AM the hallway ceiling on the A hall outside room 104 revealed it was bulging from apparent water damage. c. On 2/5/18 at 10:37 AM the hallway ceiling outside room 114, revealed an area that appeared wet and cracked. d. On 2/5/19 at 10:43 AM the fire detector on the D hallway ceiling near the nurses' station had moisture damage around it. e. On 2/5/19 at 10:45 AM the hallway ceiling outside room 156 had a hole where the support board was visible. f. On 2/5/19 at 10: 50 AM the hallway ceiling on C hall outside room 141 had multiple cracks and evidence of moisture damage. g. On 2/5/19 at 10:52 AM the hallway ceiling outside room 143 had evidence of ceiling patching with evidence of moisture damage. h. On 2/5/19 at 10:54 AM of the hallway ceiling outside room 149 had evidence of moisture damage around the vent. i. Observations of room 122 on 2/5/19 at 2:45 PM revealed the ceiling above the room's window was observed with evidence of moisture damage. Interview with the resident, who resided in the bed next to the window, stated when it rained, the ceiling leaked, and the staff moved his bed and put a trash can under the leak to catch the water that leaked from the ceiling. j. On 2/5/19 at 4:00 PM, the ceiling in the dining room had multiple areas of moisture damage.	F 584	moisture damage the facility Maintenance Director by 3/8/2019. (b) Hallway ceiling on A Hall outside of room 104 will have roof sealed and current water damage repaired by facility Maintenance Director by 3/8/2019. (c) Facility Maintenance Director will seal the roof and repair ceiling outside of room 114 by 3/8/2019. (d) Ceiling on D hallway around the fire detector near the nurses station will be repaired by the facility Maintenance Director and the Maintenance Director will seal the roof above this area by 3/8/2019. (e) Facility Maintenance Director closed the hole in the ceiling outside of room 156 on 2/8/2019 and support beam is no longer visible. (f) Facility Maintenance Director will seal roof above area outside of room 141 and repair cracks in ceiling outside of room 141 by 3/12/2019. (g) The roof above the hallway ceiling outside of room 143 will have the roof sealed and ceiling repaired by facility Maintenance Director by 3/12/2019. (h) The roof above the hallway ceiling outside of room 149 will have the roof sealed and ceiling repaired by facility Maintenance Director by 3/12/2019. (i) Residents were moved out of room 122 on 2/11/2019 until roof over the residents room is repaired. Roof repair is scheduled on begin on 3/14/2019. (j) The roof area over the multi-purpose room will be sealed by the Maintenance Director and the ceiling repaired by 3/12/2019. B. Processes that lead to the deficiency cited included facility not having an effective monitoring system to identify,	

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F 584	Continued From page 7 Observation of the multi-purpose room off from rehabilitation room had multiple areas of moisture damage to the ceiling. In an interview on 2/5/19 at 4:00 PM, the Physical Therapist stated the therapy staff used the multi-purpose room for resident therapy and that when it rained, they had to use trash cans to collect the rain water that leaked from the ceiling. In an interview on 2/5/19 at 12:10 PM, Nurse #2 and Nurse #3 stated the ceiling in the hallways and dining room leaked often and the staff used trash cans to catch the rain and put out wet floor signs when it rained. In an interview on 2/6/19 at 1:30 PM, Nursing Assistant (NA) #7 and NA #3 stated the ceiling leaked every time it rained. Both aides reported the ceiling had been leaking for a few years. In an interview on 2/6/19 at 1:40 PM, NA # 5 and NA #6 stated every time it rained, the ceiling leaked all over the facility. NA #5 stated they used trash can to catch the water. NA #6 stated she was aware of the ceiling leak in room 122. She stated she did not report it because everyone knew it leaked. In an interview on 2/6/19 at 1:45 PM, the Environmental Director stated the ceiling leaked every time it rained, and staff used trash cans to catch the rain water. She stated the facility put out wet floor signs and she frequently mobbed up rain water in the halls. In an interview on 2/7/19 at 9:10 AM, the Maintenance Director stated he had worked at the facility for 2 years. He stated the ceiling leaked since he worked at the facility. The	F 584	remove, and replace privacy curtains that are too long in length and soiled. On 2/7/2019 facility Environmental Services Director replaced privacy curtains in rooms 104,112,117, 131, 145, 146, 151, 156, and 162 with clean curtains that do not touch the floor. Curtains found too long in length were discarded. 2)The procedure for implementing an acceptable Plan of correction including identification of other potential residents affected for the deficiency cited is as follows: A. Facility Maintenance Director conducted visual inspection of facility ceilings on 2/27/2019 to ensure no other areas had holes in need of repair or residents in rooms with visible signs of water damage. Inspection did not show other areas on ceiling with holes or resident rooms with evidence of water damage. B. Facility Environmental Services Director conducted a visual audit of all the facility privacy curtains on 2/7/2019. 14 curtains identified as too long or visibly soiled and were discarded by facility Environmental Services Director on 2/7/2019. 3)The Facility implemented the following systemic changes to ensure cited deficiency does not reoccur: A. Facility Administrator educated Department Heads on March 5, 2019 to educate employees which they directly	

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F 584	Continued From page 8 Maintenance Director stated the previous Maintenance Director obtained a quote of the placement of the roof about 2 years ago and the facility was still waiting on corporate approval. He stated another quote was sent to corporate recently, but the facility was still waiting on approval. He stated he was not aware of the ceiling leak in room 122 but was aware of a ceiling leak in room 108 that was repaired. The Maintenance Director stated that room 122 was a corner room and that would explain why it was leaking. He stated he patched the ceiling holes using an acrylic resin that forms a thick rubber cover that expands and contracts with the roof. He stated the acrylic resin worked for a while, but it eventually leaks again, and he would re-patch it. The Maintenance Director stated he was not aware of the ceiling leak around the smoke detector on C hall and he noticed the hole in the ceiling outside room 150 around the vent on C hall yesterday and was planning to patch it today with a fire sealant that acts as a barrier. He stated the dining room and multi-purpose room had been repaired and that the ceiling just needed to be painted to hide the staining. The Maintenance Director provided evidence of two roof quotes dated 1/9/18 and another quote dated 11/13/18. He stated he was not aware of the status of the roof repairs since he had not heard anything regarding the quotes and corporate would let the Administrator know of the status. In an interview on 2/8/19 at 10:35 AM, the Administrator stated she received no response from corporate regarding the most recent quote to replace the facility's roof dated 11/13/18. She stated she was out of work during that time, but to	F 584	supervise to report noticed holes in ceilings, water leaks during and after rain events, as well as damage to the ceiling to the Facility Maintenance Director via facility electronic Preventative Maintenance system. Facility Maintenance Director educated licensed and unlicensed facility employees on March 8, 2019 & March 11, 2019 to report noticed holes and water leaks in ceiling in writing via facility electronic Preventative Maintenance system. Facility Employees not attending one of the above training sessions were not permitted to work until training was completed with Direct Supervisor. New Hires are provided this education by the Facility Maintenance Director during Orientation. Facility Maintenance Director Facility Maintenance Director conducts visual audits of ceiling to ensure no holes or areas showing signs of leaks are found. Resident rooms found to have significant ceiling damage will have resident moved out of room until the ceiling is repaired. Facility Administrative staff check ceilings in and around assigned resident rooms during daily visual inspections. Ceilings with problems are marked on round form and a copy of the form identifying the problem ceiling is given to the Maintenance Director. B.Facility Environmental Services Director educated facility employees on March 1, 2019 to report privacy curtains found to be soiled or too long in length via facility electronic Preventative Maintenance system. Facility Environmental Services	

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F 584	Continued From page 9	F 584		

her knowledge there had been no corporate approval. The Administrator stated it was her expectation that the roof not leak, and she was aware of the accident risk associated with the leaking roof.

2. Observations during the initial tour of the facility on 2/5/19 at 10:30 AM, the resident privacy curtains on A hall in rooms 104, 112 and 117 were observed dirty with visible shoe prints and dust resting on the floor. The privacy curtain on B hall in room 131 was observed dirty with visible shoe prints and dust resting on the floor. The privacy curtain on C hall in rooms 145, 146 and 151 were observed dirty with visible shoe prints and dust resting on the floor. The privacy curtains on D hall in rooms 156 and 162 were observed dirty with visible shoe prints and dust resting on the floor.

During an interview with the Environmental Director on 2/7/19 at 10:05 AM stated she loaned some of her privacy curtains to another facility and when they returned them, they were too long. She stated she thought she removed them from circulation, but she apparently did not. The Environmental Director was unable to explain why the rooms identified with dirty privacy curtains were recently deep cleaned.

In an interview on 2/6/19 at 1:45 PM, the Environmental Director stated when the rooms were deep cleaned, the staff inspected the privacy curtains at that time to determine if they need to be changed and laundered. She stated the computer program used at the facility let her know what rooms need to be deep cleaned.

Review of the electronic deep cleaning schedule read room 154 was cleaned on 1/2/19, room 145

Director conducts visual audits of privacy curtains to ensure none are too long in length or soiled. Curtains identified as too long or soiled are removed and replaced by an Environmental Service Department employee. Facility Administrative personnel check privacy curtains during rounds in assigned resident rooms. Curtains identified as a problem are marked on round sheet and a copy of the sheet is given to the Environmental Service Director.

4)To ensure solutions are sustained the facility will implement the following procedures to monitor performance:

A.The facility Maintenance Director will conduct visual audit of facility ceilings weekly for four weeks, then monthly thereafter, to ensue no holes currently found in need of repair or persistence of water damage post roof replacement and currently in resident rooms. Facility Maintenance Director will present audit results with proof of corrections if needed monthly to facility Quality Assurance and Performance Improvement Committee to ensure continued compliance.

B.The facility Environmental Services Director will conduct visual audits of facility privacy curtains weekly for four weeks, then monthly thereafter, to ensure on privacy curtains in residents□ rooms are soiled or too long. Facility Environmental Services Director will present audit results with proof of corrections if needed monthly to facility

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F 584	Continued From page 10 was deep cleaned on 1/3/19, room 145 was deep cleaned on 1/4/19, room 156 was deep cleaned on 1/7/19, room 162 was deep cleaned on 1/15/19, room 117 was deep cleaned on 1/21/19, room 131 was deep cleaned on 1/25/19, room 145 was deep cleaned on 2/4/19 and room 146 was deep cleaned on 2/4/19. In an interview on 2/7/19 at 5:10 PM, the Administrator stated it was her expectation that the resident privacy curtains be clean and off the resident floor.	F 584	Quality Assurance and Performance Improvement Committee to ensure continued compliance. 5)Date of Completion □ 3/14/2019	
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, observation, family interview, facility staff interviews, and laboratory company staff interviews, the facility failed to protect a resident from staff to resident physical abuse for 1 of 2 residents (Resident #1) reviewed for staff to resident abuse.	F 600	1)Processes that lead to the deficiency cited were not providing a safe environment and protecting resident from physical abuse when Certified Nursing Assistants (NA#1 &NA#2) were returned to work on January 17, 2019 in light of	3/14/19

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F 600	Continued From page 11 Immediate Jeopardy began on 1/9/19 when a Laboratory Phlebotomist observed Nursing Assistant #1 hit a cognitively impaired resident (Resident #1) on her face with a closed fist and on the shoulder with an open hand as Nursing Assistant #2 restrained the resident in her wheelchair. Immediate Jeopardy was removed on 2/8/19 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: Resident #1 was admitted to the facility on 12/21/18 with diagnoses that included stroke, aphasia, and dementia. Resident #1' s undated baseline care plan indicated she had an adjustment difficulty to new environment related to recent admission and a diagnosis of psychosocial adjustment difficulty. The interventions included: assess and monitor mood and behavior and address emotional and psychosocial needs. This baseline care plan also indicated Resident #1 had an Activities of Daily Living (ADL) decline, impaired physical mobility, and was a fall risk related to right sided paralysis/weakness following a cerebrovascular accident (CVA). The interventions included encouraging Resident #1 to do as much as possible, keep environment safe, and cue for safety awareness.	F 600	statements of Laboratory Phlebotomist and Certified Nursing Assistant (NA#1 & NA#2) stating they placed hand on the body of resident#1. On 2/8/2019 NA#1 & NA#2 were terminated from employment of the facility. 2)The procedure for implementing an acceptable Plan of correction including identification of other potential residents affected for the deficiency cited is as follows: Brief Interview of Mental Status (BIMS) of 8 or above to find out if they have been abused or have witnessed abuse. If residents have statements positive for abuse those residents will be re-interviewed by Administrator and Director of Health Services to ensure they are free from harm and statements are thoroughly investigated and reported to appropriate agency. Six residents made negative comments and were re-interviewed on 2/6/2019 and 2/7/2019 by Facility Administrator, Director of Health Services, and Assistant Director of Health Services. Two of the six residents were hallucinating, one resident was describing an event prior to admission to the facility, two residents stated the staff was trying to help them but needed more than one person to give care to them, and the last one stated they did not want the staff to speak negatively about other staff members in their presence. All six residents were asked again about abuse and stated they were not abused and had not witnessed abuse. The residents care plans were updated with their request	

