STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN TRAIL HEALTHCARE & REHAB CENTER	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223 SS=J	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must 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, staff, resident and adult protective services interviews, the facility failed to ensure 1 (Resident #8) of 4 sampled residents was free of verbal abuse, failed to provide an environment that 1 (Resident #2) of 4 sampled residents felt safe and free of physical and verbal abuse and failed to protect 1 (Resident #1) from verbal and physical abuse. Immediate Jeopardy began on 1/1/14 and was identified on 1/16/14 at 10:00 AM. Immediate Jeopardy was removed on 1/17/14 at 1:55 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete training on abuse for 100% of the staff and to implement the monitoring of its corrective action. The findings included: 1. Resident #8 was admitted to the facility on 9/30/13 and had diagnoses that included COPD	F 223	F223 Standard Disclaimer: This Plan of Correction is a necessary requirement to participate in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). F223 Resident #8 expired at the hospital on 01/13/14 for reasons unrelated to the allegations cited in F223. A report of abuse was made to the ADON on 01/03/14. The incident is alleged to have occurred on 01/01/14. The Administrator was notified of the allegation related to Resident #8 by the ADON on 01/06/14. NA #1□s employment was suspended on 01/06/14 pending an investigation of the allegations related to Resident #8. The Administrator conducted an investigation into the allegations involving Resident #8. The Administrator, based on written accounts, resident and staff interviews,	1/20/14

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

Electronically Signed | 02/07/2014

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F 223	Continued From page 1 (Chronic Obstructive Pulmonary Disease), Anxiety, Depression and Alzheimer ' s Disease. The resident was discharged to the hospital on 1/7/14 where she later expired. The Care Area Assessment (CAA) for Cognitive Status dated 10/7/13 revealed that the resident was alert and verbally responsive with periods of forgetfulness and was able to understand others and make her needs known. The CAA for Visual Function dated 10/7/13 revealed that the resident had a history of cataracts and the resident ' s vision was impaired. The Quarterly Minimum Data Set (MDS) Assessment dated 1/3/14 revealed that the resident was cognitively intact and vision was highly impaired. The Care Plan dated 10/21/13 revealed that the resident was concerned about her health and was very demanding of attention from the staff. The approach was for staff to approach the resident warmly at all times. A review of the facility ' s Grievance Log revealed an entry dated 1/2/14 that a NA (nursing assistant) had spoken rudely to Resident #8. A written statement by Med (medication) Aide #1 revealed on 1/2/14, Resident #8 rang the call bell and NA #1 entered the room and asked the resident what she wanted. According to the written statement the Resident stated that she had spilled her soda and ice and wanted some more. The statement revealed that the NA stood in front of the resident in an intimidating way and responded to the resident that when she rang her call light, she needed to tell her everything she needed right then and to stay off her call light.	F 223	concluded the investigation on 01/08/14 and could not substantiate the allegations. NA#1 returned to work on 01/10/14, but did not return to the care and services of Resident #8. The Administrator completed a 24-Hour and 5-Day Working Report specific to the allegations involving NA#1 and Resident #8 on 01/15/14, and submitted the reports to the North Carolina Healthcare Personnel Registry (NCHCPR) on 01/15/14. NA #1□s employment was terminated on 01/16/14. Currently, Resident #2 reports feeling safe and free from any and all physical and/or verbal abuse. On 01/05/14, Resident #2 reported having been mistreated by an unnamed staff member to Med Aide #2. Resident #2 described the staff member to Med Aide #2. Med Aide#2 reported the allegation to the ADON on 01/05/14. Pursuant to the facility□s Abuse Policy, the accused staff member, NA #1, was re-assigned to non-resident care duties in the laundry on 01/05/14. The ADON began an investigation on 01/05/14. The Administrator suspended NA #1□s employment 01/06/14, based on the allegations related to Resident #2, and the Administrator□s receipt, on 01/06/14, of an additional allegation involving Resident #8 and NA#1. The Administrator conducted an investigation into the allegations involving Resident #□s 2 and 8. Resident #2 was interviewed by both the ADON, and Social Worker related to the allegations involving NA#1. Resident	

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F 223	Continued From page 2 The statement revealed the resident was frightened and was throwing her hands in front of her to push the NA away from her. On 1/14/14 at 5:40 PM the Administrator stated in an interview that the incident with Resident #8 was reported by Med Aide #1 who heard the incident while standing outside the building. The Administrator stated that Resident #8 denied the incident and the resident had since expired. Review of the facility ' s investigation revealed a written complaint was made to the ADON (Assistant Director of Nursing) that a NA spoke rudely to Resident #8. The note revealed that the resident was reliable and had no complaints per the social worker. The investigation note revealed that the resident was interviewed and reported she did not feel mistreated in any way. A written statement by Med Aide #1 revealed that on 1/2/14 on second shift Resident #8 rang her call light and NA#1 was observed to enter the room and asked the resident what she wanted. The statement revealed that the resident stated that she had spilled her soda and ice and wanted some more. The statement read: "Name of NA #1 stood in front of resident and, in an intimidating way, told her when she rings her call light, to tell her everything she needs right then and to stay off her call light. Name of Resident #8 was frightened and was throwing her hands in front of her to push Name of NA #1 off of her and yelling get out of my face. " The Administrator stated in an interview on 1/15/14 at 11:35 AM that she spoke with NA #1 about the incident and the NA could not recall any unusual interactions with Resident #8.	F 223	#2□s accounts of both the allegation and the description of the accused varied from one interview to the next. The Administrator, based on written accounts, resident and staff interviews, concluded the investigation on 01/08/14 and could not substantiate the allegations specific to either of the identified residents. Subsequent to the Administrator□s investigation, NA#1 returned to work on 01/10/14, but did not return to the care and services of Resident #□s 2 or 8. The Administrator completed a 24-Hour and 5-Day Working Report specific to the allegations involving NA#1 and Resident #□s 2 and 8 on 01/15/14 and submitted the reports to the North Carolina Healthcare Personnel Registry (NCHCPR) on 01/15/14. NA #1□s employment was terminated on 01/16/14. The facility□s Social Worker shall provide Resident #2 reassurance on a weekly basis x 4 weeks and monthly x 3 months and quarterly x 4 to ensure the resident feels safe and free from abuse. Resident #2 is being followed by a psychological service on a weekly basis, as ordered prior to the alleged incident, for psychotherapy and will continue as ordered by her attending physician and psychotherapist. Resident #1 expired on 11/04/13 for reasons unrelated to the allegations cited in F223. (a)The DON states it was reported to her by an NA, but she did not recall which NA, that the NA overheard NA#1 tell resident #1 that she hoped he fell out of the wheelchair. The DON was also told there were two family members	

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F 223	Continued From page 3 On 1/15/14 at 12:35 PM the facility ' s Social Worker stated in an interview that Resident #8 was generally alert and oriented and reliable with some forgetfulness. The Social Worker stated that she asked the resident if any of the girls that help her get dressed had mistreated her in any way and the resident stated: " No. " The Social Worker stated that she has had no complaints about NA #1 from other residents. NA #1 stated in a telephone interview on 1/15/14 at 2:01 PM that she never yelled at Resident #8 or had any problems with the resident. Med Aide #1 stated in an interview on 1/15/14 at 2:40 PM that Resident #8 was unable to see very well and knocked over her drink several times on the evening of 1/2/14. The Med Aide stated that she went in to give the resident her medication and was on her way out of the room and NA #1 entered the room in response to the call light. The Med Aide stated that NA looked irritated. The Med Aide stated that she left the resident ' s room and went around the corner and into the courtyard to smoke. The Med Aide stated that she was standing in the courtyard outside the room of Resident #8 and could hear NA #1 yelling at the resident through the window. The Med Aide stated NA #1 stated: " I ' m going to get this up this time but next time you better tell me everything you need and stay off the call light. " The Med Aide stated that NA #1 was standing over the resident in an intimidating way and the resident was raising her arms and saying: " Get off of me." The Med Aide stated that NA#1 did not touch the resident but was raising her voice and in the resident ' s face. The Med Aide stated that she reported the incident to Nurse #3 who told her to write it up. The Med Aide stated that	F 223	present. According to the DON, she spoke with those two family members who both denied hearing any such statement from anyone to any resident during their visit. The DON did not report this allegation to the Administrator. (b) At no time, did NA#2 make specific allegation(s) of abuse related to Resident #1 or NA#1 to Nurse #3. Rather, NA#2 asked Nurse #3 general, non-specific resident/employee questions related to abuse. As reported in the 2567, Nurse #3 instructed NA#2 appropriately to report any suspicions of abuse. NA#2 failed to report any allegations of abuse specific to NA#1 or Resident #1. Based on the information contained in the 2567 and based on staff interviews, the alleged incident occurred at an undetermined time and date. The Administrator completed an investigation, and filed a 24-Hour 01/17/14 and 5-Working Day Report on 01/22/14. For those residents having the potential to be affected by the same alleged deficient practice: 1. All staff were re-educated on the facility□s Abuse Policy(ies). Specifically, the staff received education related to the identification and reporting of suspected abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin. 2. The Administrator and/or Social Worker will conduct random resident	

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F 223	Continued From page 4 NA #1 usually worked the 7AM-3PM shift but that day had stayed over and worked the 3PM-11PM shift as well. A review of the payroll time sheet for NA #1 revealed the NA worked 7AM to 11PM on 1/1/14 and 7AM-3PM only on 1/2/14. In an interview with Med Aide #1 on 1/15/14 at 4:40 PM, the Med Aide stated that she thought that the incident occurred on 1/2/14. The Med Aide stated that on Friday (1/3/14) she reported the incident to the Assistant Director of Nursing (ADON) and was told to write it up. The Med Aide stated that she got busy and did not write up the incident until Monday 1/6/14. The Med Aide stated that the incident must have occurred on 1/1/14. Housekeeper #1 stated in an interview on 1/15/14 at 3:00 PM that he had heard NA #1 yelling at Resident #8 several times one evening. The Housekeeper stated that he heard NA #1 tell the resident that she was doing the best she could, that she was busy and to stop bothering her. The housekeeper was unable to provide the date or time this occurred.. The Housekeeper stated that he considered the way the NA was talking to the resident to be verbal abuse. 2. Resident #2 was admitted to the facility on 5/14/13 and had diagnoses that included Parkinson ' s Disease, Dementia with Lewey Bodies, Stroke, and Debility. The Care Area Assessment (CAA) for Cognitive Status dated 7/3/13 revealed that that resident was residing at home with her husband but he was unable to provide the amount of care	F 223	interviews, with a minimum of 5 interviewable residents on a weekly basis x 4, then a minimum of 10 of all interviewable residents monthly x3, and quarterly x 4 for any resident concerns specific to abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin. Any such findings will be reported to the Administrator immediately, and an investigation will be conducted pursuant to the facility□s Abuse policies. The Administrator shall report all allegations of abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin using the 24-Hour and 5-Working Day Reports. Such reports shall be filed timely to the NCHCPR. Residents will be reminded of their right to be free of abuse and how and to whom to report any concerns. 3. For those residents unable to communicate their needs, licensed nurses shall conduct weekly skin assessments and shall report any suspicions of abuse, neglect, mistreatment, and/or injuries of unknown origin. Such assessments shall be on-going and any suspicious findings shall be reported to the Administrator and/or Director of Nursing immediately. Following any such report, the Administrator shall follow the facility abuse policy related to the identification, investigation, and reporting of such suspicions. All allegations of abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin shall be reported using the	

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needed. The CAA revealed.the resident was verbally responsive, could make her needs known and was able to understand others. The CAA for Activities of Daily Living (ADLs) revealed that the resident required assistance with ADLs and it was unsafe for the resident to transfer independently.

