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	345477	A. BUILDING _____ B. WING _____	C 02/06/2020

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THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted on 2/5/20 through 2/6/20. 2 of the 2 allegations were substantiated resulting in deficiency. Event ID#TKK011	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to protect 1 of 3 sampled residents (Resident #1) from physical abuse inflicted by a staff member that resulted in bruising and an abrasion to Resident #1's right cheek. The findings included: Resident #1 was admitted on 11/27/19 with a diagnosis that included mood disorder, dementia without behavioral disturbances, hemiparesis affecting non dominant side, cognitive communication deficit, and chronic obstructive	F 600	Past noncompliance: no plan of correction required.	

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

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pulmonary disease (COPD).

Review of Minimum Data Set (MDS) assessment dated 12/4/19 revealed Resident#1 was moderately cognitively impaired, had behavioral symptoms that significantly interfered with care and social interaction. The MDS further revealed Resident #1 required limited assistance with bed mobility and extensive assistance with transfers with a 1-person physical assist.

Review of Resident #1's care plan dated 12/6/19 revealed a focus area for the problematic manner in which Resident #1 had impaired decision making and ineffective coping skills that included cursing and yelling at staff and peers, refusing care, urinating in courtyard/smoking area, spitting on floor and walls, and throwing medical equipment. The interventions included administration of medications, intervene as necessary to protect the rights and safety of others, provide opportunity for positive interactions, and praise any indication of the resident's progress/improvement in behavior.

Review of nursing note dated 1/27/20 revealed a late entry note that stated an altercation had occurred with Resident #1 and 3rd shift Nursing Assistant #1 (NA). The note continued that Resident #1 presented with bruising noted to right cheek and complaints of pain. The physician was contacted and order was received to send Resident#1 to the emergency department for evaluation.

Review of Resident #1's Shower Review/skin assessment dated 1/27/20 revealed bruising and abrasion to right cheek. The assessment stated Resident #1 would not allow nursing staff to

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complete a full assessment.

Review of physician order dated 1/27/20 stated send Resident #1 to hospital for evaluation and treatment.

Review of the 24-hour Report dated 1/27/20 revealed an allegation of physical abuse of Resident #1 by NA #1 that occurred on 1/27/20 at 6:00AM. Notification was made to law enforcement. The 24-hour Report was signed by the Administrator on 1/27/20.

Review of the 5-Working Day Report dated 1/29/20 revealed the allegation of abuse of Resident #1 was investigated and substantiated. The report stated on 1/27/20 at approximately 6:00AM, Nurse #1 overheard a commotion on 300 Hall. Nurse #1 entered Resident #1's room (room 312) and observed Resident #1 and NA #1 were in an altercation. NA #1 stated to Nurse #1 that Resident #1 hit her, so she hit him back. NA #1 was asked to leave the building. NA #1 and NA #2 were providing care to another resident when Resident#1 struck NA#1, NA#1 then hit Resident#1. Resident #1 sustained a minor abrasion to the right cheek. Resident #1 was sent to the emergency room for evaluation. NA #1 was suspended on 1/27/20 with termination on 1/29/20.

Review of the hospital discharge summary dated 1/27/20 revealed Resident #1 entered hospital following an altercation with an NA at the facility. Resident #1 presented with an abrasion to right cheek and complaints of right facial pain. Resident #1 walked out of the emergency room prior to completion of work up.

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An interview was attempted on 2/5/20 at 2:40PM with NA #1 via telephone. There was no answer and no message could be left.

An interview with NA #2 on 2/5/20 at 3:12PM revealed on 1/27/20 at 6:00AM, NA #2 was providing care to the roommate of Resident #1 (room #312). NA #2 indicated she had asked NA #1 to aid with incontinence care. During this time, Resident #1 became upset stating NA #1, NA #2, and the roommate were too loud. Resident #1 further stated that if they didn't stop, he would hit NA #1 and the roommate. NA #1 responded to Resident #1 using explicit language, "you aren't going to do anything". Resident #1 then came behind NA #1 while she was providing care to the roommate and hit her in the face in the area of her eye and cheek bone. NA #1 then swung her arm while turning around and back handed Resident #1, resulting in a cut around Resident #1's right eye. NA #2 believed the cuts on Resident #1's eye were due to NA #1 wearing rings. Resident #1 threatened to sue and to call the police, while attempting to hit NA #1 again. Nurse #1 heard the commotion and came to the room. At this time NA #1 informed Nurse #1 she had hit Resident #1. Nurse #1 removed NA #1 from the floor and asked her to write a statement. Before exiting the building, NA #1 made a call to law enforcement.

An interview with Nurse #1 on 2/6/20 at 10:23AM revealed on 1/27/20 while passing meds, she heard a commotion on the 300 Hall. When she arrived at Resident #1's room (room #312), NA #1 and NA #2 were finishing incontinence care with Resident #1's roommate. Resident #1 was observed to be screaming at NA #1. Resident #1 revealed NA #1 had hit him, and NA #1 revealed

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Resident #1 hit her first. NA #1 indicated she was going to call law enforcement due to Resident #1 assaulting her, which she did prior to leaving the building. Nurse #1 indicated she attempted to assess Resident #1 for injuries, but he refused. Although Resident #1 refused, a small cut was observed under his right eye and the corner of his right eye. The cuts had minimal bleeding and Resident #1's right eye had ruptured blood vessels. Resident #1 originally stated he did not want to go to the emergency room but later stated he wanted to go. Nurse #1 stated she contacted the administrator to make him aware of the incident and the facility physician who provided verbal order to send Resident #1 to the hospital.