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F 600	Continued From page 12 On 12/26/18 the baseline care plan was updated to include the area of behavioral symptoms with a handwritten note that stated a new physician ' s orders was received for Resident #1 for Aricept (cognition enhancing medication) related to dementia with behaviors. There were no interventions added to the baseline care plan related to behavioral symptoms. The admission Minimum Data Set (MDS) assessment dated 12/28/18 for Resident #1 was not completed in the area of cognition as the resident interview for mental status and staff interview for mental status were blank. She was assessed with inattention and disorganized thinking fluctuating in presence. Resident #1 had no physical behaviors, no verbal behaviors, and no rejection of care. She was noted with other behavioral symptoms and wandering behaviors on 1 to 3 days. Resident #1 was assessed as requiring the limited assistance of 1 for bed mobility, transfers, and locomotion on/off the unit. She required the extensive assistance of 1 with dressing, toileting, and personal hygiene. She was not steady on her feet and was only able to stabilize with staff assistance. Resident #1 utilized a walker and wheelchair, she was occasionally incontinent of bladder and bowel, she had no skin issues, and she had sustained no falls. A body audit form dated 1/5/19 indicated no bruising to Resident #1 on her facial region or any other area. The initial allegation (24-hour report) dated 1/9/19 completed by the Administrator indicated an allegation of the staff to resident physical abuse. The incident occurred on 1/9/19 at approximately	F 600	and/or behaviors. Staring 2/6/2019 and ending 2/7/2019 facility Administrative Nurses conducted and documented skin audits for current facility residents to include those with a Brief Interview of Mental Status (BIMS) of 7 or below to ensure residents were identified via these audits for potential abuse. No areas were found during this audit to indicate abuse. 3)The Facility implemented the following systemic changes to ensure cited deficiency does not reoccur: The Regional Senior Nurse Consultant conducting education with facility Administrator, Assistant Director of Health Services, Clinical Competency Coordinator and Director of Health Services related to facility policy regarding prevention of abuse, indicators of abuse, reporting abuse, and investigation abuse on 2/6/2019 to ensure resident safety. On 2/6/2019 the Regional Senior Nurse Consultant conducted education with facility Administrator, Assistant Director of Health Services, Clinical Competency Coordinator and Director of Health Services related to prevention of abuse, indicators of abuse, reporting abuse, and investigation abuse. On 2/6/2019 the facility Clinical Competency Coordinator began educating Licensed and Unlicensed Nursing Clinical staff, Dietary staff, Environmental staff, Administrative staff, and Rehabilitation staff on proper procedures for preventing and reporting abuse to ensure resident safety. Facility staff who have not completed education will be removed from the schedule until	

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F 600	Continued From page 13 5:15 AM. The allegation details stated that Laboratory Phlebotomist (LP) witnessed Nursing Assistant (NA) #1 "strike" Resident #1 on her left shoulder while NA #2 held her by the shirt. LP stated that she stayed in the room with Resident #1 to ensure she was not touched anymore by NA #1 or NA #2. Both NAs (NA #1 and NA #2) were noted to leave the room and LP pushed Resident #1 in her wheelchair to the nurse ' s station. The details of physical or mental injury/harm read, "Body audit revealed bruise to the face area [of Resident #1]." This form was completed by the Administrator on 1/9/19. The investigation report (5-working day report) dated 1/16/19 completed by the Administrator repeated the same allegation details and had no comments written in the section for "additions/changes/updates to description of allegation details". This investigation report provided conflicting information from the previous initial allegation as it stated no physical injury/harm and no substantial risk of injury/harm for Resident #1 and it made no mention of the bruises to Resident #1 ' s face area identified during her 1/9/19 body audit (as indicated on the initial allegation report). Resident #1 ' s emotional response and behaviors indicated, "No emotional response as resident has severe cognitive deficit at time of incident". The investigative actions section of this report indicated the following: - Allegation was unsubstantiated. - The accused individuals were not terminated. - Other employment actions: Accused individuals were to receive written warning related to resident safety as well as abuse prevention and training on the care of the combative/agitated resident. - Summary of facility investigation: Facility interviewed the LP, NA #1, NA #2, and Nurse #1	F 600	education is complete. On 2/6/2019 the facility Clinical Competency Coordinator began educating Licensed and Unlicensed Nursing Clinical staff, Dietary staff, Environmental staff, Administrative staff, and Rehabilitation staff on Basic Concepts and Guidelines for caregiving for individuals with Dementia to ensure resident safety. Facility staff who have not completed education will be removed from the schedule until education is complete. New hires will be educated by the facility RN Clinical Competency Nurse during orientation on facility policy and procedure related abuse prevention and reporting as well as Basic Concepts and Guidelines for caregiving for individuals with Dementia to ensure resident safety. 4)To ensure solutions are sustained the facility will implement the following procedures to monitor performance: Starting 2/6/2018 residents with Brief Interview of Mental Status (BIMS) of 8 or above were interviewed by facility Nursing Administration interviewed to find out if they have been abused or have witnessed abuse. Continued monitoring to ensure no occurrence of resident to staff abuse will include random interviews of 10 residents with 8 or above Brief Interview of Mental Status (BIMS)and 10 random skin audits for residents Brief Interview of Mental Status (BIMS) below 8 daily for 14 days, then weekly for three weeks, then monthly. Starting 2/7/2019 facility Director of Healthcare Services, Assistant Director of Healthcare Services, Registered Nurse Clinical Competency Coordinator,	

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F 600	Continued From page 14 (charge nurse on duty during the time of the incident), residents on the hallway assigned to NA #1 an NA #2, and other staff who provided care to Resident #1. The medical record of Resident #1 was noted to be reviewed as well as skin audits. "Based on the interviews and results of the skin audit the facility is not able to substantiate the allegations of abuse. The facility did find the accused [NA #1 and NA #2] at fault for leaving an agitated resident [Resident #1] in the care of an untrained person not in the employ of the facility [LP]." The Administrator completed a typed summary of Resident #1 ' s record review related to the investigation of staff to resident abuse. This typed summary stated, "Skin audit on 1/9/2019 showed purple bruise to lower right side of [Resident #1 ' s] face ...skin audit conducted on 1/17/2019 showed no bruising [on Resident #1 ' s] face ...bruise on resident ' s face was noted on a skin audit performed on 12/13/2019". A review of the medical record showed no documentation of skin audit conducted for Resident #1 on 1/9/19. Additionally, there were no skin audits found in Resident #1 ' s medical record that showed any mention of facial bruising. An interview was conducted with the Administrator on 2/5/19 at 12:57 PM. The 24-hour report and the Administrator ' s typed summary of Resident #1 ' s medical record review that indicated a bruise was present on Resident #1 ' s lower right side of her face on 1/9/19 was reviewed with the Administrator. The part of the summary that indicated, "bruise on resident ' s face was noted on a skin audit performed on 12/13/2019" was reviewed with the	F 600	Registered Nurse MDS Coordinator, and Registered Nurse Treatment Nurses will conduct 10 random visual audits of staff to resident interaction during caregiving procedures on each shift daily for 14 days, weekly for three weeks, and monthly to ensure no instance of staff to resident abuse. On 2/7/2018 the Regional Area Vice President and Regional Senior Nurse Consultant attended the ad-hoc Quality Assurance and Performance Improvement committee meeting related to preventing staff to resident abuse. The Regional Senior Nurse Consultant will review the facility random audits weekly for 4 weeks then monthly to ensure the facility Administration is complying with the regulatory guideline. Results of the BIMS interviews and skin audits will be presented by facility Administrator monthly at facility Quality Assurance Performance Improvement Meeting to maintain continued compliance with plan of correction. 5)Compliance Date 3/14/2019	

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Administrator. The body audit form dated 1/5/19 that showed no bruising to Resident #1 ' s facial region was reviewed with the Administrator. The Administrator revealed she had not known where the information about Resident #1 ' s facial bruise came from. She also revealed that the date, 12/13/2019, was a typo, but that she had not known what the correct date was. The Administrator reviewed Resident #1 ' s medical record and she was unable to find any additional documentation of the facial bruising for Resident #1. The Administrator was asked how Resident #1 ' s facial bruising on 1/9/19 was ruled out as an injury from the 1/9/19 staff to resident abuse allegation. Her explanation was that the LP had reported to her by phone that NA #1 hit resident #1 with a closed fist on the shoulder. She denied LP reporting that NA #1 hit Resident #1 in the face in addition to the shoulder. The Administrator was unable to explain how Resident #1 ' s facial bruising was sustained.

The following interviews were conducted related to Resident #1 ' s facial bruising noted on the 1/9/19 24-hour report:

- An interview was conducted with Treatment Nurse #1 on 2/6/19 at 9:11 AM. She stated that she and Treatment Nurse #2 completed body audit forms weekly. She stated she was unaware of any facial bruising for Resident #1 at any time during her stay at the facility.

- An interview was conducted with Treatment Nurse #2 on 2/6/19 at 9:30 AM. She stated that she and Treatment Nurse #1 completed body audit forms weekly. She stated she was unaware of any facial bruising for Resident #1 at any time during her stay at the facility.

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- An interview was conducted with Nurse #1 on 2/6/19 at 10:00 AM. She stated that she had not recalled Resident #1 ever having a bruise to her face during her stay at the facility.

- A family interview was conducted by phone with Resident #1 ' s Responsible Party (RP) on 2/6/19 at 8:50 AM. He stated that Resident #1 had a bruise on her face several weeks ago, but he was not sure how she had sustained the bruise.

A verbal statement by the LP made by phone to the Administrator on 1/9/19 at approximately 1:15 PM was transcribed in handwriting by the Administrator. The report from the LP indicated that she heard a loud noise that sounded like grunting and hollering from a resident ' s room. She reported she opened the door to the resident ' s room without knocking and NA #1 stated to her, "you need to turn around because I don ' t want you to see what I do to her". LP stated that Resident #1 was seated in her wheelchair, NA #2 was behind the wheelchair and appeared to be pulling the resident by the back of her shirt to keep her seated in the wheelchair. NA #1 had her "fist drawn back, struck [Resident #1] on her [left] shoulder... [Resident #1] had hands up ...reacting to being hit". LP reported she had not seen NA #2 strike Resident #1, but that NA #2 had not stopped NA #1. LP indicated she drew Resident #1 ' s blood as ordered while NA #1 and NA #2 were still in the room. She indicated she stayed with Resident #1 until both NAs left the room.

A typed statement, undated, signed by the LP indicated that on 1/9/19 at approximately 5:45 AM

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she was walking toward Resident #1 ' s room to complete a blood draw as ordered. She reported that when she started getting close to the room she heard several voices along with Resident #1 "grunting and hollering". LP wrote that she opened the door and saw an NA (NA #2) standing behind Resident #1 holding her down in the wheelchair and another NA (NA #1) "hitting" Resident #1. LP indicated that she opened the door wider and NA #1 said to her, "you might want to go somewhere else so that you don ' t see what I am about to do to her". LP reported she told NA #1 that she was there to draw Resident #1 ' s blood. LP wrote that Resident #1 was "very agitated" at that point, so she called her name several times to get her attention and explain why she was there. NA #1 and NA #2 proceeded to change Resident #1 ' s bed linens and then left the room. LP reported that she completed the blood draw and then pushed Resident #1 in her wheelchair toward the nurse ' s desk and Nurse #1 said she was going to take care of Resident #1 from there. LP indicated she had not reported the incident to Nurse #1, but instead continued with blood draws. She completed her duties around 6:45 AM, left the facility, and then called her direct supervisor and reported the incident.

A phone interview was conducted with LP on 2/5/19 at 2:24 PM. She stated between 5:00 AM and 6:00 AM on 1/9/19 she was walking down a facility hallway enroute to Resident #1 ' s room to draw blood as ordered by the physician. She reported that as she was approaching the door, which was partially cracked open, she heard sounds of "distress" described as grunting, moaning, hollering, and screaming. She stated that she opened the door without knocking

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because the sounds she heard coming from the room made her worried. LP indicated that when she entered the room Resident #1 was seated in her wheelchair, NA #1 was standing in front of the resident and NA #2 was standing behind the resident. She reported that NA #2 was holding Resident #1 by her shirt at the shoulders (from behind) to keep her seated in the wheelchair. She explained that Resident #1 was moving around in the wheelchair and it appeared NA #2 was "restraining" her by holding her back in the chair to keep her from moving around. LP stated that NA #1 said to her something like, "you might want to go and do someone else because I don ' t want you to see what I ' m going to do to her". She reported that she witnessed NA #1 hit Resident #1 on the cheek area with a closed fist and then on the left shoulder with an open hand. She indicated that Resident #1 was swinging her arms around in a reaction after she was hit by NA #1. She indicated it appeared NA #1 was frustrated with Resident #1 as she was "gritting her teeth" at the resident. LP reported that she had not witnessed NA #2 hit Resident #1, she had only observed her holding the resident back in the wheelchair. LP stated that after NA #1 had struck Resident #1 she told NA #1 and NA #2 she was not leaving the room until she completed the blood draw. She reported that she was unable to recall if there were any marks or bruising to Resident #1 ' s face at that time. LP revealed she had not reported the incident to the nurse on duty following the incident. She stated that she believed NA #1 and NA #2 were friends with Nurse #1 and she hadn ' t felt comfortable reporting the incident to her because she feared retaliation from the staff. LP reported that she phoned her supervisor around 7:00 AM when she left the facility to report the incident and he

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instructed her to report the incident to the facility Administration.

A phone interview was conducted with LP ' s supervisor on 2/6/19 at 4:35 PM. He confirmed that LP contacted him by phone on 1/9/19 immediately after leaving the facility and reported to him the allegation of staff to resident abuse. He stated that LP was very upset and audibly crying during the phone call.