The Quarterly Minimum Data Set (MDS) Assessment dated 12/12/13 revealed that the resident was severely cognitively impaired and required extensive assistance with transfers.

The Care Plan dated 5/31/13 revealed that Resident #2 had impaired thought processes due to diagnosis of Dementia. The Care Plan listed a problem of impaired mobility due to Parkinson ' s Disease. One of the interventions was for staff to assist with transfers and ambulation as necessary and to use the stand up lift for transfers.

A psychologist consult note dated 1/3/14 revealed that Resident #2 reported that she did not know whether or not it really happened or if she dreamed an incident with a staff member during which she felt badly mistreated. The note revealed that the psychologist discussed his desire for the resident to be more assertive about her own needs and in cases like this to discuss with the facility staff.

Review of the nurse ' s schedule revealed Nurse #1 worked from 7AM to 11PM on 1/5/14. A review of the nurse ' s notes revealed an entry dated 1/5/14 at 7:50 PM by Nurse #1 that Resident #2 reported to her on day shift on her first medication pass that her NA (nursing assistant) was verbally inappropriate with her and that she was scared about her safety. The note revealed that the

24-Hour and 5-Working Day Reports. Such reports shall be filed timely to the NCHCPR.

4. The Corporate Nurse Consultant shall conduct random interviews (5 employees per week) of each department□s staff to include all three shifts, weekly for 4 weeks, monthly for three months, and for 4 quarters (i.e. 3 consecutive months) thereafter to ensure the staff has understanding of the abuse policy related to the identification and reporting of abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin. Staff who are unable to demonstrate the required competencies shall receive education related to the identification and reporting of abuse, neglect, mistreatment, misappropriation and/or injuries of unknown origin by the Corporate Nurse Consultant. Evidence of such interviews by the Corporate Nurse Consultant shall be provided to the Administrator, in a written format, weekly for four weeks, monthly for three months, and for 4 quarters thereafter. Evidence of monitoring shall include date, staff name, function, and documentation of proficiency (ies) related to the reporting of abuse, neglect, mistreatment, misappropriation of resident property and injuries of unknown origin. Any findings or suspicions of abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin will be reported to the Administrator immediately and an investigation will begin per the

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F 223	Continued From page 6 resident had also reported this very tearfully to Med (medication) Aide #2. A nurse ' s note dated 1/5/14 at 10:30 PM by Nurse #1 revealed that the resident was still voicing concern for her safety stating: " I ' m just so scared because she is so big and all I can do is yell. " Review of the facility ' s Grievance Log revealed an entry dated 1/5/14 that a NA was rough and spoke rudely to Resident #2. A review of the facility ' s investigation revealed a written statement dated 1/5/14 by Nurse #1 that Resident #2 complained that the NA with a ring in her lip was rough with her and spoke inappropriately to her during care this morning. The statement revealed that the resident complained that the NA was rough with her and got her leg caught in the side of the wheelchair and told her that she wasn ' t going to put up with her today. The statement revealed that the resident requested the NA no longer work with her. A written statement dated 1/5/14 by Med Aide #2 revealed that Resident #2 was observed in her doorway crying and stated that she was being mistreated by her NA and referred to the NA as the Mafia. Med Aide #2 wrote that the resident reported that the NA kicked her. A written statement dated 1/5/14 by NA #1 revealed that she and NA #2 went in to get Resident #2 up and the resident was yelling and screaming and refusing care. The NA reported that they went back in to get the resident up and the resident continued to yell as they got her up and dressed. NA #1 wrote in her statement that she did not kick the resident.	F 223	facility□s Abuse Policy. The Administrator shall monitor items 1 □ 4 above for compliance, and shall certify such evidence of monitoring in a written monthly monitoring report. The Plan of Correction for this alleged deficient practice(s) has been incorporated into the facility□s most recent Quality Assurance Committee meeting minutes and shall be evaluated for effectiveness no less than monthly for three months and quarterly thereafter.	

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A written statement by the social worker dated 1/6/14 revealed an interview with Resident #2 where the resident reported a nursing assistant came in her room on 1/5/14 around 6:00 AM and told her it was time to get up. The statement revealed that the resident stated she did not want to get up and the NA replied: " I have you all day and you are going to do what I want you to do. " The report revealed the resident began screaming and the NA told her to " shut up. " The statement revealed the resident stated that she told the NA to leave her alone and the NA continued to get her dressed and out of bed. The statement revealed that the resident stated that the same NA had worked with her before and had a similar situation with her last week but did not report the incident to the staff. The report revealed that the resident stated she did mention it to her psychologist who encouraged her to be more assertive about her care and this was why she started screaming at the NA yesterday that she did not want to get up.

A note by the social worker dated 1/13/14 at 12:35 PM revealed Resident #2 stated in an interview that she did not feel that any other staff members had mistreated her.

On 1/13/14 at 3:15 PM Resident #2 stated in an interview that the NAs move fast and are rough with her. The Resident stated that she had already spoken with the social worker (Adult Protective Services) and did not want to talk about the incident. During the interview the Resident was able to recall that she was from another state. The Resident stated that she was falling a lot and her husband could no longer take care of her so they moved here to be closer to

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family. The resident stated that her husband lived close by with a family member.

On 1/14/14 at 1:50 PM, an interview was conducted with NA #2 who assisted NA #1 with the resident ' s care on the morning of 1/5/14. The NA stated that she went in to assist NA #1 to get the resident up but had to leave the room prior to the completion of care. The NA stated that she did not witness inappropriate behavior by NA #1 while she was in the room.

Med Aide #2 stated in an interview on 1/14/14 at 5:00 PM that on 1/5/14 she observed Resident #2 sitting in her wheelchair in the hall with no shoes on. The Med Aide stated that the resident was upset and reported that the girls were jerking her around and had kicked her and did not like it and did not feel safe. The Med Aide stated that after the incident, NA #1 was at the nurse ' s desk and asked the Med Aide if she had called anyone to report the abuse and stated she was glad she had a witness.

Nurse #1 stated in an interview on 1/14/14 at 5:20 PM that when she got to Resident #2 on her med pass on the morning of 1/5/14, the resident was tearful and upset. The Nurse stated that the resident reported she was slung around in the bed by the NA with the ring in her lip. Nurse #1 stated that NA #1 was the only NA with a lip ring working that day and was assigned to Resident #2. Nurse #1 stated that when she asked NA #1 to get Resident #2 up that morning the NA replied that she would get the resident up when she was ready to get her up. The Nurse stated she told the NA that she did not have to yell at her and the NA stated that this was just the way she talked to people. Nurse #1 stated that she did not like the

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way NA #1 spoke to her. Nurse #1 stated that she did not know the resident had been kicked until bedtime when the resident told her the NA with the ring in her lip had kicked her. The Nurse stated that she looked at the resident ' s thigh where the resident pointed and did not see any sign of injury. The Nurse stated that she had already given her statement about the incident and did not know about the kick when she wrote her statement. The Nurse stated that Resident #2 had trouble getting the right word out but had always been oriented with her. The Nurse stated that when the resident did say the wrong word she knew it was the wrong word. The Nurse stated that at the time of the incident on 1/5/14, Resident #2 was scared of NA #1. The Nurse stated that on Saturday 1/11/14 the resident saw NA #1 from a distance several times and stated: " I guess they are not going to fire her. "

On 1/15/14 at 7:15 AM, Nurse #3 stated that in report at 11:00 PM on 1/5/14 she was told by Nurse #1 and Med Aide #2 that Resident #2 came out in tears and stated that as soon as the door closed, NA #1 was pulling and tugging on her and kicked her and that this had been going on for a week. The Nurse stated that Resident #2 was believable. The Nurse stated that the resident responded appropriately to questions and talked like she had some sense but was not totally oriented to place and time.

On 1/15/14 at 12:25 PM the facility ' s Social Worker stated in an interview that Resident #2 ' s level of orientation fluctuates and was not always exact in relation to time. The Social Worker stated that the resident could generally give a round about time frame but was not exact and her recall of information was not exact. The

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Social Worker stated that the resident told her during an interview on 1/6/14 that a NA came in her room around 6:00 AM to get her up and she told the NA that she did not want to get up and the NA told her that she had her all day and she would do what she told her to do. The Social Worker stated that the resident told her that she started screaming and the NA told her to shut up. The Social Worker stated that the resident told her the NA had facial piercing and was Hispanic.

NA #1 stated in a telephone interview on 1/15/14 at 2:01 PM that on 1/5/14 at approximately 7:30 AM she went in and asked Resident #2 if she was going to get up for breakfast. The NA stated that the resident thought it was the middle of the night and started refusing care. The NA stated that she left the room and returned with NA #2 and the resident refused to get up so they left the room. NA #1 stated that she and NA #2 returned after breakfast and got the resident up. The NA stated that the resident told the nurse that someone kicked her. The NA stated that she did not kick Resident #2. The NA stated that she did not provide care for the resident any more that day.

On 1/15/14 at 10:00 AM a written statement was provided by the Administrator that stated NA #1 had worked on the day and evening shifts on 1/1/14 and day shift on 1/2/14.

On 1/16/14 at 2:40 PM Resident #2 was observed in her room with two visitors. The Resident introduced her husband and the other visitor as a family member. An attempt was made to re-interview the resident about the incident on 1/5/14 and the resident ' s family encouraged her to talk about the incident. The Resident stated: " The issue has been discussed and that ' s it. "

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A Social Worker with Adult Protective Services stated in an interview on 1/23/14 at 9:50 AM that she interviewed Resident #2 on 1/13/15 and again on 1/15/14 at 10:00 AM. The Social Worker (SW) stated that the resident told her that she did not report prior incidents and that the incident on 1/5/14 was the first incident she had reported. The SW stated that Resident #2 had fear in her eyes when she told her that she did not want to cause a problem because she had to live there until she died and she was afraid that she would be punished. The SW stated that the resident told her that the incident on 1/5/14 was a nasty incident and she was scared out of her skin. The SW stated that Resident #2 reported that NA #1 kicked her and the resident described the kick as an intentional kick that just brushed her.

3a. Resident #1 was admitted to the facility on 5/1/13 and had diagnoses that included COPD (Chronic Obstructive Pulmonary Disease), Coronary Artery Disease, Congestive Heart Failure and Advanced Dementia.

