STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	R-C 03/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

A recertification, complaint and followup complaint survey was conducted on 02/22/16 to 02/25/16. The facility was notified of immediate jeopardy on 02/24/16 at F-223 (J), F-225 (J), F-226 (J), F-282 (J), F-490 (J), and F-520 (J) which began on 02/16/16. An extended survey was conducted on 02/25/16. Immediate jeopardy was present and remained ongoing at the completion of the survey.

483.13 (F 223) at J
Immediate Jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped a combative resident on the face and again on the right thigh (Resident #6). Each incident of physical abuse occurred on the secure unit and was witnessed by NA #2. NA #2 did not immediately intervene or report to administrative staff that she witnessed physical abuse against Resident #6 and failed to protect this Resident and other residents on the secure unit from further abuse. Resident #6 was assessed with reddened discoloration to her right thigh.

483.13 (F 225) at J
Immediate Jeopardy began on 02/16/16 when Nurse Aide (NA) #2 failed to immediately report that she witnessed physical abuse to a combative resident (Resident #6) on the secure unit which resulted in further physical abuse. NA #2 witnessed NA #1 slap Resident #6 on the face, but did not immediately report the abuse or protect the Resident from further abuse. NA #1 remained on the secure unit, working unsupervised and was witnessed again on 02/16/16, by NA #2, to slap Resident #6 on the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/21/2016

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{F 000}	Continued From page 1	{F 000}		

right thigh. The facility failed to report physical abuse to the Health Care Personnel Registry within 24 hours and the investigation of the physical abuse within 5 working days.

483.13 (F 226) at J
Immediate Jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped Resident #6 on the face when the Resident became combative during nursing care. NA #2 witnessed the physical abuse but did not immediately intervene or report to administrative staff. This resulted in a lack of protection to Resident #6 and other residents which led to a second incident of physical abuse toward Resident #6. NA #2 witnessed NA #1 slap Resident #6 on the face during morning care, but did not immediately report the abuse. NA #1 remained on the secure unit, working unsupervised and several hours later on 02/16/16, NA #2 witnessed NA #1 slap Resident #6 on the right thigh during the provision of care. The facility failed to report physical abuse to the Health Care Personnel Registry within 24 hours and the investigation of the physical abuse within 5 working days.

483.20 (F 282) at J
Immediate Jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped a combative resident on the face and again on the right thigh (Resident #6). Each incident of physical abuse occurred on the secure unit and was witnessed by NA #2. NA #2 did not immediately intervene to protect Resident #6 and other residents on the secure unit from physical abuse. Resident #6 was assessed with reddened discoloration to her right thigh.

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{F 000}	Continued From page 2	{F 000}		

483.75 (F 490) at J
Immediate jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped Resident #6 on the face and the witness, NA #2 did not intervene and did not immediately report to administrative staff for protection of Resident #6 and other residents. A second incident of physical abuse occurred on 02/16/16 when NA #1 slapped Resident #6 on the right thigh and the witness, NA #2 did not intervene for the protection of Resident #6.

483.75 (F 520) at J
Immediate jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped Resident #6 on the face and the witness, NA #2 did not intervene and did not immediately report to administrative staff for protection of Resident #6. A second incident of physical abuse occurred on 02/16/16 when NA #1 slapped Resident #6 on the right thigh and the witness, NA #2 did not intervene for the protection of Resident #6.

The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance on 03/08/16.

A revisit survey was conducted on 03/14/16 for verification of the facility's allegation of compliance and to determine the status of the ongoing Immediate Jeopardy. Immediate Jeopardy was removed on 03/14/16 at 7:15 PM. At the time of the exit on 03/14/16, the facility remained out of compliance at F-223, F-225, F-226, F-282, F-490, and F-520 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues

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{F 000}	Continued From page 3 the process of monitoring the implementation of their corrective actions.	{F 000}		
{F 164} SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on an observation, staff interviews and medical record review, the facility failed to provide	{F 164}	A resident has the right to personal privacy and confidentiality of his or her	3/18/16