A verbal statement by NA #1 typed by the Administrator and included in the facility ' s 1/17/19 summary of the investigation for the allegation of abuse involving Resident #1 was reviewed. This statement indicated that Nurse #1 asked her to help NA #2 with getting Resident #1 out of bed on 1/9/19. NA #1 indicated that Resident #1 was not making any noises while she and NA #2 were in the room. She reported that LP entered the room and she was standing to the left side of Resident #1 ' s wheelchair an NA #2 was standing behind the wheelchair. Resident #1 tried to get up and NA #2 "put one hand on [Resident #1 ' s] chest and another on her forehead. Pushed her back to an upright position in the wheelchair". NA #1 stated that she had not touched Resident #1 while the LP was in the room nor did she tell the LP to leave the room. She indicated that she and NA #2 changed Resident #1 ' s sheets and then left the room after asking LP to bring Resident #1 to the nurse ' s station when she was done with her blood draw.

A verbal statement by NA #2 typed by the Administrator and included in the facility ' s 1/17/19 summary of the investigation for the allegation of abuse involving Resident #1 was reviewed. This statement indicated that NA #2

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saw Resident #1 moving around in bed and she went to ask Nurse #1 for help with getting the resident up. Nurse #1 sent NA #1 to help NA #2 with Resident #1. NA #2 reported that she and NA #2 got Resident #1 dressed and into her wheelchair. She indicated that Resident #1 was making noises the whole time they were getting her up. NA #2 stated that she and NA #1 were standing in front of Resident #1 when LP entered the room. NA #2 reported that Resident #1 tried to stand up from her wheelchair and she had not wanted the resident to fall so she "put one hand in the center of [Resident #1 ' s] chest and the other hand on [her] forehead and pushed her back to an upright position in the chair". NA #2 indicated that LP proceeded to draw Resident #1 ' s blood and she and NA #1 changed the bed linens and left the room after asking LP to bring Resident #1 to the nurse ' s station when she was done with her blood draw.

A joint interview was conducted with NA #1 and NA #2 on 2/6/19 at 3:05 PM. The DON was present for this interview. NA #2 stated that on the morning of 1/9/19 she walked by Resident #1 ' s room and saw that she was trying to get out of bed. She indicated she went to ask Nurse #1 for assistance with getting Resident #1 out of bed because she had behaviors of swinging and hitting at staff. NA #2 stated that NA #1 was sent to help her. The NAs (NA #1 and NA #2) stated that Resident #1 was having verbal behaviors of yelling out, grunting, moaning and physical behaviors of swinging and hitting at them that morning and they had a tough time getting the resident out of the bed, providing incontinent care, getting her dressed, and then transferred to the wheelchair. They reported that LP walked in the room without knocking. They stated that at

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that time Resident #1 was already seated in the wheelchair and that NA #1 said something to the LP like, "oh honey you might not want to come in here". NA #1 stated that this was a joke and she recalled laughing when she said this to the LP because she and NA #2 had such a difficult time getting Resident #1 up that day. They indicated that NA #2 was standing in front of Resident #1 and NA #1 was standing on the side of the wheelchair. Resident #1 was reportedly leaning forward in the wheelchair. NA #1 and NA #2 revealed that Resident #1 rarely attempted to stand, but that she had frequently leaned forward in the chair and they were afraid she was going to tip over and land head first on the floor. NA #2 stated that she asked Resident #1 to sit back in the wheelchair, but she had not complied. She revealed she put one hand to Resident #1 ' s forehead and one hand to her shoulder/chest region and pushed the resident back into an upright position in the wheelchair. Then NA #2 moved to the back of the wheelchair and NA #1 remained at the side of the wheelchair. LP was then preparing for Resident #1 ' s blood draw and the resident started to lean forward again so NA #2 reached from behind the resident and placed one hand on her forehead and one on her shoulder/chest region to pull her back into an upright position. NA #1 stated that when LP was preparing for the blood draw that Resident #1 was swinging her hands around, so she placed one hand in front of her shoulder and one hand behind her shoulder to keep her from being able to swing around the arm that blood was going to be drawn from. NA #1 denied hitting Resident #1 on the face and/or on the shoulder. NA #2 denied witnessing NA #1 hit Resident #1. They both denied Resident #1 having any bruising or redness to her face on 1/9/19 or on any other

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date. NA #1 was unable to explain why her verbal statement to the Administrator indicated that Resident #1 was not making any noises during care on the morning of 1/9/19 and also was unable to explain why she previously denied touching Resident #1 while the LP was in the room and denied telling LP to leave the room. NA #1 and NA #2 were unable to explain why LP reported this allegation of staff to resident abuse if it had not happened. They indicated there had been no previous conflicts with LP.

This joint interview with NA #1 and NA #2 continued. NA #1 stated that after the incident she had been re-educated on abuse and combative behaviors. She reported that she would not have changed any of the actions taken by herself or NA #2 after being provided with the re-education. NA #2 stated that after the incident she had been re-educated on abuse and combative behaviors. She reported that she had not thought any of the actions taken by herself or NA #1 were inappropriate after being provided with the re-education. She indicated that the only thing she might have done differently would have been to stand back for a few minutes when Resident #1 swinging her arms around to give her time to calm down.

An interview was conducted with the Administrator on 2/6/19 at 4:00 PM. The Administrator was asked why she had not substantiated the allegation of staff to resident abuse related to the 1/9/19 allegation involving Resident #1. She stated that she had not found any negative physical or mental/emotional findings on behalf of the resident. She re-iterated from her previous interview that Resident #1 ' s facial bruising noted on the 1/9/19 24-hour report

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was ruled out as an injury because the LP had reported to her that NA #1 hit Resident #1 with a closed fist on the shoulder. The Administrator stated that another factor for her was that since the LP had not immediately reported the allegation to the nurse on duty at the time of the incident, she doubted that it actually happened. She explained that she thought that if the LP had observed NA #1 hit Resident #1 that she would ' ve have immediately reported it rather than waiting until she left the facility. The Administrator stated that she had thought that NA #2 ' s actions of placing her hands on Resident #1 ' s forehead and chest/shoulder region twice was not the best way to manage the leaning behaviors of a combative resident. The Administrator explained that because there was no negative intent from either staff, NA #1 or NA #2, she had not thought this was physical abuse.

A re-interview was conducted by phone with LP on 2/6/19 at 2:45 PM. She was informed that the Administrator denied LP reporting to her that NA #1 hit Resident #1 with a closed fist on the cheek. LP stated that she told the Administrator during a phone call on 1/9/19 that NA #1 was observed hitting Resident #1 once on the cheek with a closed fist and once on the left shoulder with an open hand. LP ' s typed statement that indicated NA #2 was holding Resident #1 down in the wheelchair while NA #1 was "hitting" Resident #1 was reviewed with LP. She explained that she used the word "hitting" to imply more than one hit. She stated that in hindsight she should have been more specific when she typed her statement.

An interview was conducted with the Director of Nursing (DON) on 2/8/19 at 8:48 AM. She was asked if there were any previous concerns

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reported for NA #1 or NA #2. She stated that NA #2 had no previous concerns reported. She revealed that NA #1 had disciplinary action over a year ago related to customer service. The DON reported that NA #1 pulled an alert and oriented resident ' s covers back as the resident was lying in bed and said something like, "I hate working this hall". The DON also revealed that NA #1 ' s most recent quarterly performance evaluation showed that she had grievances on file related to customer service during the review period (7/1/18 through 9/30/18).

An observation was conducted of Resident #1 lying in bed in her room on 2/5/19 at 10:45 AM. Resident #1 was alert with confusion and she was unable to be interviewed. There were no bruises or other skin conditions noted.

The Administrator and DON were notified of Immediate Jeopardy on 2/6/19 at 5:43 PM.

On 2/7/19 at 5:17 PM the facility provided the following credible allegation of Immediate Jeopardy removal:

This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and

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desire to continue to improve the quality of care and services to our residents.

- Process that lead to the deficiency
On 1/9/2019 Laboratory Phlebotomist reported to facility Administrator and Assistant Administrator at 1:15p by phone that at approximately 5:45a on 1/9/2019 she witnessed two facility Certified Nursing Assistants on night shift hit resident #1 when she entered the resident ' s room to draw blood. When further questioned during this phone call by facility Administrator and facility Assistant Director of Health Services the Laboratory Phlebotomist stated she saw one Certified Nursing Assistant (NA #1) draw back a fist and hit resident #1 on her left shoulder while the second Certified Nursing assistant (NA #2) held resident by the back of her shirt while she was sitting in her wheelchair. Facility Administrator and Assistant Director of Nursing asked Laboratory Phlebotomist why she did not report this to charge nurse at the time of the incident she stated she felt the Charge Nurse would not handle information correctly and she did not trust her to do the right thing. Laboratory Phlebotomist stated she waited to speak with Assistant Director of Health Services because she trusted her to handle information correctly as she feared retaliation from Certified Nursing Assistants (NA #1 & NA #2). In a typed statement signed by the Laboratory Phlebotomist provided to the facility the next day (1/10/2019) at approximately 6:00a placed under Administrative door the Laboratory Phlebotomist stated one Certified Nursing Assistant NA #2 was standing behind the resident ' s wheelchair holding resident #1 down while another Certified Nursing Assistant NA #1 was hitting her. Certified Nursing Assistants (NA #1 & NA #2) fitting the description provided by the

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Laboratory Phlebotomist were not in the facility while statements were taken via phone. Both Certified Nursing Assistants fitting the description provided by the Laboratory Phlebotomist were suspended pending investigation prior to working another shift on 1/9/2019. Certified Nursing Assistant (NA #2) who was suspended approximately 2:45p by facility Administrator and Certified Nursing Assistant (NA #1) was suspended approximately 10:30p by facility Registered Nurse (RN) Clinical Competency Nurse. Statements provided by Certified Nursing Assistants (NA #1 and NA #2) on 1/9/2019 to facility Administrator, Assistant Director of Health Services, and RN Clinical Competency Nurse revealed NA #2 placed hand on forehead and chest/shoulder area of resident #1 to prevent resident #1 from falling forward out of wheelchair while Certified Nursing Assistant NA #1 watched. Resident #1 is a resident with a diagnosis of Dementia. On 1/9/2019 at 1:15p with the phone call between the Laboratory Phlebotomist and facility Administrator and Assistant Director of Health Services started an investigation of the alleged incident. Investigation was closed on January 17, 2019 by facility Administrator with an unsubstantiated finding and Certified Nursing Assistants (NA #1 & NA #2) were returned to employment on January 17, 2019 after receiving education from facility RN Clinical Competency Nurse regarding facility abuse policy and Care of Dementia residents with behaviors.

Facility failed to provide a safe environment and protect resident from physical abuse when Certified Nursing Assistants (NA #1 &NA #2) were returned to work on January 17, 2019 in light of statements of Laboratory Phlebotomist and Certified Nursing Assistant (NA #1 & NA #2)

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stating they placed hand on the body of Resident #1.

Resolution includes re-suspension of Certified Nursing Assistants (NA #1) approximately 5:30p and Certified Nursing Assistant (NA #2) approximately 10:30p on February 7, 2019 by facility Administrator and Director of Nursing to ensure safety of current facility residents.

Resolution also included the Regional Senior Nurse Consultant conducting education with facility Administrator, Assistant Director of Health Services, Clinical Competency Coordinator and Director of Health Services related to prevention of abuse, indicators of abuse, reporting abuse, and investigation abuse to ensure resident safety.

To help resolve this current facility residents had skin audits conducted by facility Registered Nurse Treatment Nurse and facility Charge nurses starting 2/6/2019 to ensure residents remain safe while in facility.

Residents with a Brief Interview of Mental Status (BIMS) score of 8 or above were interviewed by facility Activities Director, Director of Health Services, MDS Coordinator, and Licensed Practical Charge Nurse to ensure any possible staff to resident abuse was reported and investigated appropriately.

- Process for implementing a plan of correction for specific deficiency
The facility Administrator should have determined if this issue could or would affect other residents.

On 2/6/2019 the Regional Senior Nurse Consultant conducted education with facility

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Administrator, Assistant Director of Health Services, Clinical Competency Coordinator and Director of Health Services related to prevention of abuse, indicators of abuse, reporting abuse, and investigation abuse.

On 2/6/2019 the facility Clinical Competency Coordinator began educating Licensed and Unlicensed Nursing Clinical staff, Dietary staff, Environmental staff, Administrative staff, and Rehabilitation staff on proper procedures for preventing and reporting abuse to ensure resident safety. Facility staff who have not completed education will be removed from the schedule until education is complete.

On 2/6/2019 the facility Clinical Competency Coordinator began educating Licensed and Unlicensed Nursing Clinical staff, Dietary staff, Environmental staff, Administrative staff, and Rehabilitation staff on Basic Concepts and Guidelines for caregiving for individuals with Dementia to ensure resident safety. Facility staff who have not completed education will be removed from the schedule until education is complete.

Beginning on 2/6/2019 accused Certified Nursing Assistants (NA #1 & NA #2) were re-interviewed and suspended pending further investigation to ensure resident safety.

Starting 2/6/2019 and ending 2/7/2019 facility Administrative Nurses interviewed residents with Brief Interview of Mental Status (BIMS) of 8 or above to find out if they have been abused or have witnessed abuse. If residents have statements positive for abuse those residents will be re-interviewed by Administrator and Director of

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Health Services to ensure they are free from harm and statements are thoroughly investigated and reported to appropriate agency.