The Care Area Assessment (CAA) for Cognitive Status and Communication dated 5/13/13 revealed that the resident was unable to be oriented due to progressive cognitive decline. The CAA revealed that the resident was alert to self but confused to time and place and unable to verbalize needs and concerns secondary to vascular dementia. The CAA revealed that the resident was resistive to care, hitting, kicking and cursing at staff.

The Quarterly Minimum Data Set (MDS) Assessment dated 11/1/13 revealed that the resident had short and long term memory

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problems and was severely cognitively impaired. The MDS revealed the resident was totally dependent on staff for all activities of daily living. The MDS revealed that the resident had no behaviors during the 7 day assessment period.

The Care Plan dated 5/13/13 included a problem that the resident was resistive to care by hitting, kicking and cursing. Among the approaches was to check the resident frequently for anticipated needs and address to reduce risks for agitation, anxiety or resistive behaviors and redirect as needed.

The Director of Nursing (DON) stated in an interview on 1/14/14 at 1:15 PM it was reported to her that NA #1 told Resident #1 that she hoped he fell out of the wheelchair..

NA (nursing assistant) #3 stated in an interview on 1/15/14 at 12:55 PM that she observed NA #1 push Resident #1 to the dining room in his geri-chair. The NA stated that the resident was trying to scoot out of the chair like he always did. The NA stated she heard NA #1 say to the resident: " I hope you fall out of the chair so they can send you to the hospital. " The NA stated that this happened in August or September of 2013. The NA stated that NA #1 talked very nasty to the residents and she had told the NA that this was not the kind of work for her.

On 1/15/14 at 2:01 PM, NA #1 stated in a telephone interview that she never told Resident #1 that she hoped he fell out of his chair and had to go to the hospital.

3b. Resident #1 was admitted to the facility on 5/1/13 and had diagnoses that included COPD

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(Chronic Obstructive Pulmonary Disease), Coronary Artery Disease, Congestive Heart Failure and Advanced Dementia.

The Care Area Assessment (CAA) for Cognitive Status and Communication dated 5/13/13 revealed that the resident was unable to be oriented due to progressive cognitive decline. The CAA revealed that the resident was alert to self but confused to time and place and unable to verbalize needs and concerns secondary to vascular dementia. The CAA revealed that the resident was resistive to care, hitting, kicking and cursing at staff.

The Quarterly Minimum Data Set (MDS) Assessment dated 11/1/13 revealed the resident had short and long term memory problems and was severely cognitively impaired. The MDS revealed that the resident was totally dependent on staff for all activities of daily living. The MDS revealed that the resident had no behaviors during the 7 day assessment period.

The Care Plan dated 5/13/13 included a problem that the resident was resistive to care by hitting, kicking and cursing. Among the approaches was to check the resident frequently for anticipated needs and address to reduce risks for agitation, anxiety or resistive behaviors and redirect as needed.

NA (nursing assistant) #2 stated in an interview on 1/14/14 at 1:50 PM that she walked in Resident #1 ' s room and observed NA #1 thumping the resident on the head. The NA stated that this happened awhile back but could not be specific about a date. The NA stated that this happened around the time that NA #1 was heard

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to tell the resident that she hoped he fell out of the wheelchair and had to go to the hospital (August/September 2013).

The Administrator stated in an interview on 1/14/14 at 3:45 PM that she was not aware of the allegation that NA #1 thumped Resident #1 on the head. The Administrator stated that she considered thumping the resident on the head to be abuse.

On 1/15/14 at 2:01 PM, NA #1 stated in an interview that she never thumped Resident #1 on the head.

The Administrator was notified of the Immediate Jeopardy on 1/16/14 at 10:00 AM. The facility provided a credible allegation of compliance on 1/17/14 at 1:55 PM. The allegation of compliance indicated:

For Resident #1, the facility Administrator was unaware of allegation #1 against NA #1 to Resident #1. The DON was aware and failed to report the allegation to the administrator. It is undetermined when the alleged incident took place. The resident is deceased (11/4/13). A 24-hour report has been completed 1/17/14. A 5-day will be completed by 1/21/14. The accused NA #1 was terminated 1/16/14.

· The DON has received disciplinary action by the administrator and the corporate nurse consultant for failing to report an allegation of abuse to the administrator. The DON was retrained by the director of operations and the corporate nurse consultant on the abuse policy with concentration on requirements for reporting all allegations.

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For the second allegation, the Administrator was notified on 1/16/14 by surveyor concerning Resident #1. The C.N.A. was aware and failed to clearly report to the nurse the alleged abuse and the employee responsible.
It is undetermined when the alleged incident took place. The resident is deceased (11/4/13).
A 24-hour report has been completed 1/17/14. A 5-day will be completed by 1/21/14.
The accused NA #1 was terminated 1/16/14.

· The C.N.A. has received disciplinary action by the DON and an inservice on the abuse policy with concentration on requirements for reporting all allegations.

· The Nurse has received disciplinary action by the DON and an inservice on the abuse policy with concentration on requirements for reporting all allegations.

For Resident #2, remains in the facility.
NA #1 was suspended 1/6/14 pending investigation. An investigation of the allegation was completed 1/9/14. NA #1 was returned to work 1/10/14 after completion of the investigation but not to the care and service of Resident #2.
NA #1 was suspended again 1/13/14 and subsequently terminated 1/16/14.
A 24-hour and 5-day report was completed 1/15/14.

· The Administrator has received disciplinary action from the director of operations for failing to initiate and complete the 24-hour and 5-day reports on allegations. The Administrator was retrained by the director of operations and the corporate nurse consultant on the abuse policy

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with concentration on requirements for reporting all allegations.

· The DON has received disciplinary action by the administrator and the corporate nurse consultant for failing to report an allegation of abuse to the administrator. The DON was retrained by the director of operations and the corporate nurse consultant on the abuse policy with concentration on requirements for reporting all allegations.

For Resident #8, an investigation was completed 1/9/14. NA #1 was suspended 1/6/14 pending investigation. An investigation of the allegation was completed 1/9/14 pending investigation. NA #1 was returned to work 1/10/14 after completion of the investigation but not to the care and service of #2.
Resident #3 was discharged 1/7/14.
On 1/13/14 the resident deceased in the hospital.
NA #1 was suspended again 1/13/14 and subsequently terminated 1/16/14.
A 24-hour and 5-day report was completed on 1/15/14.

· The Administrator has received disciplinary action from the director of operations for failing to initiate and complete the 24-hour and 5-day reports on allegations. The administrator was retrained by the director of operations and the corporate nurse consultant on the abuse policy with concentration on requirements for reporting all allegations.

For those residents having the potential to be affected by the same alleged deficient practice:

· The Social Worker asked all residents

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capable of being interviewed if they had ever felt mistreated by a staff member of the facility. All residents interviewed denied feeling mistreated by any member of the staff.

· The residents of the facility had a Resident Council meeting on Thursday, January 16, 2014. The residents were reminded of their right to be free from abuse, different types of abuse and how and who to report it to.

· The administrative staff have been re-educated on the facility ' s Abuse Policy and Procedure by the Corporate Nurse Consultant.

· All facility employees will be re-educated on the facility ' s Abuse Policy and Procedure by the Administrator and Director of Nursing and will be mandated to attend the Abuse Policy and Procedure inservice quarterly. On 1/17/14 at 11:30 AM, 90% of all employees had been inserviced on the abuse policy. Employees will not be allowed to work until they have been inserviced.

· The Social Worker contacted all responsible parties of residents unable to speak for themselves to inquire of any concerns or changes in resident behavior that could indicate possible abuse.

· The nursing staff has completed a skin check for injuries of unknown origin of residents unable to speak for themselves.

· Employees who reportedly knew of resident abuse and failed to report have received disciplinary action.

· The Administrator has received disciplinary action from the Director of Operations for failing to initiate and complete the 24-hour and 5-day reports on allegations. The Administrator was retrained by the Director of Operations and the Corporate Nurse Consultant on the abuse policy with concentration on requirements for reporting

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F 223	Continued From page 18 all allegations. · The DON has received disciplinary action by the administrator and the Corporate Nurse Consultant for failing to report an allegation of abuse to the administrator. The DON was retrained by the Director of Operations and the Corporate Nurse Consultant on the abuse policy with concentration on requirements for reporting all allegations. On 1/17/14 at 3:00 PM the credible allegation was validated by random interviews with staff showing that the staff had received inservices on the facility ' s abuse policies and procedures. Interviews revealed that the staff was knowledgeable about the definition of abuse and the different kinds of abuse. The staff voiced understanding they were to report instances of abuse immediately to their nurse or supervisor.	F 223		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		1/20/14

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F 225	Continued From page 19 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to file 24 hour and 5 day reports with the Health Care Personnel Registry for allegations of abuse for 3 (Resident #8, Resident #2 and Resident #1) of 4 sampled residents reviewed for abuse. The Director of Nursing failed to notify the Administrator of alleged verbal abuse for 1 (Resident #1) of 4 sampled residents and the facility failed to complete a thorough investigation of the alleged abuse. Facility staff failed to report physical abuse to the Administrator for 1 (Resident #1) of 4 sampled residents which resulted in the resident not being protected from further abuse by the accused employee and no investigation of the alleged abuse.	F 225	F225 Standard Disclaimer: This Plan of Correction is a necessary requirement to participate in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). F225 Resident #8 expired at the hospital on 01/13/14 for reasons unrelated to the allegations cited in F223. A report of	

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F 225	Continued From page 20 The findings included: Immediate Jeopardy began on 1/1/14 and was identified on 1/16/14 at 10:00 AM. Immediate Jeopardy was removed on 1/17/14 at 1:55 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete training on abuse for 100% of the staff and for the facility to implement the monitoring of its corrective action. 1. Resident #8 was admitted to the facility on 9/30/13 and had diagnoses that included Chronic Obstructive Pulmonary Disease, Alzheimer ' s Disease and Depression. Review of the facility ' s investigation file revealed that Med (medication) Aide #1 reported in writing that on 1/2/14 Resident #8 rang her call light and told NA #1 that she had spilled her soda and ice and wanted some more. The Med Aide ' s written statement revealed that the Med Aide observed NA #1 to stand over the resident in an intimidating way and say to the resident that when she rang her call light she needed to tell her everything she needed right then and to stay off her call light. The statement revealed that the resident was frightened and was throwing her hands in front of her to push the NA away and was yelling: " Get out of my face. " The Statement revealed the incident was reported to the Assistant Director of Nursing. There was not a 24-hour or 5-day report in the file. The Administrator stated in an interview on	F 225	abuse was made to the ADON on 01/03/14. The incident is alleged to have occurred on 01/01/14. The Administrator was notified of the allegation related to Resident #8 by the ADON on 01/06/14. NA #1□s employment was suspended on 01/06/14 pending an investigation of the allegations related to Resident #8. The Administrator conducted an investigation into the allegations involving Resident #8. The Administrator, based on written accounts, resident and staff interviews, concluded the investigation on 01/08/14 and could not substantiate the allegations. NA#1 returned to work on 01/10/14, but did not return to the care and services of Resident #8. The Administrator completed a 24-Hour and 5-Day Working Report specific to the allegations involving NA#1 and Resident #8 on 01/15/14; the reports were submitted to the North Carolina Healthcare Personnel Registry (NCHCPR) on 01/15/14. NA #1□s employment was terminated on 01/16/14. Currently, Resident #2 reports feeling safe and free from any and all physical and/or verbal abuse. On 01/05/14, Resident #2 reported having been mistreated by an unnamed staff member to Med Aide #2. Resident #2 described the staff member to Med Aide #2. Med Aide#2 reported the allegation to the ADON on 01/05/14. Pursuant to the facility□s Abuse Policy, the accused staff member, NA #1, was re-assigned to non-resident care duties in the laundry on 01/05/14. The ADON began an investigation on 01/05/14. The	