An interview with Nurse #2 on 2/6/20 at 10:45AM revealed she was not in the facility at the time of the incident on 1/27/20 but did observe Resident #1 on his way out to hospital that same day. He was agitated and she noted a bruise that was blue in color on his right cheek.

An interview of Director of Nursing (DON) on 2/6/20 at 1:15PM revealed she was notified via phone on 1/27/20 regarding the incident of abuse between NA #1 and Resident #1. The DON spoke with the Administrator and Nurse #1 and was notified NA #1 had left the building. The DON stated that staff should not get back at residents if a resident was aggressive, staff should ensure the resident's safety and approach later.

An interview of Administrator on 2/6/20 at 1:20PM revealed he had been notified of the incident on 1/27/20 at 6:12AM. He immediately came into the building. The Administrator stated NA #1 should have walked away from Resident #1 when

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he showed agitation. The NA should have reported the incident to the responsible staff member so relief could have been provided and the situation de-escalated.

On 2/6/20 at 11:00AM, the facility provided shared the following plan to address the incident:

" The corrective action for the alleged deficient practice was accomplished by:

Resident #1 was offered a focal assessment from witness, on 1/27/2020 but refused full assessment. Resident was observed to have an abrasion on his right check. The local Police Department was notified and arrived at the facility on 1/27/2020 to investigate incident. The Primary Care Physician was notified with orders to transfer resident to Emergency Department of local hospital for assessment. Resident's responsible party was notified by licensed nurse of incident and transfer.

" Residents with the potential to be affected by alleged deficient practice:

Current facility residents who could be interviewed with a BIMS of 8 and above were asked if they had any concerns about their safety by Social Services on 1/27/2020 to include:
" If anyone has mistreated you since residing here?
" Has anyone threatened you or verbally abused you since residing here?
" Are you fearful of anyone while residing here?
" Do you feel like you are receiving the care that you need while residing here?
None voiced concerns.

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The skin of current residents residing in the facility was checked for suspicious injuries or injuries of unknown origin that would be indicative of abuse/neglect by licensed nurse by 1/28/2020. No issues were found.
Employee files for accused, witnesses were reviewed by facility HR Coordinator and Regional HR for background checks and abuse training. Their background checks were clear and all three employees had received Abuse/Reporting education.
The facility's grievance book was reviewed by the Regional Director of Clinical Services on 1/27/2020 and no allegations of abuse were noted that needed to be reported to the State of North Carolina.
All current employee files were reviewed by the facility HR Coordinator and Regional HR 1/27/2020 thru 1/30/2020.
Interdisciplinary Team met on 01/28/2020 to ensure residents with targeted behaviors are documented, care planned, and appropriate interventions are in place. No new concerns were identified.

" Systemic Changes:
Abuse and Abuse Reporting education related to staff acknowledgment that they were aware of the different types of abuse/neglect and who to report it to and how soon to report it began immediately by Nursing Administration with validation of understanding on the morning of 1/27/2020. Education completed as of midnight on 1/27/2020 with 7 nursing employees remaining, one (1) employee with Dietary and (2) two Rehabilitation employees. These were all completed prior to the employee's next scheduled shift. 100% staff education was completed by 1/29/2020. Abuse and Abuse Reporting education included all

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contract staff of Healthcare Services Group (Dietary, Laundry and Housekeeping) and Genesis Rehabilitation Department. Validation of education was obtained.

Each employee reviewed and signed the Abuse and Abuse Reporting Policy and Procedure.

" QAPI:

Ad Hoc QAPI was held on 01/28/2020 and PIP was developed and accepted by the IDT team.

QI monitoring will be conducted by the Director of Clinical Services or designee in questioning at least 10 residents and 5 employees 5 x weekly for 4 weeks, 1 x weekly for 4 weeks and then monthly. Quality Improvement Monitoring on abuse and neglect will be accomplished by using:

" Resident and staff interviews
" Skin sweeps
" Chart reviews
" Facility concerns
" Employee personnel files.

The Director of Nursing Services or designee will report results of QI monitoring to the Quality Assurance Performance Improvement Committee weekly. The QAPI committee will monitor the plan on Abuse/Abuse Reporting. Results of the monitoring will be reported monthly to the QA Committee with revision of plan as identified by the committee.

As part of the validation process on 2/6/20, the plan of correction was reviewed and included the in-services related to Abuse and Abuse Reporting for all staff members, including contracted staff, documentation that revealed 100% of all residents with a Brief Interview of Mental Status

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F 600	Continued From page 8 (BIMS) of 8 or higher were interviewed regarding concerns about safety/abuse, all in- house residents had a skin assessment conducted on 1/27/20, employee files were reviewed to verify background checks and abuse training was completed upon hire, the grievance logs were reviewed to verify no complaints related to abuse were reported, and the QAPI plan to include monitoring to be completed. Date of correction action completion. Final Compliance date 1/31/20.	F 600		