Staring 2/6/2019 and ending 2/7/2019 facility Administrative Nurses conducted and documented skin audits for current facility residents to include those with a Brief Interview of Mental Status (BIMS) of 7 or below to ensure residents were identified via these audits for potential abuse. Any abnormal bruising will be flagged with complete investigation to be completed by Director of Nursing and Assistant Director of Nursing with report to appropriate agency to ensure current facility residents are free from harm.

New hires will be educated by the facility RN Clinical Competency Nurse during orientation on facility policy and procedure related abuse prevention and reporting as well as Basic Concepts and Guidelines for caregiving for individuals with Dementia to ensure resident safety.

- The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Starting 2/6/2019 residents with Brief Interview of Mental Status (BIMS) of 8 or above were interviewed by facility Nursing Administration interviewed to find out if they have been abused or have witnessed abuse. Continued monitoring to ensure no occurrence of resident to staff abuse will include random interviews of 10 residents with 8 or above Brief Interview of Mental Status (BIMS)and 10 random skin audits for residents Brief Interview of Mental Status (BIMS) below 8

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daily for 14 days, then weekly for three weeks, then monthly.

Starting 2/7/2019 facility Director of Healthcare Services, Assistant Director of Healthcare Services, Registered Nurse Clinical Competency Coordinator, Registered Nurse MDS Coordinator, and Registered Nurse Treatment Nurses will conduct 10 random visual audits of staff to resident interaction during caregiving procedures on each shift daily for 14 days, weekly for three weeks, and monthly to ensure no instance of staff to resident abuse.

On 2/7/2019 the Regional Area Vice President and Regional Senior Nurse Consultant attended the ad-hoc Quality Assurance and Performance Improvement committee meeting related to preventing staff to resident abuse.

The Regional Senior Nurse Consultant will review the facility random audits weekly for 4 weeks then monthly to ensure the facility Administration is complying with the regulatory guideline.

- Title of person responsible for implementing the POC
The Administrator is responsible for implementing the plan of correction.
Date of Allegation of Compliance 2/7/2019

The credible allegation of Immediate Jeopardy removal was validated on 2/8/19 at 10:00 AM.

Record review indicated skin audits were conducted for all current residents on 2/6/19 and 2/7/19. All alert and oriented residents were

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F 600	Continued From page 31 interviewed on 2/6/19 and 2/7/19 to ensure any possible staff to resident abuse was reported and investigated properly. These resident interviews were documented on an audit form. A review of inservice sign in sheets as well as staff interviews verified education was provided on 2/6/19 on proper procedures for preventing abuse, reporting abuse, and basic concepts and guidelines for caregiving for individuals with dementia. Staff who had not received the inservice on 2/6/19 were to be removed from the schedule until education was completed. NA #1 and NA #2 were re-interviewed on 2/6/19 and were re-suspended on 2/7/19.	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, facility staff interviews, and laboratory company staff interviews, the facility failed to implement their policy and procedure in the areas of reporting and investigating allegations of abuse. The facility also failed to ensure contracted staff providing services to residents within the facility were	F 607	1)Processes that lead to the deficiency cited were facility abuse prevention policy and procedure were not followed when Certified Nursing Assistants (NA#1 &NA#2) were returned to work on January 17, 2019 in light of witness statements of Laboratory Phlebotomist Certified Nursing	3/14/19

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F 607	Continued From page 32 trained on abuse reporting requirements for 1 of 2 residents (Resident #1) reviewed for staff to resident abuse. Immediate Jeopardy began on 1/9/19 when a Laboratory Phlebotomist failed to immediately report an observation of Nursing Assistant #1 hitting a cognitively impaired resident (Resident #1) on her face with a closed fist and on the shoulder with an open hand while Nursing Assistant #2 restrained the resident in her wheelchair. Immediate Jeopardy was removed on 2/8/19 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: A review of the facility ' s Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property policy, last revised 4/26/17, stated that this policy applied to all facility employees and its affiliated entities that provided goods or services to residents. This policy indicated that any allegation of resident abuse was to be immediately reported to the Administrator. The Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property policy, last revised 11/21/16, indicated the Administrator was responsible for assuring that an accurate and timely investigation was completed. This policy also indicated that for investigations when the alleged perpetrator was a Nursing Assistant that	F 607	Assistant (NA#1 & NA#2) statements given on 1/9/2019 to facility administration. Laboratory Phlebotomist failed to follow contractual standards of conduct related to resident safety and facility policy and procedure related to reporting of abuse to facility when they did not immediately report the incident after witnessing it on 1/9/2019. On 2/8/2019 NA#1 & NA#2 were terminated from employment of the facility. On 1/9/2019 Laboratory Phlebotomist was verbally trained via phone by Assistant Director of Nursing regarding timely and appropriate abuse reporting. Management of the Laboratory Phlebotomist were trained on 2/7/2019 by facility Registered Nurse Clinical Competency Nurse regarding facility policy related to abuse prevention, identification, and reporting. On 2/7/2019 Management of the Laboratory Phlebotomist told the Registered Nurse Clinical Competency Nurse they would ensure staff assigned to the facility receive training prior to working with facility residents. 2)The procedure for implementing an acceptable Plan of correction including identification of other potential residents affected for the deficiency cited is as follows: Current facility residents had skin audits conducted by facility Registered Nurse Treatment Nurse and facility Charge nurses starting 2/6/2019 to ensure residents remain safe while in facility. These audits ensure residents with Brief Interview of Mental Status (BIMS) of 7 or	

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the facility ' s investigation was to include any personnel actions taken by the facility. The No Retaliation for Good Faith Reporting of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property policy, last revised, 11/21/16, indicated that if there was any suspicion of abuse the suspected staff was not to have direct contact with the resident at issue until the investigation was completed and the issue was resolved.

Resident #1 was admitted to the facility on 12/21/18 with diagnoses that included stroke, aphasia, and dementia.

The admission Minimum Data Set (MDS) assessment dated 12/28/18 for Resident #1 was not completed in the area of cognition as the resident interview for mental status and staff interview for mental status were blank. She was assessed with inattention and disorganized thinking fluctuating in presence. Resident #1 had no physical behaviors, no verbal behaviors, and no rejection of care. She was noted with other behavioral symptoms and wandering behaviors on 1 to 3 days. Resident #1 was assessed as requiring the limited assistance of 1 for bed mobility, transfers, and locomotion on/off the unit. She required the extensive assistance of 1 with dressing, toileting, and personal hygiene. She was not steady on her feet and was only able to stabilize with staff assistance. Resident #1 utilized a walker and wheelchair, she was occasionally incontinent of bladder and bowel, she had no skin issues, and she had sustained no falls.

The initial allegation (24-hour report) dated 1/9/19 below were checked for signs of possible physical abuse. No areas were found during this audit to indicate abuse. Residents with a Brief Interview of Mental Status (BIMS) score of 8 or above were interviewed by facility Activities Director, Director of Health Services, MDS Coordinator, and License Practical Charge Nurse starting 2/6/2019 and ending 2/7/2019 to ensure any possible staff to resident abuse was reported and investigated appropriately. Six residents made negative comments and were re-interviewed on 2/6/2019 and 2/7/2019 by Facility Administrator, Director of Health Services, and Assistant Director of Health Services. Two of the six residents were hallucinating, one resident was describing an event prior to admission to the facility, two residents stated the staff was trying to help them but needed more than one person to give care to them, and the last one stated they did not want the staff to speak negatively about other staff members in their presence. All six residents were asked again about abuse and stated they were not abused and had not witnessed abuse. The residents care plans were updated with their request and/or behaviors.

3)The Facility implemented the following systemic changes to ensure cited deficiency does not reoccur:
The Regional Senior Nurse Consultant conducting education with facility Administrator, Assistant Director of Health Services, Clinical Competency Coordinator and Director of Health

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F 607	Continued From page 34 completed by the Administrator indicated an allegation of staff to resident physical abuse. The incident occurred on 1/9/19 at approximately 5:15 AM and the facility became aware of the incident on 1/9/19 at 1:15 PM. The allegation details stated that Laboratory Phlebotomist (LP) witnessed Nursing Assistant (NA) #1 "strike" Resident #1 on her left shoulder while NA #2 held her by the shirt. The LP stated that she stayed in the room with Resident #1 to ensure she was not touched anymore by NA #1 or NA #2. Both NAs (NA #1 and NA #2) were noted to leave the room and the LP pushed Resident #1 in her wheelchair to the nurse ' s station. The details of physical or mental injury/harm read, "Body audit revealed bruise to the face area [of Resident #1]." This form was completed by the Administrator on 1/9/19. NA #1 and NA #2 were suspended on 1/9/19 pending the results of the investigation. The police were notified on 1/9/19 at 2:08 PM as required. The investigation report (5-working day report) dated 1/16/19 completed by the Administrator repeated the same allegation details and had no comments written in the section for "additions/changes/updates to description of allegation details". This investigation report provided conflicting information from the previous initial allegation as it stated no physical injury/harm and no substantial risk of injury/harm for Resident #1 and it made no mention of the bruises to Resident #1 ' s face area identified during her 1/9/19 body audit (as indicated on the initial allegation report). Resident #1 ' s emotional response and behaviors indicated, "No emotional response as resident has severe cognitive deficit at time of incident". The investigative actions section of this report indicated the following:	F 607	Services related to facility policy regarding prevention of abuse, indicators of abuse, reporting abuse, and investigation abuse on 2/6/2019 to ensure resident safety. On 2/6/2019 facility Administrator, Director of Healthcare Services, Assistant Director of Healthcare Services, Registered Nurse (RN) Clinical Competency Nurse and Registered Nurse (RN) MDS Coordinator received education from Registered Nurse (RN) Regional Senior Nurse Consultant regarding facility abuse policy to include investigation procedures. On 2/6/2019 the facility Administrator, Director of Healthcare Services, Assistant Director of Healthcare Services, Registered Nurse (RN) Clinical Competency Nurse and Registered Nurse (RN) MDS Coordinator received education from Registered Nurse (RN) Regional Senior Nurse Consultant on F607 Regulatory Guideline interpretation and adherence thereof. On 2/6/2019 the facility Registered Nurse (RN) Clinical Competency Coordinator began educating Nursing Clinical staff, Dietary staff, Environmental staff, Administrative staff, and Rehabilitation staff on facility policy and procedures related to preventing abuse and reporting abuse to ensure resident safety. Facility staff who have not completed education have been removed from the schedule until education is completed. On 2/6/2019 the facility Clinical Competency Coordinator started educating Nursing Licensed and Unlicensed staff, Dietary staff, Environmental staff, Administrative staff, and Rehabilitation staff on Basic Concepts and Guidelines for caregiving	

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F 607	Continued From page 35 - Allegation was unsubstantiated. - The accused individuals were not terminated. - Other employment actions: Accused individuals were to receive written warning related to resident safety as well as abuse prevention and training on the care of the combative/agitated resident. - Summary of facility investigation: Facility interviewed the LP, NA #1, NA #2, and Nurse #1 (charge nurse on duty during the time of the incident), residents on the hallway assigned to NA #1 an NA #2, and other staff who provided care to Resident #1. The medical record of Resident #1 was noted to be reviewed as well as skin audits. "Based on the interviews and results of the skin audit the facility is not able to substantiate the allegations of abuse. The facility did find the accused [NA #1 and NA #2] at fault for leaving an agitated resident [Resident #1] in the care of an untrained person not in the employ of the facility [LP]." NA #1 and NA #2 returned to work on 1/17/19 following completion of the investigation. An interview was conducted with the Administrator on 2/5/19 at 12:57 PM. The 24-hour report and the Administrator ' s typed summary of Resident #1 ' s medical record review that indicated a bruise was present on Resident #1 ' s lower right side of her face on 1/9/19 was reviewed with the Administrator. The part of the summary that indicated, "bruise on resident ' s face was noted on a skin audit performed on 12/13/2019" was reviewed with the Administrator. The body audit form dated 1/5/19 that showed no bruising to Resident #1 ' s facial region was reviewed with the Administrator. The Administrator revealed she had not known where the information about Resident #1 ' s facial bruise came from. She also revealed that the date, 12/13/2019, was a typo, but that she had not	F 607	for individuals with Dementia to ensure resident safety. Facility staff who have not completed education have been removed from the schedule until education is completed. On 1/9/2019 Laboratory Phlebotomist was verbally trained via phone by Assistant Director of Nursing regarding timely and appropriate abuse reporting. Management of the Laboratory Phlebotomist were trained on 2/7/2019 by facility Registered Nurse Clinical Competency Nurse regarding facility policy related to abuse prevention, identification, and reporting. On 2/7/2019 Management of the Laboratory Phlebotomist told the Registered Nurse Clinical Competency Nurse they would ensure staff assigned to the facility receive training prior to working with facility residents. Beginning on 2/6/2019 accused Certified Nursing Assistants (NA#1 & NA#2) were re-interviewed and suspended pending investigation to ensure resident safety. On 2/8/2019 accused Certified Nursing Assistants (NA#1 & NA#2) were terminated from facility employment by facility Administrator and Registered Nurse Regional Senior Nurse Consultant. Starting 2/6/2019 facility Assistant Director of Nursing, Director of Nursing, and MDS Coordinator interviewed residents with BIMS of 8 or above to find out if they have been abused or have witnessed abuse. Residents having statements positive for possible abuse will be re-interviewed by Administrator and Director of Health Services to ensure they are free from harm and statements are thoroughly	

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known what the correct date was. The Administrator reviewed Resident #1 ' s medical record and she was unable to find any additional documentation of the facial bruising for Resident #1. The Administrator was asked how Resident #1 ' s facial bruising on 1/9/19 was ruled out as an injury from the 1/9/19 staff to resident abuse allegation. Her explanation was that the LP had reported to her by phone that NA #1 hit Resident #1 with a closed fist on the shoulder. She denied the LP reporting that NA #1 hit Resident #1 in the face in addition to the shoulder. The Administrator was unable to explain how Resident #1 ' s facial bruising was sustained.