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F 225	Continued From page 21 1/15/14 at 11:35 AM that she did not do a 24-hour or 5-day report because the resident denied that the incident occurred. On 1/17/14 at 2:45 PM the Administrator stated in an interview that she did not know she had to file the 24-hour and 5-day report to the state unless the abuse was substantiated. 2. Resident #2 was admitted to the facility on 5/14/13 and had diagnoses that included Parkinson ' s Disease, Dementia with Lewey Bodies, Stroke and Debility. A Nurse ' s Note by Nurse #1 dated 1/5/14 at 7:50 PM revealed that on the 7AM-3PM shift on the first medication (med) pass, Resident #2 reported very tearfully that her NA (nursing assistant) was verbally inappropriate with her and that she was scared about her safety. The note revealed the on-call nurse who was the Assistant Director of Nursing (ADON) was notified. A Nurse ' s Note by Nurse #1 dated 1/5/14 at 10:30 PM revealed that upon the last med pass, Resident #2 was still voicing concern for her safety stating: " I ' m just so scared because she is so big and all I can do is yell. " The facility' investigation file included written statements dated 1/5/14 by Nurse #1 and Med Aide #2 that revealed Resident #2 alleged NA #1 had kicked her and had been verbally inappropriate with her during care that morning. The file did not include a 24 hour or 5 day report to the state regarding the allegation of abuse. The Administrator stated in an interview on 1/17/14 at 10:45 AM she thought the 24 hour and	F 225	Administrator suspended NA #1□s employment 01/06/14, based on the allegations related to Resident #2, and the Administrator□s receipt, on 01/06/14, of an additional allegation involving Resident #8 and NA#1. The Administrator conducted an investigation into the allegations involving Resident #□s 2 and 8. Resident #2 was interviewed by both the ADON, and Social Worker related to the allegations involving NA#1. Resident #2□s accounts of both the allegation and the description of the accused varied from one interview to the next. The Administrator, based on written accounts, resident and staff interviews, concluded the investigation on 01/08/14 and could not substantiate the allegations specific to either of the identified residents. Subsequent to the Administrator□s investigation, NA#1 returned to work on 01/10/14, but did not return to the care and services of Resident #□s 2 or 8. The Administrator completed a 24-Hour and 5-Day Working Report specific to the allegations involving NA#1 and Resident #□s 2 and 8 on 01/15/2014 and submitted the reports to the North Carolina Healthcare Personnel Registry (NCHCPR) on 01/15/14. NA #1□s employment was terminated on 01/16/14. The facility□s Social Worker shall provide Resident #2 reassurance on a weekly basis x 4 weeks and monthly x 3 months and quarterly x 4 to ensure the resident feels safe and free from abuse. Resident #2 is being followed by a psychological service on a weekly basis, as ordered prior to the alleged incident, for psychotherapy and will	

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F 225	Continued From page 22 5 day reports only had to be filed with the state if the abuse allegation was substantiated. 3a. Resident #1 was admitted to the facility on 5/1/13 with diagnoses that included Chronic Obstructive Pulmonary Disease, Congestive Heart Failure and Advanced Dementia. On 1/14/14 at 1:15 PM the Director of Nursing (DON) stated in an interview she had a report that a NA told the resident that she hoped he fell out of the wheelchair. The DON stated this happened back in the summer, maybe August or September of 2013. The DON stated she did not report this to the Administrator. The Administrator stated in an interview on 1/14/14 at 3:45 PM she was not aware of the allegation that NA #1 told Resident #1 that she hoped he fell out of the chair and had to go to the hospital until yesterday when the social worker from Adult Protective Services came in and told her the allegation was being investigated. NA #3 stated in an interview on 1/15/14 at 12:55 PM that she observed NA #1 roll Resident #1 to the dining room in his geri-chair and heard NA #1 say to the resident: " I hope you fall out of the chair so they will send you to the hospital. " NA #3 stated she reported the incident to the weekend supervisor and wrote a statement about the incident. The NA stated that the supervisor no longer worked at the facility. There was not a 24-hour or 5-day report filed as there was no investigation. 3b. Resident #1 was admitted to the facility on 5/1/13 with diagnoses that included Chronic Obstructive Pulmonary Disease, Congestive	F 225	continue as ordered by her attending physician and psychotherapist. Resident #1 expired on 11/04/13 for reasons unrelated to the allegations cited in F223. a)The DON states it was reported to her by an NA, but she did not recall which NA, that the NA overheard NA#1 tell resident #1 that she hoped he fell out of the wheelchair. The DON was also told there were two family members present. According to the DON, she spoke with those two family members who both denied hearing any such statement from anyone to any resident during their visit. The DON did not report this allegation to the Administrator. (b) At no time, did NA#2 make specific allegation(s) of abuse related to Resident #1 or NA#1 to Nurse #3. Rather, NA#2 asked Nurse #3 general, nonspecific resident/employee questions related to abuse. As reported in the 2567, Nurse #3 instructed NA#2 appropriately to report any suspicions of abuse. NA#2 failed to report any allegations of abuse specific to NA#1 or Resident #1. Based on the information contained in the 2567 and based on staff interviews, the alleged incident occurred at an undetermined time and date. At no time, has Adult Protective Services conducted an investigation specific to Resident #1. At no time, was the DON aware of allegation #2, as identified in the 2567. The Administrator completed an investigation, and filed a 24-Hour Report 01/17/14 and 5-Working Day Report with the NCHCPR on 01/22/14.	

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F 225	Continued From page 23 Heart Failure and Advanced Dementia. NA #2 stated in an interview on 1/14/14 at 1:50 PM that she walked in Resident #1 ' s room and observed NA #1 thumping the resident on the head twice. The NA stated she reported this to Nurse #3. The NA stated she was never questioned about the incident or asked to write a statement regarding the incident. Nurse #3 stated in an interview on 1/14/14 at 2:55 PM that NA #2 asked her what she should do if she saw someone being thumped on the head but did not say who was involved in the incident. The Nurse stated she told the NA to report it to her nurse. The Nurse stated that shortly after, NA #1 was suspended so she thought the NA had reported the incident to her nurse. NA #2 was asked to join the interview and stated she thought she reported the incident to Nurse #3. The NA stated she told Nurse #3 she saw someone thumping a resident on the head. The NA stated that she did not tell anyone else. Nurse #3 stated she did not report what she was told about the incident to anyone and thought that NA #2 told her nurse. On 1/14/14 at 3:45 PM the Administrator stated in an interview that she was not aware of the allegation that Resident #1 was thumped on the head until yesterday when the social worker from Adult Protective Services came in and told her the allegation was being investigated. The Administrator stated that she considered thumping a resident on the head to be abuse and Nurse #3 should have reported what she was told. The Administrator stated that if the incident had been reported, she would have attempted to get a statement from NA #2. There was not a	F 225	For those residents having the potential to be affected by the same alleged deficient practice(s): 1. The Administrator, Director of Nursing, and all other administrative staff were in-serviced on the facility□s Abuse Policy, including any reporting requirements, by the Director of Operations and Corporate Nurse Consultant on 01/16/14. 2. All staff, including direct and indirect care staff, was required to receive education on the facility□s Abuse Policy and the importance of reporting allegations of abuse, neglect, mistreatment, misappropriation of property and/or injuries of unknown origin. No employee was allowed to work without completing the referenced training. For newly hired staff, such education shall be included in the staff□s general orientation, prior to the staff□s beginning work. All staff will be required to attend an in-service related to the facility abuse and neglect policy quarterly. 3. The Director of Operations shall monitor the facility□s Grievance Log monthly for three months to ensure there are no grievances demonstrative of suspicions of abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin which the facility has not reported pursuant to the facility□s Abuse Policy. Similarly, the Director of Operations shall	

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F 225	Continued From page 24 24-hour or 5-day report done as the Administrator was not aware of the allegation. On 1/15/14 at 10:10 AM Nurse #3 stated in an interview that NA #2 did not tell her the name of the resident or the NA involved and she did not know what to report. The Nurse stated that it did not occur to her to report what she had heard regarding a resident being thumped on the head. The Administrator was notified of the Immediate Jeopardy on 1/16/14 at 10:00 AM. The facility provided a credible allegation of compliance on 1/17/14 at 1:55 PM. The allegation of compliance indicated: For Resident #1, the facility Administrator was unaware of allegation #1 against NA #1 to Resident #1. The DON was aware and failed to report the allegation to the administrator. It is undetermined when the alleged incident took place. The resident is deceased (11/4/13). A 24-hour report has been completed 1/17/14. A 5-day will be completed by 1/21/14. The accused NA #1 was terminated 1/16/14. · The DON has received disciplinary action by the administrator and the corporate nurse consultant for failing to report an allegation of abuse to the administrator. The DON was retrained by the director of operations and the corporate nurse consultant on the abuse policy with concentration on requirements for reporting all allegations. For the second allegation, the Administrator was notified on 1/16/14 by surveyor concerning Resident #1. The C.N.A. was aware and failed to clearly report to the nurse the alleged abuse and	F 225	review the facility□s incident reports monthly for three months to ensure there are no reported incidents which may be indicative of abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin which the facility has not reported pursuant to the facility□s Abuse Policy. The Administrator shall review any and all reports of abuse, neglect, mistreatment, misappropration of resident property and/or injuries of unknown origin with the Director of Operations to ensure the investigation and reporting is consistent with the facility□s Abuse Policy. Evidence of monitoring by the Director of Operations shall be certified by signature of the monitoring tool monthly. Identified discrepancies shall be remediated and reported pursuant to the facility□s Abuse Policy. The Plan of Correction for this alleged deficient practice(s) has been incorporated into the facility□s most recent Quality Assurance Committee meeting minutes and shall be evaluated for effectiveness no less than monthly for three months and quarterly thereafter.	

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F 225	Continued From page 25 the employee responsible. It is undetermined when the alleged incident took place. The resident is deceased (11/4/13). A 24-hour report has been completed 1/17/14. A 5-day will be completed by 1/21/14. The accused NA #1 was terminated 1/16/14. · The C.N.A. has received disciplinary action by the DON and an inservice on the abuse policy with concentration on requirements for reporting all allegations. · The Nurse has received disciplinary action by the DON and an inservice on the abuse policy with concentration on requirements for reporting all allegations. For Resident #2, remains in the facility. NA #1 was suspended 1/6/14 pending investigation. An investigation of the allegation was completed 1/9/14. NA #1 was returned to work 1/10/14 after completion of the investigation but not to the care and service of Resident #2. NA #1 was suspended again 1/13/14 and subsequently terminated 1/16/14. A 24-hour and 5-day report was completed 1/15/14. · The Administrator has received disciplinary action from the director of operations for failing to initiate and complete the 24-hour and 5-day reports on allegations. The Administrator was retrained by the director of operations and the corporate nurse consultant on the abuse policy with concentration on requirements for reporting all allegations. · The DON has received disciplinary action by the administrator and the corporate nurse	F 225		

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consultant for failing to report an allegation of abuse to the administrator. The DON was retrained by the director of operations and the corporate nurse consultant on the abuse policy with concentration on requirements for reporting all allegations.

For Resident #8, an investigation was completed 1/9/14. NA #1 was suspended 1/6/14 pending investigation. An investigation of the allegation was completed 1/9/14 pending investigation. NA #1 was returned to work 1/10/14 after completion of the investigation but not to the care and service of #2.
Resident #3 was discharged 1/7/14.
On 1/13/14 the resident deceased in the hospital. NA #1 was suspended again 1/13/14 and subsequently terminated 1/16/14.
A 24-hour and 5-day report was completed on 1/15/14.

· The Administrator has received disciplinary action from the director of operations for failing to initiate and complete the 24-hour and 5-day reports on allegations. The administrator was retrained by the director of operations and the corporate nurse consultant on the abuse policy with concentration on requirements for reporting all allegations.

For those residents having the potential to be affected by the same alleged deficient practice:

· The Social Worker asked all residents capable of being interviewed if they had ever felt mistreated by a staff member of the facility. All residents interviewed denied feeling mistreated by any member of the staff.
· The residents of the facility had a Resident

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Council meeting on Thursday, January 16, 2014. The residents were reminded of their right to be free from abuse, different types of abuse and how and who to report it to.

· The administrative staff have been re-educated on the facility ' s Abuse Policy and Procedure by the Corporate Nurse Consultant.

· All facility employees will be re-educated on the facility ' s Abuse Policy and Procedure by the Administrator and Director of Nursing and will be mandated to attend the Abuse Policy and Procedure inservice quarterly. On 1/17/14 at 11:30 AM, 90% of all employees had been inserviced on the abuse policy. Employees will not be allowed to work until they have been inserviced.

· The Social Worker contacted all responsible parties of residents unable to speak for themselves to inquire of any concerns or changes in resident behavior that could indicate possible abuse.

· The nursing staff has completed a skin check for injuries of unknown origin of residents unable to speak for themselves.

· Employees who reportedly knew of resident abuse and failed to report have received disciplinary action.

· The Administrator has received disciplinary action from the Director of Operations for failing to initiate and complete the 24-hour and 5-day reports on allegations. The Administrator was retrained by the Director of Operations and the Corporate Nurse Consultant on the abuse policy with concentration on requirements for reporting all allegations.

· The DON has received disciplinary action by the administrator and the Corporate Nurse Consultant for failing to report an allegation of abuse to the administrator. The DON was

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F 225	Continued From page 28 retrained by the Director of Operations and the Corporate Nurse Consultant on the abuse policy with concentration on requirements for reporting all allegations. On 1/17/14 at 3:00 PM the credible allegation was validated by random interviews with staff showing that the staff had received inservices on the facility ' s abuse policies and procedures. Interviews revealed that the staff was knowledgeable about the definition of abuse and the different kinds of abuse. The staff voiced understanding they were to report instances of abuse immediately to their nurse or supervisor.	F 225		
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on policy and record review and staff and resident interviews, the facility failed to implement their abuse policies and procedures by: 1. Failed to protect 1 (Resident #8) of 4 sampled residents from verbal abuse by failing to report an allegation of abuse to the administrator within 24 hours and failing to report other instances of verbal abuse. 2. Failed to protect 1 (Resident #2) of 4 sampled residents from verbal and physical abuse by not suspending the staff member accused of the abuse. 3. Failed to protect 1 (Resident #1) of 4 sampled residents from	F 226	F226 Standard Disclaimer: This Plan of Correction is a necessary requirement to participate in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Standard Disclaimer: F226	1/20/14

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F 226	Continued From page 29 physical and verbal abuse by failing to report allegations of abuse to the administrator and failing to conduct a thorough investigation of the alleged abuse. The findings included: Immediate Jeopardy began on 1/1/14 and was identified on 1/16/14 at 10:00 AM. Immediate Jeopardy was removed on 1/17/14 at 1:55 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete training on abuse for 100% of the staff and for the facility to implement the monitoring of its corrective action. The facility ' s abuse policy titled Abuse and Neglect Policies and Procedures last revised on 09/2011 on Page 4 under Reporting read: " 1. Persons witnessing an accident or incident involving a resident must report such information to their department supervisor and/or the facility Administrator. 2. Allegations of abuse shall be reported to the Administrator immediately. Immediately is defined as " as soon as possible, but ought not exceed 24 hours after discovery of the incident. " Page 4 of the policy under Protection read: " 1.This facility shall initiate measures to protect residents from harm during the investigatory process. 3. Employees of the facility who have been accused of resident abuse may be reassigned to nonresident care duties or suspended from duty for up to ten working days until the results of the investigation have been reviewed by the Administrator. "	F 226	Resident #8 expired at the hospital on 01/13/14 for reasons unrelated to the allegations cited in F223. A report of abuse was made to the ADON on 01/03/14. The incident is alleged to have occurred on 01/01/14. The Administrator was notified of the allegation related to Resident #8 by the ADON on 01/06/14. NA #1□s employment was suspended on 01/06/14 pending an investigation of the allegations related to Resident #8. The Administrator conducted an investigation into the allegations involving Resident #8. The Administrator, based on written accounts, resident and staff interviews, concluded the investigation on 01/08/14 and could not substantiate the allegations. NA#1 returned to work on 01/10/14, but did not return to the care and services of Resident #8. The Administrator completed a 24-Hour and 5-Day Working Report specific to the allegations involving NA#1 and Resident #8 on 01/15/14; the reports were submitted to the North Carolina Healthcare Personnel Registry (NCHCPR) on 01/15/14. NA #1□s employment was terminated on 01/16/14. Currently, Resident #2 reports feeling safe and free from any and all physical and/or verbal abuse. On 01/05/14, Resident #2 reported having been mistreated by an unnamed staff member to Med Aide #2. Resident #2 described the staff member to Med Aide #2. Med Aide#2 reported the allegation to the ADON on 01/05/14. Pursuant to the facility□s Abuse Policy,	

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F 226	Continued From page 30 1. Resident #8 was admitted to the facility on 9/30/13 and had diagnoses that included Chronic Obstructive Pulmonary Disease, Anxiety, Depression and Alzheimer ' s Disease. The resident was discharged to the hospital on 1/7/14 where she later expired. The Care Area Assessment (CAA) for Cognitive Status dated 10/7/13 revealed that the resident was alert and verbally responsive with periods of forgetfulness and was able to understand others and make her needs known. The CAA for Visual Function dated 10/7/13 revealed that the resident had a history of cataracts and the resident ' s vision was impaired. The Quarterly Minimum Data Set (MDS) Assessment dated 1/3/14 revealed that the resident was cognitively intact and vision was highly impaired. The Care Plan dated 10/21/13 revealed that the resident was concerned about her health and was very demanding of attention from the staff. The approach was for staff to approach the resident warmly at all times. A review of the facility ' s Grievance Log revealed an entry dated 1/2/14 that a nursing assistant (NA) had spoken rudely to Resident #8. A written statement by Med (medication) Aide #1 revealed on January 2, 2014, Resident #8 rang the call bell and NA #1 entered the room and asked the resident what the resident wanted. According to the written statement the Resident stated that she had spilled her soda and ice and wanted some more. The statement revealed that the NA stood in front of the resident in an intimidating way and responded to the resident that when she rang her	F 226	the accused staff member, NA #1, was re-assigned to non-resident care duties in the laundry on 01/05/14. The ADON began an investigation on 01/05/14. The Administrator suspended NA #1□s employment 01/06/14, based on the allegations related to Resident #2, and the Administrator□s receipt, on 01/06/14, of an additional allegation involving Resident #8 and NA#1. The Administrator conducted an investigation into the allegations involving Resident #□s 2 and 8. Resident #2 was interviewed by both the ADON, and Social Worker related to the allegations involving NA#1. Resident #2□s accounts of both the allegation and the description of the accused varied from one interview to the next. The Administrator, based on written accounts, resident and staff interviews, concluded the investigation on 01/08/14 and could not substantiate the allegations specific to either of the identified residents. Subsequent to the Administrator□s investigation, NA#1 returned to work on 01/10/14, but did not return to the care and services of Resident #□s 2 or 8. The Administrator completed a 24-Hour and 5-Day Working Report specific to the allegations involving NA#1 and Resident #□s 2 and 8 on 01/15/14 and submitted the reports to the North Carolina Healthcare Personnel Registry (NCHCPR) on 01/15/14. NA #1□s employment was terminated on 01/16/14. The facility□s Social Worker shall provide Resident #2 reassurance on a weekly basis x 4 weeks and monthly x 3 months and quarterly x 4 to ensure the resident feels safe and free	

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call light, she needed to tell her everything she needed right then and to stay off her call light. The statement revealed that the resident was frightened and was throwing her hands in front of her to push the NA away from her.

Review of the facility ' s investigation revealed a written statement was given to the ADON that NA #1 spoke rudely to Resident #8. The note revealed that the resident was reliable and had no complaints per the social worker. The investigation note revealed that the resident was interviewed and reported she did not feel mistreated in any way. A written statement by Med Aide #1 revealed that on 1/2/14 on second shift Resident #8 rang her call light and NA#1 was observed to enter the room and asked the resident what she wanted. The statement revealed that the resident stated that she had spilled her soda and ice and wanted some more. The statement read: " (Name of NA #1) stood in front of resident and, in an intimidating way, told her when she rings her call light, to tell her everything she needs right then and to stay off her call light. Name of Resident #8 was frightened and was throwing her hands in front of her to push (Name of NA) #1 off of her yelling get out of my face. "

The Administrator stated in an interview on 1/14/14 at 3:45 PM the Assistant Director of Nursing (ADON) brought statements from an incident with Resident #8 that occurred on 1/2/14 and an incident with Resident #2 that occurred on 1/5/14 while she was in the morning meeting on 1/6/14 (Monday). The Administrator stated that a statement regarding the incident with Resident #2 on 1/5/14 alleged the NA had kicked the resident. The Administrator stated that because of that from abuse. Resident #2 is being followed by a psychological service on a weekly basis, as ordered prior to the alleged incident, for psychotherapy and will continue as ordered by her attending physician and psychotherapist.