A family interview was conducted by phone with Resident #1 ' s Responsible Party (RP) on 2/6/19 at 8:50 AM. He stated that Resident #1 had a bruise on her face several weeks ago, but he was not sure how she had sustained the bruise. Resident #1 ' s RP revealed he was aware that an allegation of staff to resident abuse was made involving Resident #1, but he stated he had not been made aware of the results of the investigation.

A verbal statement by the LP made by phone to the Administrator on 1/9/19 at approximately 1:15 PM was transcribed in handwriting by the Administrator. The report from the LP indicated that she heard a loud noise that sounded like grunting and hollering from a resident ' s room. She reported she opened the door to the resident ' s room without knocking and NA #1 stated to her, "you need to turn around because I don ' t want you to see what I do to her". Resident #1 was seated in her wheelchair, NA #2 was behind resident #1 and appeared to be pulling the resident by the back of her shirt to keep her

investigated and reported. New hires will be educated by the facility RN Clinical Competency Nurse during orientation on facility policy and procedure related to abuse prevention and reporting as well as Basic Concepts and Guidelines for caregiving for individuals with Dementia to ensure all facility personnel protect facility residents.

4)To ensure solutions are sustained the facility will implement the following procedures to monitor performance: Facility Administrative team will conduct random interviews of 10 residents with 8 or above Brief Interview of Mental Status (BIMS)and RN Treatment Nurses conduct 10 random skin audits for residents Brief Interview of Mental Status (BIMS) below 8 daily for 14 days, then weekly for three weeks, then monthly. Starting 2/7/2019 facility Director of Healthcare Services, Assistant Director of Healthcare Services, Registered Nurse Clinical Competency Coordinator, Registered Nurse MDS Coordinator, and Registered Nurse Treatment Nurses will conduct 10 random visual audits of staff to resident interaction during caregiving procedures on each shift daily for 14 days, weekly for three weeks, and monthly to ensure no instance of staff to resident abuse. Starting 2/8/2019 facility Registered Nurse Clinical Competency Nurse, Housekeeping Supervisor, Dietary Supervisor, Financial Counselor, Social Worker, and Admissions Director interviewed 10 random staff members regarding facility abuse policy with scenarios to ensure staff

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F 607	Continued From page 37 seated in the wheelchair. NA #1 had her "fist drawn back, struck [Resident #1] on her [left] shoulder... [Resident #1] had hands up ...reacting to being hit". The LP reported she had not seen NA #2 strike Resident #1, but that NA #2 had not stopped NA #1. The LP indicated she drew Resident #1 ' s blood as ordered while NA #1 and NA #2 were still in the room. She indicated she stayed with Resident #1 until both NAs left the room. A typed statement, undated, signed by the LP indicated that on 1/9/19 at approximately 5:45 AM she was walking toward Resident #1 ' s room to complete a blood draw as ordered. She reported that when she started getting close to the room she heard several voices along with Resident #1 "grunting and hollering". The LP wrote that she opened the door and saw an NA (NA #2) standing behind Resident #1 holding her down in the wheelchair and another NA (NA #1) "hitting" Resident #1. The LP indicated that she opened the door wider and NA #1 said to her, "you might want to go somewhere else so that you don ' t see what I am about to do to her". The LP reported she told NA #1 that, "I don ' t have anything to do with that, I ' m here to draw her blood and she is first on my list". The LP wrote that Resident #1 was "very agitated" at that point, so she called her name several times to get her attention and explain why she was there. NA #1 and NA #2 changed Resident #1 ' s bed and then left the room. The LP reported that she completed the blood draw and then pushed Resident #1 in her wheelchair toward the nurse ' s desk and Nurse #1 said she was going to take care of Resident #1 from there. The LP indicated she had not reported the incident to Nurse #1, but instead continued to complete blood draws,	F 607	members have knowledge of and are able to implement facility policy and procedure regarding staff to resident abuse identification and prevention daily for 14 days, then weekly for three weeks, then monthly. On 2/7/2018 the Regional Area Vice President and Regional Senior Nurse Consultant attended the ad-hoc Quality Assurance and Performance Improvement committee meeting related to facility following policy and procedure regarding abuse investigation to ensure continued resident safety. Starting 2/8/2019 the Regional Senior Nurse Consultant or will review the facility random audits and 24 hour abuse for timely reporting as well as thorough and timely completion of subsequent investigation weekly for 4 weeks then monthly to ensure the facility Administration is complying with the regulatory guideline. Results of the BIMS interviews and skin audits will be presented by facility Administrator monthly at facility Quality Assurance Performance Improvement Meeting to maintain continued compliance with plan of correction. 5)Compliance Date3/14/2019	

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completed her duties around 6:45 AM, left the facility, and then called her direct supervisor and reported the incident. The LP ' s Supervisor recommended she report the incident "urgently" to the Director of Nursing (DON) at the facility. She indicated she phoned the Assistant Director of Nursing (ADON) around 11:00 AM, but that during the phone call she had to disconnect the call because she was at work and needed to attend to a patient. The LP wrote that she became very busy and it took a while for her to call back to finish her report of the incident.

A phone interview was conducted with the LP on 2/5/19 at 2:24 PM. She stated between 5:00 AM and 6:00 AM on 1/9/19 she was walking down a facility hallway enroute to Resident #1 ' s room to draw blood as ordered by the physician. She reported that as she was approaching the door, which was partially cracked open, she heard sounds of "distress" described as grunting, moaning, hollering, and screaming. She stated that she opened the door without knocking because the sounds she heard coming from the room made her worried. The LP indicated that when she entered the room Resident #1 was seated in her wheelchair, NA #1 was standing in front of the resident and NA #2 was standing behind the resident. She reported that NA #2 was holding Resident #1 by her shirt at the shoulders (from behind) to keep her seated in the wheelchair. She explained that Resident #1 was moving around in the wheelchair and it appeared NA #2 was "restraining" her by holding her back in the chair to keep her from moving around. The LP stated that NA #1 said to her something like, "you might want to go and do someone else because I don ' t want you to see what I ' m going

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to do to her". She reported that she witnessed NA #1 hit Resident #1 on the cheek area with a closed fist and then on the left shoulder with an open hand. She indicated that Resident #1 was swinging her arms around in a reaction after she was hit by NA #1. The LP reported that she had not witnessed NA #2 hit Resident #1, she had only observed her holding the resident back in the wheelchair. The LP stated that after NA #1 had struck Resident #1 she told NA #1 and NA #2 she was not leaving the room until she completed the blood draw. She indicated that she had not wanted to leave Resident #1 alone in the room with either of the NAs (NA #1 or NA #2). She reported that she approached Resident #1 and the NAs left her side and began to change the linens on Resident #1 ' s bed. She stated that after the NAs had changed the linens they left the room and she was able to complete with blood draw with no issues. She reported that Resident #1 was not combative with her during the blood draw. The LP stated that she pushed Resident #1 from her room to the nurse ' s station, so she was not alone. She reported that she was unable to recall if there were any marks or bruising to Resident #1 ' s face at that time. The LP revealed she had not reported the incident to the nurse on duty following the incident. She stated that she believed NA #1 and NA #2 were friends with Nurse #1 and she hadn ' t felt comfortable reporting the incident to her because she feared retaliation from the staff. The LP reported that she phoned her supervisor around 7:00 AM when she left the facility to report the incident and he instructed her to report the incident to the facility Administration. She stated that she had a good relationship with the ADON and she wanted to make sure the information got into the right hands and so it was taken seriously. She reported that

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she phoned the ADON later that morning around 10:00 AM/11:00 AM to report the incident. She was asked why she had waited until 10:00 AM/11:00 AM and she stated that she knew the ADON was not present at the facility at 7:00 AM so she proceeded to her next job and she phoned the ADON when she had an opportunity to step away from work.

A phone interview was conducted with the LP ' s supervisor on 2/6/19 at 4:35 PM. He confirmed that the LP contacted him by phone on 1/9/19 immediately after leaving the facility and reported to him the allegation of staff to resident abuse. He stated that the LP was very upset and audibly crying during the phone call. He stated that he instructed her to contact the facility ' s DON and report the incident. The LP ' s supervisor was asked if they provided any training to their employees related to reporting allegations of abuse. He revealed that they had not provided any training related to reporting allegations of abuse.

An interview was conducted with the ADON on 2/5/19 at 4:20 PM. She stated that the LP contacted her by phone on 1/9/19 around 10:00 AM and reported an incident of staff to resident abuse. She indicated the LP had not provided her with the resident ' s name or the staff members name during this phone call. The LP reported that she walked into the resident ' s room and she saw 1 staff member standing behind the resident "restraining" her in the wheelchair while the other staff member hit the resident from the front. The ADON stated that the LP was crying when she reported the information. She indicated the LP told her that she had not wanted to get involved, but that she

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also knew it was her job to protect the residents. She indicated that the LP was at work while she was reporting this information and she told the ADON she had to call her back later. The ADON stated that she reported this phone call to the DON and the Administrator. She reported that it was not until later that afternoon that she and the Administrator spoke to the LP by phone to obtain the more detailed verbal statement.

An interview was conducted with the Administrator on 2/6/19 at 4:00 PM. The Administrator stated that she was initially informed of the allegation of staff to resident abuse by the ADON around 10:00 AM/11:00 AM on 1/9/19. She stated that at that time she had no actionable information because she had no resident name and no staff names. She reported that she needed to at least have a resident or staff name to make her initial allegation report and to begin an investigation. The Administrator stated she asked the ADON to try to get in touch with the LP to get more information. She reported that she also contacted the LPs supervisor and asked him to have the LP contact them as soon as possible. She indicated it was not until later that afternoon, around 1:00 PM, that she was able to get in touch with the LP by phone and obtain a verbal report identifying Resident #1, NA #1, and NA #2. The Administrator stated that NA #1 and NA #2 were no longer present at the facility at that time, so they were notified by phone that they were suspended pending the results of investigation.

A joint interview was conducted with NA #1 and NA #2 on 2/6/19 at 3:05 PM. The DON was present for this interview. NA #2 stated that on

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the morning of 1/9/19 she walked by Resident #1 ' s room and saw that she was trying to get out of bed. She indicated she went to ask Nurse #1 for assistance with getting Resident #1 out of bed because she had behaviors of swinging and hitting at staff. NA #2 stated that NA #1 was sent to help her. The NAs (NA #1 and NA #2) stated that Resident #1 was having verbal behaviors of yelling out, grunting, moaning and physical behaviors of swinging and hitting at them that morning and they had a tough time getting the resident out of the bed, providing incontinent care, getting her dressed, and then transferred to the wheelchair. They reported that the LP walked in the room without knocking. They stated that at that time Resident #1 was already seated in the wheelchair and that NA #1 said something to the LP like, "oh honey you might not want to come in here". NA #1 stated that this was a joke and she recalled laughing when she said this to the LP because she and NA #2 had such a difficult time getting Resident #1 up that day. They indicated that NA #2 was standing in front of Resident #1 and NA #1 was standing on the side of the wheelchair. Resident #1 was reportedly leaning forward in the wheelchair. NA #1 and NA #2 revealed that Resident #1 rarely attempted to stand, but that she had frequently leaned forward in the chair and they were afraid she was going to tip over and land head first on the floor. NA #2 stated that she asked Resident #1 to sit back in the wheelchair, but she had not complied. She revealed she put one hand to Resident #1 ' s forehead and one hand to her shoulder/chest region and pushed the resident back into an upright position in the wheelchair. Then NA #2 moved to the back of the wheelchair and NA #1 remained at the side of the wheelchair. The LP was then preparing for Resident #1 ' s blood draw

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and the resident started to lean forward again so NA #2 reached from behind the resident and placed one hand on her forehead and one on her shoulder/chest region to pull her back into an upright position. NA #1 stated that when the LP was preparing for the blood draw that Resident #1 was swinging her hands around, so she placed one hand in front of her shoulder and one hand behind her shoulder to keep her from being able to swing around the arm that blood was going to be drawn from. NA #1 denied hitting Resident #1 on the face and/or on the shoulder. NA #2 denied witnessing NA #1 hit Resident #1. They both denied Resident #1 having any bruising or redness to her face on 1/9/19 or on any other date. NA #1 was unable to explain why her verbal statement to the Administrator indicated that Resident #1 was not making any noises during care on the morning of 1/9/19 and also was unable to explain why she previously denied touching Resident #1 while the LP was in the room and denied telling the LP to leave the room. NA #1 and NA #2 were unable to explain why the LP reported this allegation of staff to resident abuse if it had not happened.

This joint interview with NA #1 and NA #2 continued. NA #1 stated that after the incident she had been re-educated on abuse and combative behaviors. She reported that she would not have changed any of the actions taken by herself or NA #2 after being provided with the re-education. NA #2 stated that after the incident she had been re-educated on abuse and combative behaviors. She reported that she had not thought any of the actions taken by herself or NA #1 were inappropriate after being provided with the re-education. She indicated that the only thing she might have done differently would have

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been to stand back for a few minutes when Resident #1 was swinging her arms around to give her time to calm down.