Resident #1 expired on 11/04/13 for reasons unrelated to the allegations cited in F223. (a)The DON states it was reported to her by an NA, but she did not recall which NA, that the NA overheard NA#1 tell resident #1 that she hoped he fell out of the wheelchair. The DON was also told there were two family members present. According to the DON, she spoke with those two family members who both denied hearing any such statement from anyone to any resident during their visit. The DON did not report this allegation to the Administrator. (b) At no time, did NA#2 make specific allegation(s) of abuse related to Resident #1 or NA#1 to Nurse #3. Rather, NA#2 asked Nurse #3 general, non-specific resident/employee questions related to abuse. As reported in the 2567, Nurse #3 instructed NA#2 appropriately to report any suspicions of abuse. NA#2 failed to report any allegations of abuse specific to NA#1 or Resident #1. Based on the information contained in the 2567 and based on staff interviews, the alleged incident occurred at an undetermined time and date. The Administrator completed an investigation, and filed a 24-Hour 01/17/14 and 5-Working Day Report 01/22/14 with the NCHCPR.

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F 226	Continued From page 32 statement, NA #1 was suspended pending results of the investigation. On 1/14/14 at 5:40 PM the Administrator stated in an interview that the incident was reported by Med Aide #1 who heard the incident while standing outside the building. The Administrator stated that Resident #8 denied the incident and the resident had since expired. The Administrator stated in an interview on 1/15/14 at 11:35 AM that she spoke with NA #1 about the incident dated 1/2/14 and the NA could not recall any unusual interactions with Resident #8. On 1/15/14 at 12:35 PM the facility ' s Social Worker stated in an interview that Resident #8 was generally alert and oriented and reliable with some forgetfulness. The Social Worker stated that she asked the resident if any of the girls that help her get dressed had mistreated her in any way and the resident stated: " No. " The Social Worker stated that she has had no complaints about NA #1 from other residents. Med Aide #1 stated in an interview on 1/15/14 at 2:40 PM that Resident #8 was unable to see very well and knocked over her drink several times on the evening of 1/2/14. The Med Aide stated that she went in to give the resident her medication and was on her way out of the room and NA #1 entered the room in response to the call light. The Med Aide stated that NA #1 looked irritated. The Med Aide stated that when she left the resident ' s room she went around the corner and into the courtyard to smoke. The Med Aide stated that she was standing in the courtyard outside the room of Resident #8 and could hear NA #1 yelling at the	F 226	For those residents having the potential to be affected by the same alleged deficient practice: 1. The Administrator, Director of Nursing, and all other administrative staff were in-serviced on the facility□s Abuse Policy, including any reporting requirements, by the Director of Operations and Corporate Nurse Consultant on 01/16/14. 2. All staff, including direct and indirect care staff, was required to receive education on the facility□s Abuse Policy and the importance of reporting allegations of abuse, neglect, mistreatment, misappropriation of property and/or injuries of unknown origin. No employee was allowed to work/return to work without completing the referenced training. Training for all staff was completed on 01/20/14. For newly hired staff, such education shall be included in the staff□s general orientation, prior to the staff□s beginning work. All staff will be required to attend an inservice related to the facility abuse and neglect policy quarterly. 3. The Administrator and/or Social Worker will conduct random resident interviews, with a minimum of 5 interviewable residents on a weekly basis x 4, then a minimum of 10 of all	

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F 226	Continued From page 33 resident through the window. The Med Aide stated NA #1 stated: " I ' m going to get this up this time but next time you better tell me everything you need and stay off the call light. " The Med Aide stated that NA #1 was standing over the resident in an intimidating way and the resident was raising her arms and saying: " Get off of me. " The Med Aide stated that NA#1 did not touch the resident but was raising her voice and in the resident ' s face. The Med Aide stated she could not remember what time the incident occurred but it was dark outside. The Med Aide stated that she reported the incident to Nurse #5 and the nurse told her to write it up. The Med Aide stated that NA #1 usually worked the 7AM-3PM shift but that day had stayed over and worked the 3PM-11PM shift as well. A review of the payroll sheet for NA #1 revealed that the NA worked from 7AM to 11PM on 1/1/14 and worked 7AM-3PM only on 1/2/14. A payroll sheet for Med Aide #1 revealed that the Med Aide worked 3PM-11PM on 1/1/14, 1/2/14 and 1/3/14. In an interview with Med Aide #1 on 1/15/14 at 4:40 PM, the Med Aide stated that she thought the incident occurred on Thursday (1/2/14). The Med Aide stated that on Friday (1/3/14) she reported the incident to the Assistant Director of Nursing (ADON) and was told to write it up. The Med Aide stated that she got busy and did not write up the incident until Monday morning (1/6/14). The Med Aide stated that the incident must have occurred on 1/1/14. Housekeeper #1 stated in an interview on 1/15/14 at 3:00 PM that he had heard NA #1 yelling at Resident #8 several times one evening. The Housekeeper stated that he heard NA #1 tell the	F 226	interviewable residents monthly x3, and quarterly x 4 for any resident concerns specific to abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin. Any such findings will be reported to the Administrator immediately, and an investigation will be conducted pursuant to the facility□s Abuse policies. The Administrator shall report all allegations of abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin using the 24-Hour and 5-Working Day Reports. Such reports shall be filed timely to the NCHCPR. Residents will be reminded of their right to be free of abuse and how and to whom to report any concerns. 4. For those residents unable to communicate their needs, licensed nurses shall conduct weekly skin assessments and shall report any suspicions of abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin. Such assessments shall be on-going and any suspicious findings shall be reported to the Administrator and/or Director of Nursing immediately. Following any such report, the Administrator shall follow the facility abuse policy related to the identification, investigation, and reporting of such suspicions. All allegations of abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin shall be reported using the 24-Hour and 5-Working Day Reports. Such reports shall be filed timely to the	

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F 226	Continued From page 34 resident that she was doing the best she could, that she was busy and to stop bothering her. The housekeeper was unable to provide the date or time this occurred. The Housekeeper stated that he did not report the incident because he was focused on his work and trying to complete his assignment. The Housekeeper stated that he guessed he should have reported the incident as he considered the way the NA was talking to the resident to be verbal abuse. Nurse #5 stated in an interview on 1/15/14 at 4:30 PM that she did not remember Med Aide #1 telling her about NA #1 yelling at Resident #8. The Nurse stated that this would be verbal abuse and would have called the on call nurse. The Nurse stated that she remembered hearing about the incident but was on a different day. Med Aide #1 was asked to join the interview and stated that she thought she told Nurse #5 about the incident. The Med Aide stated that when she arrived at work on Friday (1/3/14) at 3:00 PM she told the ADON and was told to write it up. The Med Aide stated that she got busy and did not write up the incident. The Med Aide stated that the ADON was in the building on Sunday (1/5/14) investigating an incident with Resident #2 and NA #1 and the ADON again encouraged me to write up the incident. The Med Aide stated that she wrote up the incident and put the report under the ADON ' s door so she would have it on Monday (1/6/14) morning. On 1/15/14 at 4:55 PM the Administrator stated in an interview that the ADON thought they could not investigate an allegation without statements and waited until Monday 1/6/14 to report the incident between Resident #8 and NA #1. The Administrator stated that Resident #8 walked to	F 226	NCHCPR. 1. The Corporate Nurse Consultant shall conduct random interviews (5 employees per week) of each department□s staff to include all three shifts, weekly for 4 weeks, monthly for three months, and for 4 quarters thereafter to ensure the staff has understanding of the abuse policy related to the identification and reporting of abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin. Staff who are unable to demonstrate the required competencies shall receive education related to the identification and reporting of abuse, neglect, mistreatment, misappropriation and/or injuries of unknown origin by the Corporate Nurse Consultant. Evidence of such interviews by the Corporate Nurse Consultant shall be provided to the Administrator, in a written format, weekly for four weeks, monthly for three months, and for 4 quarters thereafter. Evidence of monitoring shall include date, staff name, function, and documentation of proficiency (ies) related to the reporting of abuse, neglect, mistreatment, misappropriation of resident property and injuries of unknown origin. Any findings or suspicions of abuse, neglect, mistreatment, misappropriation of resident property and/or injuries of unknown origin will be reported to the Administrator immediately and an investigation will begin per the facility□s Abuse Policy.	

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F 226	Continued From page 35 her office every day and talked with her and the resident never said anything about a problem with NA #1. The Assistant Director of Nursing (ADON) stated in an interview on 1/15/14 at 7:40 PM that Med Aide #1 told her she was standing outside by the window of Resident #8 ' s room and observed NA #1 in the resident ' s face. The ADON stated that Med Aide #1 reported this on 1/2/14 (Thursday) around 3:30 PM as she was getting ready to leave for the day. The ADON stated she told the Med Aide that it needed to be in writing and would pick up her statement the next morning. The ADON stated she looked for the statement the next morning but did not find one. The ADON stated that she was in the building on Sunday (1/5/14) investigating another incident and did not see the Med Aide ' s statement and told the Med Aide that if she wanted to report the incident it would have to be put in writing. The ADON stated that conversations could be heard through the windows in the building. The ADON stated that on one occasion she was standing outside, near the dining room window and could hear conversations in the dining room. 2. The facility ' s abuse policy titled Abuse and Neglect Policies and Procedures last revised on 09/2011 on page 4 under Protection read: " 1. This facility shall initiate measures to protect residents from harm during the investigatory process. 3. Employees of the facility who have been accused of resident abuse may be reassigned to nonresident care duties or suspended from duty for up to ten working days until the results of the investigation have been reviewed by the Administrator. "	F 226	The Administrator shall monitor items 2 □ 5 above for compliance, and shall certify such evidence of monitoring in a written monthly monitoring report. The Plan of Correction for this alleged deficient practice(s) has been incorporated into the facility□s most recent Quality Assurance Committee meeting minutes and shall be evaluated for effectiveness no less than monthly for three months and quarterly thereafter.	

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Resident #2 was admitted to the facility on 5/14/13 and had diagnoses that included Parkinson ' s Disease, Dementia with Lewey Bodies, Stroke and Debility.

The Care Area Assessment (CAA) for Cognitive Status dated 7/3/13 revealed the resident was verbally responsive and could make her needs known and understand others. The CAA for Activities of Daily Living (ADLs) revealed the resident required assistance with ADLs and was unsafe to transfer independently.

The Quarterly Minimum Data Set (MDS) Assessment dated 12/12/13 revealed the resident was severely cognitively impaired and required extensive assistance for bed mobility and transfers.

The Care Plan dated 5/31/13 revealed that Resident #2 had impaired thought processes due to diagnosis of Dementia. The Care Plan listed a problem of impaired mobility due to Parkinson ' s Disease. One of the interventions was for staff to assist with transfers and ambulation as necessary and to use the stand up lift for transfers.

The nurse ' s schedule revealed that Nurse #1 worked 7 AM to 11 PM on 1/5/14.

A Nurse ' s Note by Nurse #1 dated 1/5/14 at 7:50 PM revealed that on the 7AM-3PM shift on the first medication (med) pass, Resident #2 reported very tearfully that her NA (nursing assistant) was verbally inappropriate with her and that she was scared about her safety. The note revealed the on-call nurse who was the Assistant Director of Nursing (ADON) was notified. The note revealed the Nurse took over care for the resident and

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removed reported NA from providing care for Resident #2.

A Nurse ' s Note by Nurse #1 dated 1/5/14 at 10:30 PM revealed that upon the last med pass, Resident #2 was still voicing concern for her safety stating: " I ' m just so scared because she is so big and all I can do is yell. " The note revealed the nurse reassured the resident that the NA was not in the building.

The facility' investigation file included written statements dated 1/5/14 by Nurse #1 and Med Aide #2 that revealed Resident #2 alleged NA #1 had kicked her and had been verbally inappropriate with her during care that morning.

The investigation report included documentation of counseling for NA #1 dated 1/6/14 that included the following: " The employee has violated the following behavior and/or work rule standards: " 3 resident complaints. Corrective Action: Suspension pending investigation. Was offered non care but employee chose to leave. "

NA #2 stated in an interview on 1/14/14 at 1:50 PM that on 1/5/14, NA #1 asked her to help get Resident #2 out of bed and the resident did not want to get up. NA #2 stated that about 30 minutes later, Nurse #1 told them that the resident was ready to get up and the resident stated she did not want to get up. NA #2 stated as she and NA #1 were leaving the room, the resident stated she would just get up. NA #2 stated when putting the side rail down she injured her finger and had to leave the room to put ice it and left NA #1 in the room with the resident. NA #2 stated a little bit later, NA #1 asked her to come in and help get the resident out of bed. NA

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#1 stated when she went back in the room the resident was dressed and NA #1 used the stand-up lift to get the resident out of bed. The NA stated she did not witness inappropriate behavior by NA #1 while she was in the room.

The Administrator stated in an interview on 1/14/14 at 3:45 PM that when she was notified of the incident on 1/5/14 it was the end of the shift and time for NA #1 to go home. The Administrator stated that in the morning meeting on 1/6/14 with the Director of Nursing and the Social Worker there was discussion about whether or not NA #1 should be suspended. The Administrator stated the Social Worker had a consult note dated 1/3/14 by the resident ' s psychologist that the resident had relayed to him an event with similar circumstances. The Administrator stated that shortly after, the ADON brought her the employee statements and saw that Resident #2 alleged the NA had kicked her. The Administrator stated that NA #1 was suspended around 11:00 on the morning of 1/6/14.

Med Aide #2 stated in an interview on 1/14/14 at 5:00 PM that on 1/5/14 she observed Resident #1 sitting in her wheel chair in the hall with no shoes on and was upset. The Med Aide stated Resident #1 told her the girls were jerking her around and she did not like it and had been kicked and did not feel safe. The Med Aide stated that NA #1 came up to the desk and asked if she had called anyone to report the abuse and stated she was glad she had a witness. Med Aide #2 stated she called the Assistant Director of Nursing (ADON) and gave the phone to Nurse #1. The Med Aide stated she tried to take the resident back to her room but the resident was upset and did not want to go back to her room. The Med Aide stated later

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on that day the resident was in the dining room and stated she talked to the lady in the office but they probably would not do anything. The Med Aide stated that she had heard NA #1 say that as long as the (Name of Administrator) was in the building she would have a job.

Nurse #1 stated in an interview on 1/14/14 at 5:20 PM that during her first medication pass she got to Resident #2 ' s room and the resident was tearful and upset. The Nurse stated the resident told her the aide with a ring in her lip slung her around in the bed. The Nurse stated that NA #1 was the only NA working with a lip ring. The Nurse stated that the resident had told her she wanted to go to church so she instructed NA #1 to go ahead and get the resident up and to take NA #2 with her. The Nurse stated that NA #1 stated: " I ' ll get her up when I ' m good and ready to get her up " and kept walking down the hall. The Nurse stated that NA #2 came out of the room with an injured finger and NA #1 was left in the resident ' s room by herself. Nurse #1 stated she told NA #1 she did not have to yell at her and NA #1 stated: " That is just the way I talk to people. " Nurse #1 stated that Med Aide #2 told her that the NA with the lip ring kicked her. The Nurse stated she did not learn about the kick until bedtime and assured the resident that NA #1 would not be back in her room. Nurse #1 stated that Resident #2 had trouble getting the right word out but had always been oriented with her. The Nurse stated when the resident used the wrong word, the resident was aware that it was the wrong word. The Nurse stated that on 1/11/14, Resident #2 saw NA #1 several times from a distance and stated: " Well, I guess they didn ' t fire her. The Nurse stated at the time of the incident on 1/5/14, Resident #2 was scared of NA #1. The Nurse

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stated she wrote NA #1 up one day and NA #1 stated: " (Name of Administrator) will not fire me. "

Nurse #2 stated in an interview on 1/15/14 at 7:15 AM that she got to work on 1/5/14 at 11:00 PM and Nurse #1 and Med Aide #2 told her that Resident #2 came out in tears and told them that as soon as the door closes, NA #1 was tugging and pulling on her and kicked her and that this had been going on for a week. The Nurse stated that Resident #1 was believable and that the resident responded appropriately to questions. The Nurse stated the resident talked like she had some sense but was not completely oriented to place and time. The Nurse stated that NA #1 would be suspended and then come back to work and go around the facility saying that no matter what she did, the Administrator will not fire her because she is her daughter ' s best friend.

The Administrator stated in an interview on 1/15/14 at 7:50 AM that NA #1 should have been suspended by the ADON (Assistant Director of Nursing) on 1/5/14.

On 1/15/14 at 9:00 AM, Nurse #6 stated in an interview that recently Nurse #5 was talking with her about an incident between NA #1 and a resident and how upset she was about it. Nurse #6 stated she asked Nurse #5 if she had reported the incident and Nurse #5 told her that she had reported NA #1. Nurse #6 stated that NA #1 had a poor attitude and was a mean spirited girl.

On 1/15/14 at 7:40 PM the ADON stated in an interview that she was the nurse on call on 1/5/14. The ADON stated she received a call on 1/15/14 at 10:30 in the morning and spoke with

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Nurse #1. The ADON stated that she went to church and then went to the facility and started taking statements. The ADON stated she pulled the abuse policy which stated that the employee could be reassigned or suspended. The ADON stated that she texted the Administrator about the incident and that the NA had been reassigned. The ADON stated that by then it was 2:30 PM and NA #1 ' s shift was almost over and assigned the NA to transport laundry. The ADON stated that she spoke with Resident #2 who was tearful and told her that her knee was pinched in the wheelchair. The ADON stated she told the resident that she would handle it with the Administrator in the morning and she left the facility at approximately 3:00 PM. The ADON stated that NA #1 reported to work the next morning. The ADON stated she put the statements under the Administrator ' s door because she had to round with the physicians. The ADON stated around lunchtime she learned that NA #1 had been suspended. The ADON stated when she was hired as ADON on 4/15/13 she received no orientation. The ADON stated that her first few days there she was told to go through charts and get familiar with the residents. The ADON stated that she looked through policy books and rounded with the doctors. The ADON stated that she did go through the facility computer course that included resident rights, abuse, work safety, etc. The ADON stated the social worker did the abuse training but did not go over the abuse policy. The ADON stated she thought she had to have statements from the involved staff before the allegation could be investigated.

The Director of Nursing (DON) stated in an interview on 1/16/15 at 10:34 AM that the ADON

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did not get a very good orientation. The DON stated that she spoke with the ADON about tasks that had to be performed like Infection Control to make sure everything was covered and that was basically the ADON ' s orientation. The DON stated that the ADON did go through the facility ' s computer training program.

The Administrator stated in an interview on 1/17/14 at 10:45 AM that when NA #1 came to work on the morning of 1/6/14 she was assigned to resident care on the 600 hall and was suspended at 11:00 AM.

The Administrator stated in an interview on 1/17/14 at 2:00 PM that the facility ' s abuse policy stated that the accused employee could be reassigned or suspended.

3a.The facility ' s abuse policy titled Abuse and Neglect Policies and Procedures last revised on 09/2011 on Page 4 under Reporting read: " 1. Persons witnessing an accident or incident involving a resident must report such information to their department supervisor and/or the facility Administrator. 2. Allegations of abuse shall be reported to the Administrator immediately. Immediately is defined as " as soon as possible, but ought not exceed 24 hours after discovery of the incident. " Page 4 of the policy under Protection read: " 1.This facility shall initiate measures to protect residents from harm during the investigatory process. 3. Employees of the facility who have been accused of resident abuse may be reassigned to nonresident care duties or suspended from duty for up to ten working days until the results of the investigation have been reviewed by the Administrator. "

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Resident #1 was admitted to the facility on 5/1/13 and had diagnoses that included COPD (Chronic Obstructive Pulmonary Disease), Coronary Artery Disease, Congestive Heart Failure and Advanced Dementia.

The Care Area Assessment (CAA) for Cognitive Status and Communication dated 5/13/13 revealed that the resident was unable to be oriented due to progressive cognitive decline. The CAA revealed that the resident was alert to self but confused to time and place and unable to verbalize needs and concerns secondary to vascular dementia. The CAA revealed that the resident was resistive to care, hitting, kicking and cursing at staff.

The Quarterly Minimum Data Set (MDS) Assessment dated 11/1/13 revealed that the resident had short and long term memory problems and was severely cognitively impaired. The MDS revealed that the resident was totally dependent on staff for all activities of daily living. The MDS revealed that the resident had no behaviors during the 7 day assessment period.

The Care Plan dated 5/13/13 included a problem that the resident was resistive to care by hitting, kicking and cursing. Among the approaches was to check the resident frequently for anticipated needs and address to reduce risks for agitation, anxiety or resistive behaviors and redirect as needed.

The Director of Nursing (DON) stated in an interview on 1/14/14 at 1:15 PM that she received a report that NA #1 told Resident #1 that she hoped he fell out of the wheelchair. The DON stated that she was told that the resident ' s family

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was sitting in the dining room with the resident when this occurred. The DON stated that she called the family of Resident #1 and they denied that this occurred. The DON stated that her interview with the resident ' s family revealed they did not witness the incident so she did not go any further because she did not think it happened. The DON stated that the incident occurred back in the summer of 2013, maybe August or September. The DON stated she had received training on abuse by the facility. The DON stated if she received an allegation of abuse she was supposed to fill out a concern form and interview the resident and the staff members involved and have the staff write a statement regarding the incident. The DON stated she then turned in this information to the Administrator and they discussed the findings. The DON stated the Administrator did separate interviews with the employees and the social worker talked with the resident about the incident. The DON stated that she then would get together with the Administrator and compare interviews and try to determine what actually happened. The DON stated if there was a concern about abuse the employee was suspended pending results of the investigation. The DON stated she did not document the allegation or the family interview. The DON stated she failed to report the incident to the Administrator. The DON stated at the time she was DON and doing MDS assessments and was busy.