An interview was conducted with the Administrator on 2/6/19 at 4:00 PM. The Administrator was asked why she had not substantiated the allegation of staff to resident abuse related to the 1/9/19 allegation involving Resident #1. She stated that she had not found any negative physical or mental/emotional findings on behalf of the resident. She re-iterated from her previous interview that Resident #1 ' s facial bruising noted on the 1/9/19 24-hour report was ruled out as an injury because the LP had reported to her that NA #1 hit Resident #1 with a closed fist on the shoulder. The Administrator stated that another factor for her was that since the LP had not immediately reported the allegation to the nurse on duty at the time of the incident, she doubted that it actually happened. She explained that she thought that if the LP had observed NA #1 hit Resident #1 that she would ' ve have immediately reported it rather than waiting until she left the facility. The Administrator stated that she had thought that NA #2 ' s actions of placing her hands on Resident #1 ' s forehead and chest/shoulder region twice was not the best way to manage the leaning behaviors of a combative resident. The Administrator explained that because there was no negative intent from either staff, NA #1 or NA #2, she had not thought this was physical abuse. She was asked if NA #1 or NA #2 had any previous disciplinary actions during their employment at the facility and she reported she was unsure and needed to look at their personnel records to find out. She indicated this information was not included in their investigation of staff to resident abuse involving

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Resident #1, NA #1, and NA #2. The Administrator was then asked who was responsible for providing training on abuse reporting to their contracted providers, such as the LP. She stated that she was not sure, but she thought the contracted provider was responsible for providing training to their own staff. She revealed she had not checked with the laboratory company after this incident to verify if training on abuse reporting had been provided to their staff.

A re-interview was conducted by phone with the LP on 2/6/19 at 2:45 PM. She re-iterated the information provided during the 2/5/19 phone interview that took place at 2:24 PM. She was informed that the Administrator denied the LP reporting to her that NA #1 hit Resident #1 with a closed fist on the cheek. The LP stated that she told the Administrator during a phone call on 1/9/19 that NA #1 was observed hitting Resident #1 once on the cheek with a closed fist and once on the left shoulder with an open hand. The LP ' s typed statement that indicated NA #2 was holding Resident #1 down in the wheelchair while NA #1 was "hitting" Resident #1 was reviewed with the LP. She explained that she used the word "hitting" to imply more than one hit. She stated that in hindsight she should have been more specific when she typed her statement.

An interview was conducted with the DON on 2/8/19 at 8:48 AM. She was asked if there were any previous concerns reported for NA #1 or NA #2. She stated that NA #2 had no previous concerns reported. She stated that NA #1 had disciplinary action over a year ago related to customer service. The DON reported that NA #1 said something like, "I hate working this hall",

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when she was providing care to an alert and oriented resident. NA #1 ' s most recent quarterly performance evaluation revealed that she had grievances on file related to customer service during the review period (7/1/18 through 9/30/18).

A final interview was conducted with the Administrator on 2/8/19 at 10:33 AM. She indicated that she expected all staff, including contracted providers, to immediately report any allegation of abuse. She additionally indicated that she expected abuse investigations to be thorough to ensure residents were protected from physical abuse. The Administrator acknowledged that the LP failed to follow facility policy and procedure related to reporting of abuse to facility when she had not immediately reported the incident after witnessing it on 1/9/19. She also acknowledged that the facility failed to follow its abuse policy when the allegation of abuse was unsubstantiated, and NA #1 and NA #2 returned to work on 1/17/19 despite a verbal statement and typed statement by the LP of staff to resident abuse.

The Administrator and DON were notified of Immediate Jeopardy on 2/6/19 at 5:43 PM.

On 2/8/19 at 10:54 AM the facility provided the following credible allegation of Immediate Jeopardy removal:

This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is

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prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.

- Process that lead to the deficiency
On 1/9/2019 Laboratory Phlebotomist reported to facility Administrator and Assistant Administrator at 1:15p by phone that at approximately 5:45a on 1/9/2019 she witnessed two facility Certified Nursing Assistants on night shift hit resident #1 when she entered the resident ' s room to draw blood. When further questioned during this phone call by facility Administrator and facility Assistant Director of Health Services the Laboratory Phlebotomist stated she saw one Certified Nursing Assistant (NA #1) draw back a fist and hit resident #1 on her left shoulder while the second Certified Nursing assistant (NA #2) held resident by the back of her shirt while she was sitting in her wheelchair. Facility Administrator and Assistant Director of Nursing asked Laboratory Phlebotomist why she did not report this to charge nurse at the time of the incident she stated she felt the Charge Nurse would not handle information correctly and she did not trust her to do the right thing. Laboratory Phlebotomist stated she waited to speak with Assistant Director of Health Services because she trusted her to handle information correctly as she feared retaliation from Certified Nursing Assistants (NA #1 & NA #2). In a typed statement signed by the Laboratory Phlebotomist provided to the facility the next day (1/10/2019) at approximately 6:00a placed under Administrative door the Laboratory Phlebotomist stated one Certified Nursing Assistant (NA #2) was standing behind the resident ' s wheelchair holding resident #1 down

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while another Certified Nursing Assistant (NA#1) was hitting her. Certified Nursing Assistants (NA #1 & NA #2) fitting the description provided by the Laboratory Phlebotomist were not in the facility while statements were taken via phone. Both Certified Nursing Assistants fitting the description provided by the Laboratory Phlebotomist were suspended pending investigation prior to working another shift on 1/9/2019. Certified Nursing Assistant NA#2 who was suspended at approximately 2:45p by facility Administrator and Certified Nursing Assistant (NA #1) was suspended at approximately 10:30p by facility Registered Nurse (RN) Clinical Competency Nurse. Statements provided by Certified Nursing Assistants (NA #1 and NA #2) on 1/9/2019 to facility Administrator, Assistant Director of Health Services, and RN Clinical Competency Nurse revealed NA #2 placed hand on forehead and chest/shoulder area of resident #1 to prevent resident #1 from falling forward out of wheelchair while NA#1 watched. Resident #1 is a resident with a diagnosis of Dementia. On 1/9/2019 at 1:15p with the phone call between the Laboratory Phlebotomist and facility Administrator and Assistant Director of Health Services started an investigation of the alleged incident. Investigation was closed on January 17, 2019 by facility Administrator with an unsubstantiated finding and Certified Nursing Assistants (NA #1 & NA #2) were returned to employment on January 17, 2019 after receiving education from facility RN Clinical Competency Nurse regarding facility abuse policy and Care of Dementia residents with behaviors.

Facility failed to follow abuse prevention policy related to staff to resident abuse when Certified Nursing Assistants (NA #1 & NA #2) were

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returned to work on January 17, 2019 in light of witness statements of Laboratory Phlebotomist and Certified Nursing Assistant (NA #1 & NA #2) statements given on 1/9/2019 to facility administration. Laboratory Phlebotomist failed to follow contractual standards of conduct related to resident safety and facility policy and procedure related to reporting of abuse to facility when they did not immediately report the incident after witnessing it on 1/9/2019.

Resolution includes re-suspension of Certified Nursing Assistants (NA #1) approximately 5:30p and Certified Nursing Assistant (NA#2) approximately 10:30p on February 7, 2019 by facility Administrator and Director of Nursing to ensure safety of current facility residents. Facility Administrator and Regional Registered Nurse Senior Nurse Consultant terminated NA #1 and NA#2 from employment on February 8, 2019 related to allegations of resident abuse with supporting Laboratory Phlebotomist witness statement and statements of NA #1 and NA #2. NA #1 and NA #2 did not work in facility after re-suspension on February 7, 2019 in accordance with facility policy regarding protecting residents from abuse.

Resolution includes Phlebotomist being verbally trained via phone by Assistant Director of Nursing regarding timely and appropriate abuse reporting. Management of the Laboratory Phlebotomist were trained on 2/7/2019 by facility Registered Nurse Clinical Competency Nurse regarding facility policy related to abuse prevention, identification, and reporting. On 2/7/2019 Management of the Laboratory Phlebotomist told the Registered Nurse Clinical Competency Nurse they would ensure staff assigned to the facility

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receive training prior to working with facility residents.

Resolution also included the Regional Senior Nurse Consultant conducting education with facility Administrator, Assistant Director of Health Services, Clinical Competency Coordinator and Director of Health Services related to facility policy regarding prevention of abuse, indicators of abuse, reporting abuse, and investigation abuse on 2/6/2019 to ensure resident safety.

Current facility residents had skin audits conducted by facility Registered Nurse Treatment Nurse and facility Charge nurses starting 2/6/2019 to ensure residents remain safe while in facility. These audits ensure residents with Brief Interview of Mental Status (BIMS) of 7 or below were checked for signs of possible physical abuse.

Residents with a Brief Interview of Mental Status (BIMS) score of 8 or above were interviewed by facility Activities Director, Director of Health Services, MDS Coordinator, and Licensed Practical Charge Nurse starting 2/6/2019 to ensure any possible staff to resident abuse was reported and investigated appropriately.

- Process for implementing a plan of correction for specific deficiency
The facility Administrator should have conducted a thorough investigation to determine if this issue could or would affect other residents.

On 2/6/2019 facility Administrator, Director of Healthcare Services, Assistant Director of Healthcare Services, Registered Nurse (RN) Clinical Competency Nurse and Registered Nurse

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(RN) MDS Coordinator received education from Registered Nurse (RN) Regional Senior Nurse Consultant regarding facility abuse policy to include investigation procedures.

On 2/6/2019 the facility Administrator, Director of Healthcare Services, Assistant Director of Healthcare Services, Registered Nurse (RN) Clinical Competency Nurse and Registered Nurse (RN) MDS Coordinator received education from Registered Nurse (RN) Regional Senior Nurse Consultant on F607 Regulatory Guideline interpretation and adherence thereof.

On 2/6/2019 the facility Registered Nurse (RN) Clinical Competency Coordinator began educating Nursing Clinical staff, Dietary staff, Environmental staff, Administrative staff, and Rehabilitation staff on facility policy and procedures related to preventing abuse and reporting abuse to ensure resident safety. Facility staff who have not completed education will be removed from the schedule until education is completed.

On 2/6/2019 the facility Clinical Competency Coordinator started educating Nursing Licensed and Unlicensed staff, Dietary staff, Environmental staff, Administrative staff, and Rehabilitation staff on Basic Concepts and Guidelines for caregiving for individuals with Dementia to ensure resident safety. Facility staff who have not completed education will be removed from the schedule until education is completed.

On 1/9/2019 Laboratory Phlebotomist was verbally trained via phone by Assistant Director of Nursing regarding timely and appropriate abuse reporting. Management of the Laboratory

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Phlebotomist were trained on 2/7/2019 by facility Registered Nurse Clinical Competency Nurse regarding facility policy related to abuse prevention, identification, and reporting. On 2/7/2019 Management of the Laboratory Phlebotomist told the Registered Nurse Clinical Competency Nurse they would ensure staff assigned to the facility receive training prior to working with facility residents.

Beginning on 2/6/2019 accused Certified Nursing Assistants (NA#1 & NA#2) were re-interviewed and suspended pending investigation to ensure resident safety. On 2/8/2019 accused Certified Nursing Assistants (NA#1 & NA#2) were terminated from facility employment by facility Administrator and Registered Nurse Regional Senior Nurse Consultant.

Starting 2/6/2019 facility Assistant Director of Nursing, Director of Nursing, and MDS Coordinator interviewed residents with BIMS of 8 or above to find out if they have been abused or have witnessed abuse. Residents having statements positive for possible abuse will be re-interviewed by Administrator and Director of Health Services to ensure they are free from harm and statements are thoroughly investigated and reported.

Starting 2/6/2019 facility Treatment Nurses conducted and documented skin audits for current facility residents. Abnormal bruising will be flagged for further investigation by facility Administrator and Director of Nursing to ensure resident safety. These audits ensure residents with BIMS score of 7 or below are audited for possible signs of abuse.

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New hires will be educated by the facility RN Clinical Competency Nurse during orientation on facility policy and procedure related to abuse prevention and reporting as well as Basic Concepts and Guidelines for caregiving for individuals with Dementia to ensure all facility personnel protect facility residents.

On 2/7/2019 the Regional Area Vice President and Regional Senior Nurse Consultant attended the ad-hoc Quality Assurance and Performance Improvement committee meeting related to facility following policy and procedure regarding abuse investigation to ensure continued resident safety.

- Monitoring to ensure effectiveness of POC
Starting 2/6/2019 residents with Brief Interview of Mental Status (BIMS) of 8 or above were interviewed by facility Nursing Administration interviewed to find out if they have been abused or have witnessed abuse. Continued monitoring to ensure no occurrence of resident to staff abuse will include random interviews of 10 residents with 8 or above Brief Interview of Mental Status (BIMS)and 10 random skin audits for residents Brief Interview of Mental Status (BIMS) below 8 daily for 14 days, then weekly for three weeks, then monthly.

Starting 2/7/2019 facility Director of Healthcare Services, Assistant Director of Healthcare Services, Registered Nurse Clinical Competency Coordinator, Registered Nurse MDS Coordinator, and Registered Nurse Treatment Nurses will conduct 10 random visual audits of staff to resident interaction during caregiving procedures on each shift daily for 14 days, weekly for three weeks, and monthly to ensure no instance of staff

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to resident abuse.

Starting 2/8/2019 facility Registered Nurse Clinical Competency Nurse, Housekeeping Supervisor, Dietary Supervisor, Financial Counselor, Social Worker, and Admissions Director interviewed 10 random staff members regarding facility abuse policy with scenarios to ensure staff members have knowledge of and are able to implement facility policy and procedure regarding staff to resident abuse identification and prevention daily for 14 days, then weekly for three weeks, then monthly.

On 2/7/2019 the Regional Area Vice President and Regional Senior Nurse Consultant attended the ad-hoc Quality Assurance and Performance Improvement committee meeting related to review of facility policy preventing staff to resident abuse.

Starting 2/8/2019 the Regional Senior Nurse Consultant will review the facility random audits and 24 hour abuse for timely reporting as well as thorough and timely completion of subsequent investigation weekly for 4 weeks then monthly to ensure the facility Administration is complying with the regulatory guideline.

- Title of person responsible for implementing the POC
The Administrator is responsible for implementing the plan of correction.
Date of Allegation of Compliance 2/8/2019

The credible allegation of Immediate Jeopardy removal was validated on 2/8/19 at 10:55 AM.

Interviews verified NA #1 and NA #2 were

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F 607	Continued From page 55 re-suspended on 2/7/19 and terminated on 2/8/19. A review of inservice sign in sheets and staff interviews verified education was provided on 2/6/19 to facility administrative staff on the facility abuse policy to include investigation procedures and on F607 Regulatory Guideline interpretation and adherence thereof. Education was also verified to be provided to facility staff on 2/6/19 on proper procedures for preventing abuse, reporting abuse, and basic concepts and guidelines for caregiving for individuals with dementia. Staff who had not received the inservice on 2/6/19 were to be removed from the schedule until education was completed. Education was also verified to be provided to the Laboratory Phlebotomist and Management of the Laboratory Phlebotomist on 2/7/19 regarding facility policy related to abuse prevention, identification, and reporting. Management of the Laboratory Phlebotomist indicated that their staff assigned to the facility were to receive training prior to working with facility residents. Record review indicated skin audits were conducted for all current residents on 2/6/19 and 2/7/19. All alert and oriented residents were interviewed on 2/6/19 and 2/7/19 to ensure any possible staff to resident abuse was reported and investigated properly. These resident interviews were documented on an audit form.	F 607		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		3/14/19

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§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive

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F 636	Continued From page 57 assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to comprehensively assess a resident on the Minimum Data Set (MDS) assessment in the areas of cognition and mood and also failed to complete the admission MDS assessment within the first 14 days after admission for 1 of 5 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 12/21/18 with diagnoses that included stroke, aphasia, and dementia. The admission Minimum Data Set (MDS) assessment dated 12/28/18 indicated Resident #1 had clear speech, was usually understood by others, and usually understands others. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #1. Question C0100 was coded to indicate that a Brief Interview for Mental Status (BIMS) was to be conducted for Resident #1. Questions C0200	F 636	1) Processes that lead to the deficiency cited were resident Minimum Data Set (MDS) completion is optimally handled by two Registered Nurse(RN) MDS Coordinators and facility has been operating with one RN MDS Coordinator. Resident #1 received mood and cognition assessment with 30 day comprehensive assessment completed on 1/18/2019. 2) The procedure for implementing an acceptable Plan of correction including identification of other potential residents affected for the deficiency cited is as follows: Facility Administrator conducted an audit ending 3/5/2019 of residents admitted to the facility in the past 30 days for timely completion of admission assessment with mood (Section PHQ9) and cognitive (Section C) section completed. Four residents found without completed admission assessments will have them completed by the RN MDS Coordinator by	

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F 636	Continued From page 58 through C0500 were not assessed indicating the BIMS was not completed with Resident #1. Section D, the Mood section, was not comprehensively assessed for Resident #1. Question D0100 was coded to indicate a resident mood interview was to be conducted for Resident #1. Questions D0200 through D0300 were not assessed indicating the resident mood interview was not completed. Section C and D of Resident #1' s 12/28/18 MDS was completed by the MDS Coordinator. Section Z, the Assessment Administration section, revealed this 12/28/18 admission MDS for Resident #1 was signed as complete by the MDS Coordinator on 1/24/19. An interview was conducted with the MDS Coordinator on 2/5/19 at 12:35 PM. She stated that she completed Section C and Section D of Resident #1 ' s 12/28/18 admission MDS. She revealed that the facility ' s previous Social Worker (SW) was supposed to complete this section of the MDS, but she had not done so. She stated this SW was no longer employed at the facility. She reported that when she realized that the previous SW had not completed the resident BIMS or resident mood interview for Resident #1 it was after the Assessment Reference Date (ARD) and therefore she had to leave the resident interviews for Section C and Section D as not assessed. A second interview was conducted with the MDS Coordinator on 2/6/19 at 11:20 AM. Section Z of Resident #1 ' s 12/28/18 admission MDS that indicated the assessment was completed on 1/24/19 was reviewed with the MDS Coordinator. She revealed that this assessment was completed late. She further revealed that she was the only MDS Nurse at the facility and she	F 636	3/10/2019. Residents needing completion of mood and cognition section had them completed by members of the Interdisciplinary Team (IDT) to include Social Worker, Dietary Supervisor, Activities Director, and Nursing Administration by 3/8/2019. 3) The Facility implemented the following systemic changes to ensure cited deficiency does not reoccur: Facility has a RN MDS Coordinator helping with timely completion of admission assessments starting 3/1/2019. Facility Administrator assigned facility Social Worker, Activities Director, Admission Director, Director of Health Services, Therapy Outcomes Coordinator, and Dietary Supervisor education via facility electronic training system on 3/2/2019 to be completed by 3/8/2019 regarding timely completion of MDS Sections PHQ9 and Section C. The assessment calendar will be provided to and reviewed by facility Interdisciplinary Team to include facility Social Worker, Director of Health Services, Activities Director, Dietary Supervisor, and Therapy Outcomes Coordinator each morning in clinical meeting to ensure timely completion of admission assessments. 4)To ensure solutions are sustained the facility will implement the following procedures to monitor performance: The facility Administrator and Director of Health Services will review the assessment calendar for Admission assessments to include mood and	

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F 636	Continued From page 59 had difficulty completing the assessments on time. She stated that occasionally she had a corporate MDS Nurse help her out with some of the assessments, but primarily she had been on her own for almost a year. An interview was conducted with the Administrator on 2/8/19 at 10:33 AM. She indicated her expectation was for all residents to be comprehensively assessed in all areas of the MDS and for the assessments to be completed timely as per the regulations.	F 636	cognition section completion 5 days a week for 4 weeks, then weekly for 3 months and then monthly thereafter to ensure timely completion. Findings of the review will be reported to the facility Quality Assurance Performance Improvement Committee monthly by facility Administrator and/or RN MDS Coordinator to maintain compliance. 5) Compliance Date 3/14/2019	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		3/14/19

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F 657	Continued From page 60 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the comprehensive care plan within 21 days of admission for 1 of 5 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 12/21/18 with diagnoses that included stroke, aphasia, and dementia. Resident #1' s undated baseline care plan indicated the following focus areas: - Discharge planning - Activities of Daily Living (ADL) Decline relayed to cerebrovascular accident (CVA) - Risk for falls related to right sided weakness - Risk for impaired skin integrity - Risk for cardiac output relayed to hypertension and Coronary Artery Disease (CAD) - Candidate for bowel and bladder retraining as evidence by continent with incontinent episodes - Adjustment difficulty to new environment related to recent admission and diagnosis of psychosocial adjustment difficulty - Potential for social isolation and low activity participation related to new admission and short stay resident - Alteration in dentition - Nutrition and/or hydration risk as evidenced by chewing problems The comprehensive care plan for Resident #1	F 657	1) Processes that lead to the deficiency cited include oversight of comprehensive care plan completion for facility residents are optimally handled by two RN MDS Coordinators and facility has been operating with one RN MDS Coordinator. Resident #1 had a comprehensive care plan completed 1/18/2019. 2) The procedure for implementing an acceptable Plan of correction including identification of other potential residents affected for the deficiency cited is as follows: Facility Administrator conducted an audit ending 3/5/2019 of residents admitted to the facility in the past 30 days for timely completion comprehensive care plan within 21 days of admissions per regulation. Five residents found with comprehensive assessments needing to be completed had them completed facility RN MDS Coordinator by 3/10/19. 3) The Facility implemented the following systemic changes to ensure cited deficiency does not reoccur: Facility Administrator assigned facility Social Worker, Activities Director, Admission Director, Director of Health Services, Therapy Outcomes Coordinator, and Dietary Supervisor education via facility electronic training system on	

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F 657	Continued From page 61 was initiated on 12/24/18 with the problem/need of the potential for social isolation due to facility admission. This was the only focus area initiated on 12/24/18. On 12/26/18 the baseline care plan for Resident #1 was updated to include the area of behavioral symptoms with a handwritten note that stated a new physician ' s orders was received for Resident #1 for Aricept (cognition enhancing medication) related to dementia with behaviors. The admission Minimum Data Set (MDS) assessment dated 12/28/18 for Resident #1 was not completed in the area of cognition as the resident interview for mental status and staff interview for mental status were blank. She was assessed with inattention and disorganized thinking fluctuating in presence. Resident #1 had no physical behaviors, no verbal behaviors, and no rejection of care. She was noted with other behavioral symptoms and wandering behaviors on 1 to 3 days. Resident #1 was assessed as requiring the limited assistance of 1 for bed mobility, transfers, and locomotion on/off the unit. She required the extensive assistance of 1 with dressing, toileting, and personal hygiene. She was not steady on her feet and was only able to stabilize with staff assistance. Resident #1 utilized a walker and wheelchair, she was occasionally incontinent of bladder and bowel, she had no skin issues, and she had sustained no falls. Section Z, the Assessment Administration section, revealed this 12/28/18 admission MDS for Resident #1 was signed as complete by the MDS Coordinator on 1/24/19. The comprehensive care plan for Resident #1	F 657	3/2/2019 to be completed by 3/8/2019 regarding OBRA completion requirements for resident care plans. The facility Administrator and Director of Health Services will review comprehensive care plan due date calendar with IDT in clinical meeting to ensure comprehensive assessments are completed within 21 days of resident admitting to the facility. 4) To ensure solutions are sustained the facility will implement the following procedures to monitor performance: The facility Administrator and Director of Health Services will review the assessment calendar for Admission assessments to include mood and cognition section completion 5 days a week for 4 weeks, then weekly for 3 months and then monthly thereafter to ensure timely completion. Findings of the review will be reported to the facility Quality Assurance Performance Improvement Committee monthly by facility Administrator and/or RN MDS Coordinator to maintain compliance. 5) Compliance Date 3/14/2019	

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F 657	Continued From page 62 was updated on 1/24/19 with the following 11 problems/needs: - Advance Directive - Do not Resuscitate (DNR) - Resident wants to return home - Risk for falls due to impaired mobility, right sided weakness, shortness of breath with exertion noted, impaired cognition related to dementia, and a fall since admission - Alteration in elimination: incontinent episodes of bowel and bladder - Requires limited to extensive assistance with ADLs due to impaired mobility, right sided hemiparesis status post CVA, impaired cognition related to diagnosis of dementia, edentulous and does not wear dentures, shortness of breath noted with exertion and while lying flat - Potential for alteration in skin integrity due to impaired mobility, incontinent episodes of bowel and bladder, cellulitis to lower extremities - Exit seeking behavior noted, required use of wanderguard device (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) - Socially inappropriate/disruptive behavior such as yelling, fluctuating inattention/disorganized thinking - Risk for constipation due to impaired mobility, as needed use of opioids - At risk for complications related to hypo/hyperglycemia, diagnosis of Diabetes Mellitus (DM) - Potential for weight loss due to: edentulous, does not wear dentures, new surroundings, impaired cognition, use of diuretic for edema of bilateral lower extremities, admitted with 2000 cc (cubic centimeter) fluid restriction	F 657		

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F 657	Continued From page 63 An interview was conducted with the MDS Coordinator on 2/6/19 at 11:20 AM. Resident #1 ' s 12/28/18 admission MDS that indicated the assessment was completed on 1/24/19 was reviewed with the MDS Coordinator. She revealed that this assessment was completed late. She further revealed that she was the only MDS Nurse at the facility and she had difficulty completing the assessments on time. The MDS Coordinator stated that when the MDS assessment was completed late the comprehensive care plan was also completed late. She explained she had not completed the Care Area Assessments (CAAs) for Resident #1 ' s 12/28/18 admission MDS until 1/24/19 which was why she had not developed any of the care plans until 1/24/19. She stated that the only care plan for Resident #1 in place prior to 1/24/19 was the care plan related to activities which was created by the Activities Director on 12/24/18. The MDS Coordinator revealed that the comprehensive care plan was pertinent to a resident ' s care as it identified problems/needs, goals, and interventions for the staff to utilize to meet the goals of each identified problem/need. She further revealed that Resident #1 had multiple care needs that required care plans to be put in place for, so staff were aware of the appropriate interventions, such as inappropriate behaviors, exit seeking, ADL assistance, and fall risk. An interview was conducted with the Administrator on 2/8/19 at 10:33 AM. She indicated her expectation was for comprehensive care plans to be completed within 21 days of admission as per the regulations.	F 657		
F 835	Administration	F 835		3/14/19