The Administrator stated in an interview on 1/14/14 at 3:45 PM that she was not aware of the allegation that NA #1 stated that she hoped that the resident fell out of the wheelchair until 1/13/14 when the social worker from Adult Protective Services entered the building and told her the

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incident was being investigated.

Nurse #2 stated in an interview on 1/15/14 at 7:15 AM that she heard that NA #1 told Resident #1 she hoped he fell out of the wheelchair so he had to go to the hospital and would not have to take care of him. The Nurse stated that she did not witness the incident. The Nurse stated that NA #1 would be suspended and then come back to work and go around the facility saying that no matter what she does, the Administrator will not fire her because she is her daughter ' s best friend.

NA (nursing assistant) #3 stated in an interview on 1/16/14 at 10:50 AM that she observed NA #1 push Resident #1 to the dining room in his geri-chair. The NA stated that the resident was trying to scoot out of the chair like he always did. The NA stated she heard NA #1 say to the resident: " I hope you fall out of the chair so they can send you to the hospital. " The NA stated that this happened in August or September of 2013. The NA stated that another resident and his spouse were sitting at the next table and the NA made the statement loud enough for them to hear but did not know if they actually heard the statement made by NA #1. NA #3 stated that she reported the incident to the weekend supervisor on duty that day and the supervisor had her write a statement about the incident. The NA stated that the weekend supervisor no longer worked at the facility. NA #3 stated that NA #1 talked very nasty to the residents and she had told the NA that this was not the kind of work for her. NA #3 stated that NA #1 gets written up and suspended with pay and she comes right back to work and nothing happens. NA #3 stated that NA #1 gets suspended and comes back and brags that they suspended her but she got paid.

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Nurse #5 stated in an interview of 1/16/15 at 3:00 PM that she had reported NA #1 multiple times and was told to write a letter to the Administrator. The Nurse stated she did not write the letter because she knew nothing would happen. The Nurse stated a NA was hired and there was an incident where a resident ' s arm was hurt and the NA was terminated. The Nurse stated NA #1 brags that she is the best friend of the administrator ' s daughter and the Administrator will not do anything to her.

3b.The facility ' s abuse policy titled Abuse and Neglect Policies and Procedures last revised on 09/2011 on Page 4 under Reporting read: " 1. Persons witnessing an accident or incident involving a resident must report such information to their department supervisor and/or the facility Administrator. 2. Allegations of abuse shall be reported to the Administrator immediately. Immediately is defined as " as soon as possible, but ought not exceed 24 hours after discovery of the incident. " The facility ' s abuse policy titled Abuse and Neglect Policies and Procedures last revised on 09/2011 on Page 4 under Reporting read: " 1. Persons witnessing an accident or incident involving a resident must report such information to their department supervisor and/or the facility Administrator. 2. Allegations of abuse shall be reported to the Administrator immediately. Immediately is defined as " as soon as possible, but ought not exceed 24 hours after discovery of the incident. " Page 4 of the policy under Protection read: " 1.This facility shall initiate measures to protect residents from harm during the investigatory process. 3. Employees of the facility who have been accused of resident abuse may be reassigned to nonresident care

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duties or suspended from duty for up to ten working days until the results of the investigation have been reviewed by the Administrator. "

Resident #1 was admitted to the facility on 5/1/13 and had diagnoses that included COPD (Chronic Obstructive Pulmonary Disease), Coronary Artery Disease, Congestive Heart Failure and Advanced Dementia.

The Care Area Assessment (CAA) for Cognitive Status and Communication dated 5/13/13 revealed that the resident was unable to be oriented due to progressive cognitive decline. The CAA revealed that the resident was alert to self but confused to time and place and unable to verbalize needs and concerns secondary to vascular dementia. The CAA revealed that the resident was resistive to care, hitting, kicking and cursing at staff.

The Quarterly Minimum Data Set (MDS) Assessment dated 11/1/13 revealed that the resident had short and long term memory problems and was severely cognitively impaired. The MDS revealed that the resident was totally dependent on staff for all activities of daily living. The MDS revealed that the resident had no behaviors during the 7 day assessment period.

The Care Plan dated 5/13/13 included a problem that the resident was resistive to care by hitting, kicking and cursing. Among the approaches was to check the resident frequently for anticipated needs and address to reduce risks for agitation, anxiety or resistive behaviors and redirect as needed.

NA (nursing assistant) #2 stated in an interview

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on 1/14/14 at 1:50 PM that she walked in Resident #1 ' s room and observed NA #1 thumping the resident on the head. The NA stated that this happened awhile back but could not be specific about a date. The NA stated that this happened around the time that NA #1 was heard to tell the resident that she hoped he fell out of the wheelchair and had to go to the hospital (August/September 2013). The NA stated that she reported the incident Nurse #3 but was never questioned about the incident.

Nurse #3 stated in an interview on 1/14/14 at 2:55 PM that NA #2 came to her and asked her what she should do if she saw someone being thumped on the head. The Nurse stated the NA did not say who the resident was or who was thumping a resident on the head. The Nurse stated she told the NA she should report it to her nurse. NA #2 was asked to join the interview and stated that she thought she reported the incident to Nurse #3. Nurse #3 stated that she took it that NA #2 wanted information. NA #2 stated she did not report the incident to anyone else but it got out. Nurse #3 stated she did not report what the NA told her to anyone else but shortly afterwards, NA #1 was suspended so she thought the NA had reported the incident to her nurse.

The Administrator stated in an interview on 1/14/14 at 3:45 PM that she was not aware of the allegation that NA #1 thumped Resident #1 on the head. The Administrator stated that she considered thumping the resident on the head to be abusive and Nurse #3 should have reported what she was told and would have attempted to get a statement from the NA.

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The Administrator was notified of the Immediate Jeopardy on 1/16/14 at 10:00 AM. The facility provided a credible allegation of compliance on 1/17/14 at 1:55 PM. The allegation of compliance indicated:

For Resident #1, the facility Administrator was unaware of allegation #1 against NA #1 to Resident #1. The DON was aware and failed to report the allegation to the administrator. It is undetermined when the alleged incident took place. The resident is deceased (11/4/13). A 24-hour report has been completed 1/17/14. A 5-day will be completed by 1/21/14. The accused NA #1 was terminated 1/16/14.

· The DON has received disciplinary action by the administrator and the corporate nurse consultant for failing to report an allegation of abuse to the administrator. The DON was retrained by the director of operations and the corporate nurse consultant on the abuse policy with concentration on requirements for reporting all allegations.

For the second allegation, the Administrator was notified on 1/16/14 by surveyor concerning Resident #1. The C.N.A. was aware and failed to clearly report to the nurse the alleged abuse and the employee responsible.
It is undetermined when the alleged incident took place. The resident is deceased (11/4/13).
A 24-hour report has been completed 1/17/14. A 5-day will be completed by 1/21/14.
The accused NA #1 was terminated 1/16/14.

· The C.N.A. has received disciplinary action by the DON and an inservice on the abuse policy with concentration on requirements for reporting

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F 226	Continued From page 50 all allegations. · The Nurse has received disciplinary action by the DON and an inservice on the abuse policy with concentration on requirements for reporting all allegations. For Resident #2, remains in the facility. NA #1 was suspended 1/6/14 pending investigation. An investigation of the allegation was completed 1/9/14. NA #1 was returned to work 1/10/14 after completion of the investigation but not to the care and service of Resident #2. NA #1 was suspended again 1/13/14 and subsequently terminated 1/16/14. A 24-hour and 5-day report was completed 1/15/14. · The Administrator has received disciplinary action from the director of operations for failing to initiate and complete the 24-hour and 5-day reports on allegations. The Administrator was retrained by the director of operations and the corporate nurse consultant on the abuse policy with concentration on requirements for reporting all allegations. · The DON has received disciplinary action by the administrator and the corporate nurse consultant for failing to report an allegation of abuse to the administrator. The DON was retrained by the director of operations and the corporate nurse consultant on the abuse policy with concentration on requirements for reporting all allegations. For Resident #8, an investigation was completed 1/9/14. NA #1 was suspended 1/6/14 pending investigation. An investigation of the allegation	F 226		

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F 226	Continued From page 51 was completed 1/9/14 pending investigation. NA #1 was returned to work 1/10/14 after completion of the investigation but not to the care and service of #2. Resident #3 was discharged 1/7/14. On 1/13/14 the resident deceased in the hospital. NA #1 was suspended again 1/13/14 and subsequently terminated 1/16/14. A 24-hour and 5-day report was completed on 1/15/14. · The Administrator has received disciplinary action from the director of operations for failing to initiate and complete the 24-hour and 5-day reports on allegations. The administrator was retrained by the director of operations and the corporate nurse consultant on the abuse policy with concentration on requirements for reporting all allegations. For those residents having the potential to be affected by the same alleged deficient practice: · The Social Worker asked all residents capable of being interviewed if they had ever felt mistreated by a staff member of the facility. All residents interviewed denied feeling mistreated by any member of the staff. · The residents of the facility had a Resident Council meeting on Thursday, January 16, 2014. The residents were reminded of their right to be free from abuse, different types of abuse and how and who to report it to. · The administrative staff have been re-educated on the facility ' s Abuse Policy and Procedure by the Corporate Nurse Consultant. · All facility employees will be re-educated on the facility ' s Abuse Policy and Procedure by the Administrator and Director of Nursing and will be	F 226		

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F 226	Continued From page 52 mandated to attend the Abuse Policy and Procedure inservice quarterly. On 1/17/14 at 11:30 AM, 90% of all employees had been inserviced on the abuse policy. Employees will not be allowed to work until they have been inserviced. · The Social Worker contacted all responsible parties of residents unable to speak for themselves to inquire of any concerns or changes in resident behavior that could indicate possible abuse. · The nursing staff has completed a skin check for injuries of unknown origin of residents unable to speak for themselves. · Employees who reportedly knew of resident abuse and failed to report have received disciplinary action. · The Administrator has received disciplinary action from the Director of Operations for failing to initiate and complete the 24-hour and 5-day reports on allegations. The Administrator was retrained by the Director of Operations and the Corporate Nurse Consultant on the abuse policy with concentration on requirements for reporting all allegations. · The DON has received disciplinary action by the administrator and the Corporate Nurse Consultant for failing to report an allegation of abuse to the administrator. The DON was retrained by the Director of Operations and the Corporate Nurse Consultant on the abuse policy with concentration on requirements for reporting all allegations. On 1/17/14 at 3:00 PM the credible allegation was validated by random interviews with staff showing that the staff had received inservices on the facility ' s abuse policies and procedures. Interviews revealed that the staff was	F 226		

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F 226	Continued From page 53 knowledgeable about the definition of abuse and the different kinds of abuse. The staff voiced understanding they were to report instances of abuse immediately to their nurse or supervisor.	F 226		