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F 835 SS=E	Continued From page 64 CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, facility staff interviews and resident interviews, and laboratory company staff interviews, the facility failed ensure contracted staff met professional standards of care for immediately reporting resident abuse for 1 of 2 residents reviewed for staff to resident abuse (Resident #1) and to provide leadership and oversight to maintain the facility's roof in good repair with evidence of multiple leaks in the facility's ceiling in areas including; 1 resident room, hallways, the multi-purpose room, and the dining room. The findings included: This tag is cross-referred to: 1. F840: Based on record review, facility staff interview, and laboratory staff interview, the facility failed to ensure contracted staff providing services to residents within the facility met professional standards of care for immediately reporting abuse for 1 of 2 residents (Resident #1) sampled for staff to resident physical abuse. 2. F584. Based on observations, staff and resident interviews and record review, the facility failed to maintain the roof in good repair with evidence of multiple leaks in the facility's ceiling.	F 835	1) Processes that lead to the deficiency cited were: A) Laboratory Phlebotomist failed to follow contractual standards of conduct related to resident safety as well as facility policy and procedure related to reporting of abuse to facility when they did not immediately report the incident after witnessing it on 1/9/2019 with Laboratory Phlebotomist was verbally trained via phone by Assistant Director of Nursing regarding timely and appropriate abuse reporting on 1/9/2017, Management of the Laboratory Phlebotomist were trained on 2/7/2019 by facility Registered Nurse Clinical Competency Nurse regarding facility policy related to abuse prevention, identification, and reporting. On 2/7/2019 Management of the Laboratory Phlebotomist told the Registered Nurse Clinical Competency Nurse they would ensure staff assigned to the facility receive training prior to working with facility resident. B) Flat top roof on facility is in need of replacement. Facility roof approved for replacement on 2/22/2019 and scheduled for replacement to start on 3/14/2019. (1) a. Hallway ceiling vents on B hall outside	

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F 835	Continued From page 65 This was observed in 1 resident room, on the hallways, the multi-purpose room and the dining room.	F 835	of rooms 125 and 126 will have roof sealed to prevent future moisture damage and repair of current moisture damage the facility Maintenance Director by 3/8/2019. (b) Hallway ceiling on A Hall outside of room 104 will have roof sealed and current water damage repaired by facility Maintenance Director by 3/8/2019. (c) Facility Maintenance Director will seal the roof and repair ceiling outside of room 114 by 3/8/2019. (d) Ceiling on D hallway around the fire detector near the nurses station will be repaired by the facility Maintenance Director and the Maintenance Director will seal the roof above this area by 3/8/2019. (e) Facility Maintenance Director closed the hole in the ceiling outside of room 156 on 2/8/2019 and support beam is no longer visible. (f) Facility Maintenance Director will seal roof above area outside of room 141 and repair cracks in ceiling outside of room 141 by 3/12/2019. (g) The roof above the hallway ceiling outside of room 143 will have the roof sealed and ceiling repaired by facility Maintenance Director by 3/12/2019. (h) The roof above the hallway ceiling outside of room 149 will have the roof sealed and ceiling repaired by facility Maintenance Director by 3/12/2019. (i) Residents were moved out of room 122 on 2/11/2019 until roof over the residents room is repaired. Roof repair is scheduled on begin on 3/14/2019. (j) The roof area over the multi-purpose room will be sealed by the Maintenance Director and the ceiling repaired by 3/12/2019. 2) The procedure for implementing an	

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F 835	Continued From page 66	F 835	acceptable Plan of correction including identification of other potential residents affected for the deficiency cited is as follows: A. On 2/7/2019 Management of contracted Laboratory service provider to facility received training from facility Registered Nurse (RN) Clinical Competency Coordinator regarding facility abuse prevention policy to include timely reporting of abuse. Management of contracted Laboratory service provider stated they will train phlebotomist on abuse prevention policy prior to them working in facility. B. Facility Maintenance Director conducted visual inspection of facility ceilings on 2/27/2019 to ensure no other areas had holes in need of repair or residents in rooms with visible signs of water damage. Inspection did not show other areas on ceiling with holes or resident rooms with evidence of water damage. 3) The Facility implemented the following systemic changes to ensure cited deficiency does not reoccur: A. Management of the Laboratory Phlebotomist were trained on 2/7/2019 by facility Registered Nurse Clinical Competency Nurse regarding facility policy related to abuse prevention, identification, and reporting. On 2/7/2019 Management of the Laboratory Phlebotomist told the Registered Nurse Clinical Competency Nurse they would ensure staff assigned to the facility	

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F 835	Continued From page 67	F 835	receive training prior to working with facility residents. By 3/12/2019 facility RN Clinical Competency Coordinator completed training for other contracted service providers to facility residents regarding facility abuse policy to include timely reporting of possible abuse. B. Facility Administrator educated Department Heads on March 5, 2019 to educate employees which they directly supervise to report noticed holes in ceilings, water leaks during and after rain events, as well as damage to the ceiling to the Facility Maintenance Director via facility electronic Preventative Maintenance system. Facility Maintenance Director educated licensed and unlicensed facility employees on March 8, 2019 & March 11, 2019 to report noticed holes and water leaks in ceiling in writing via facility electronic Preventative Maintenance system. Facility Employees not attending one of the above training sessions were not permitted to work until training was completed with Direct Supervisor. New Hires are provided this education by the Facility Maintenance Director during Orientation. Facility Maintenance Director Facility Maintenance Director conducts visual audits of ceiling to ensure no holes or areas showing signs of leaks are found. Resident rooms found to have significant ceiling damage will have resident moved out of room until the ceiling is repaired. Facility Administrative staff check ceilings in and around assigned resident rooms during daily visual inspections. Ceilings with problems are marked on round form	

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F 835	Continued From page 68	F 835	and a copy of the form identifying the problem ceiling is given to the Maintenance Director. 4) To ensure solutions are sustained the facility will implement the following procedures to monitor performance: A. Facility Starting 3/1/2019 facility Administrative personnel interviewed 4 random contracted service providers to facility residents regarding facility abuse policy with scenarios to ensure contracted service providers have knowledge of and are able to implement facility policy and procedure regarding staff to resident abuse identification and reporting weekly for 4 weeks, then monthly for three months, and quarterly thereafter. Results of interviews will be presented by RN Clinical Competency Coordinator or Facility Administrator to facility Quality Assurance Performance Improvement Committee monthly for 4 months then quarterly thereafter to ensure continued compliance. B. The facility Maintenance Director will conduct visual audit of facility ceilings weekly for four weeks, then monthly thereafter, to ensue no holes currently found in need of repair or persistence of water damage post roof replacement and currently in resident rooms. Facility Maintenance Director will present audit results with proof of corrections if needed monthly to facility Quality Assurance and Performance Improvement Committee to ensure continued compliance. 5) Compliance Date 3/14/2019	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 840	Continued From page 69	F 840		
F 840 SS=D	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review, facility staff interview, and laboratory staff interview, the facility failed to ensure contracted staff providing services to residents within the facility met professional standards of care for immediately reporting abuse for 1 of 2 residents (Resident #1) sampled for staff to resident physical abuse. The findings included: Resident #1 was admitted to the facility on 12/21/18 with diagnoses that included stroke, aphasia, and dementia.	F 840	1)Processes that lead to the deficiency cited were Laboratory Phlebotomist failed to follow contractual standards of conduct related to resident safety as well as facility policy and procedure related to reporting of abuse to facility when they did not immediately report the incident after witnessing it on 1/9/2019. Laboratory Phlebotomist was verbally trained via phone by Assistant Director of Nursing regarding timely and appropriate abuse reporting on 1/9/2019. 2)The procedure for implementing an	3/14/19

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F 840	Continued From page 70 The admission Minimum Data Set (MDS) assessment dated 12/28/18 for Resident #1 was not completed in the area of cognition as the resident interview for mental status and staff interview for mental status were blank. She was assessed with inattention and disorganized thinking fluctuating in presence. An initial allegation (24-hour report) dated 1/9/19 completed by the Administrator indicated an allegation of staff to resident physical abuse. The incident occurred on 1/9/19 at approximately 5:15 AM and the facility became aware of the incident on 1/9/19 at 1:15 PM. The allegation details stated that Laboratory Phlebotomist (LP) witnessed Nursing Assistant (NA) #1 "strike" Resident #1 on her left shoulder while NA #2 held her by the shirt. LP stated that she stayed in the room with Resident #1 to ensure she was not touched anymore by NA #1 or NA #2. Both NAs (NA #1 and NA #2) were noted to leave the room and LP pushed Resident #1 in her wheelchair to the nurse' s station. The details of physical or mental injury/harm read, "Body audit revealed bruise to the face area [of Resident #1]." This form was completed by the Administrator on 1/9/19. A phone interview was conducted with LP on 2/5/19 at 2:24 PM. She stated that between 5:00 AM and 6:00 AM on 1/9/19 she witnessed NA #1 hit Resident #1 on the cheek area with a closed fist and then on the left shoulder with an open hand as NA #2 held Resident #1 by her shirt at the shoulders (from behind) to keep her seated in her wheelchair. LP revealed she had not reported the incident to the nurse on duty following the incident. She stated that she believed NA #1 and NA #2 were friends with	F 840	acceptable Plan of correction including identification of other potential residents affected for the deficiency cited is as follows: On 2/7/2019 Management of contracted Laboratory service provider to facility received training from facility Registered Nurse(RN) Clinical Competency Coordinator regarding facility abuse prevention policy to include timely reporting of abuse. Management of contracted Laboratory service provider stated they will train phlebotomist on abuse prevention policy prior to them working in facility. 3)The Facility implemented the following systemic changes to ensure cited deficiency does not reoccur: Management of the Laboratory Phlebotomist were trained on 2/7/2019 by facility Registered Nurse Clinical Competency Nurse regarding facility policy related to abuse prevention, identification, and reporting. On 2/7/2019 Management of the Laboratory Phlebotomist told the Registered Nurse Clinical Competency Nurse they would ensure staff assigned to the facility receive training prior to working with facility residents. By 3/12/2019 facility RN Clinical Competency Coordinator completed training for other contracted service providers to facility residents regarding facility abuse policy to include timely reporting of possible abuse. 4)To ensure solutions are sustained the facility will implement the following	

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F 840	Continued From page 71 Nurse #1 and she hadn ' t felt comfortable reporting the incident to her because she feared retaliation from the staff. The LP reported that she phoned her supervisor around 7:00 AM when she left the facility to report the incident and he instructed her to report the incident to the facility administration. She stated that she had a good relationship with the Assistant Director of Nursing (ADON) and she wanted to make sure the information got into the right hands and that it was taken seriously. She reported that she phoned the ADON later that morning around 10:00 AM/11:00 AM to report the incident. She was asked why she had waited until 10:00 AM/11:00 AM and she stated that she knew the ADON was not present at the facility at 7:00 AM so she proceeded to her next job and she phoned the ADON when she had an opportunity to step away from work. The LP stated that it was not until that afternoon, 1/9/19, that she provided a verbal statement to the Administrator by phone. She explained that she had gotten tied up with work and was unable to provide a detailed account of the incident until after 1:00 PM on 1/9/19. A phone interview was conducted with LP ' s supervisor on 2/6/19 at 4:35 PM. He confirmed that the LP contacted him by phone on 1/9/19 immediately after leaving the facility and reported to him the allegation of staff to resident abuse. He stated that he instructed her to contact the facility ' s administration and report the incident. The LP ' s supervisor was asked if they provided any training to their employees related to reporting allegations of abuse. He revealed that they had not provided any training related to reporting allegations of abuse.	F 840	procedures to monitor performance: Starting 3/1/2019 facility Administrative personnel interviewed 4 random contracted service providers to facility residents regarding facility abuse policy with scenarios to ensure contracted service providers have knowledge of and are able to implement facility policy and procedure regarding staff to resident abuse identification and reporting weekly for 4 weeks, then monthly for three months, and quarterly thereafter. Results of interviews will be presented by RN Clinical Competency Coordinator or Facility Administrator to facility Quality Assurance Performance Improvement Committee monthly for 4 months then quarterly thereafter to ensure continued compliance. 5)Compliance Date 3/14/2019	

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An interview was conducted with the ADON on 2/5/19 at 4:20 PM. She stated that the LP contacted her by phone on 1/9/19 around 10:00 AM and reported an incident of staff to resident abuse. She indicated the LP had not provided her with the resident ' s name or the staff members name during this phone call. The LP reported to the ADON that she walked into a resident ' s room and she saw 1 staff member standing behind the resident "restraining" her in the wheelchair while the other staff member hit the resident from the front. The ADON indicated the LP told her that she had not wanted to get involved, but that she also knew it was her job to protect the residents. She indicated that the LP was at work while she was reporting this information and she told the ADON she had to call her back later. The ADON stated that it was not until later that afternoon that she and the Administrator spoke to the LP by phone to obtain the more detailed verbal statement which allowed them to initiate an investigation.

An interview was conducted with the Administrator on 2/6/19 at 4:00 PM. The Administrator confirmed the LP had not immediately reported the allegation of staff to resident abuse. She was asked who was responsible for providing training on abuse reporting to their contracted providers, such as the LP. She stated that she was not sure, but she thought the contracted provider was responsible for providing training to their own staff. She revealed she had not checked with the laboratory company after this 1/9/19 incident to verify if training on abuse reporting had been provided to their staff.

A follow up interview was conducted with the

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F 840	Continued From page 73 Administrator on 2/8/19 at 10:33 AM. She stated that she expected contracted providers to meet professional standards of practice and report any allegation of resident abuse to her immediately.	F 840		