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{F 164}	Continued From page 4 privacy, to a tube fed resident, by closing the blinds and the privacy curtain during medication administration and when an enteral feeding product was administered for 1 of 3 sample residents reviewed for enteral feeding products (Resident #36) The findings included: Resident #36 was admitted to the facility on 09/17/14. Diagnoses included cognitive deficit, artificial opening of digestive tract, intestinal obstruction, and peritonitis. On 02/24/16 at 05:35 AM Resident #36 was in her bed with the head of the bed elevated to approximately 30 degrees. On 02/24/16 at 05:48 AM, the enteral feeding bottle of Glucerna 1.2 was empty and the enteral feeding pump was noted beeping. Nurse #7 was observed to turn off the enteral feeding pump per the request of Nurse #6. Nurse #6 was noted to gather supplies and medications for Resident #36 which included an enteral feeding bottle of Glucerna 1.2. On 02/24/16 at 06:05 AM, Nurse #7 lifted the shirt of Resident #36, which exposed her brief, torso, and the skin just underneath her breast area. Nurse #6 administered medications to Resident #36 via the PEG tube and started the enteral feeding product. The privacy curtain was open, the roommate was present in the room, the room door was open and the blinds were open. Resident #36 was in the first bed next to the room door and the window in the room faced the facility's parking lot. There was car activity noted and people observed in the parking lot. Nurse #6 was interviewed on 02/24/16 at 6:10 AM and stated he was trained to provide privacy	{F 164}	personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. F 164 1) Since 2/24/16 resident#36 has been provided privacy by closing the blinds and the privacy curtain during medication administration and when eternal feeding product is administered. 2) On 2/26/16 Nurse#6 and Nurse#7 were in-serviced by staff facilitator related to providing privacy during medication administration and when enteral feeding administration to tube fed resident to include closing blinds and pulling the privacy curtain. Privacy is being provided to all tube fed residents by closing the blinds and the privacy curtain during medication administration and when eternal feeding product is administered. 3) On 2/26/16 the staff facilitator initiated in-servicing with all nursing staff related to providing privacy (pulling curtains, closing blinds etc.) during care including during medication administration and enteral feeding administration to the tube fed resident. All new hires will continue to receive in-service during orientation	

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{F 164}	Continued From page 5 when he administered medications by closing the privacy curtain between residents and to make sure the blinds were closed; he apologized for not providing privacy to Resident #36 when he administered her medications. The Interim Director of Nursing (DON) was interviewed on 02/25/16 at 8:48 AM. During the interview she stated that due to the recent incident of sexual abuse, staff were encouraged to leave room doors open when care was provided unless the resident requested to have their door closed. The Interim DON stated she expected staff to provide privacy to a resident by closing the privacy curtain between residents and closing the blinds when nursing care was provided.	{F 164}	process. 4) The provision of resident privacy will be monitored by the administrative staff (DON, ADON, nursing supervisor, staff facilitator, MDS, social worker, activities director, maintenance director, admissions director, medical records, dietary manager, housekeeping supervisor). Administrative staff is monitoring staff performance for pulling of privacy curtains and closing window blinds to ensure resident privacy is being provided during care . Tube fed residents will be included in the monitoring to ensure privacy is provided during medication /tube feeding administration using the Privacy/Choices/ADLs/Wheelchair audit tool. To make sure that the solutions are sustained, the audit tool will be completed on 10 residents per working week to include all 3 shifts x 4 weeks, then 10 residents bi-weekly for 8 weeks, then 10 residents monthly x 3 months. The DON and/or administrator will review the audit results on a weekly basis to make sure any area of concern regarding privacy is corrected at time of identification and solutions are sustained. The monthly QI committee will review the results of the "Privacy/Choices/ADL's/Wheelchair audit tool monthly for 6 months for identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for	

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{F 164}	Continued From page 6	{F 164}	continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
{F 166} SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews the facility failed to resolve a grievance regarding bed baths for 1 of 4 residents sampled for grievances. (Resident #24) The findings included: Resident #24 was readmitted to the facility on 12/18/15 with diagnosis that included hypertension, anxiety, depression, dysphagia, and weakness. Review of the most recent quarterly Minimum Data Set (MDS) dated 01/25/16 indicated that Resident #24 was cognitively intact and required extensive assistance with activities of daily living (ADL). The MDS further indicated no behaviors were identified. Review of the facility's bathing log dated 01/28/16 through 02/24/16 for Resident #24 revealed that Resident #24 had received no type of bathing or bathing assistance for 21 of the last 30 days. Review of "Resident Concern" form dated	{F 166}	A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. F 166 1) On 2/25/16 resident #24 was interviewed by the DON to discuss concern related to bathing schedule. Resident #24 is satisfied with receiving three bed baths per week. Resident #24 bathing schedule was adjusted by the DON to ensure resident would receive three baths per week. 2) On 2/29/16 resident concerns were reviewed for the past thirty days to ensure residents and/or the resident RP are satisfied with the resolution and follow-up.	3/18/16

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{F 166}	Continued From page 7 02/04/16 revealed Resident #24's friend and responsible party (RP) filed a grievance on Resident #24's behalf that read in part Resident #24 is not receiving baths this is not including bed baths given by hospice on Tuesdays and Thursdays. The expected outcome stated that Resident #24 would receive an extra bath weekly. The resolution to the grievance stated that Resident #24 would receive an extra bath a week for a total of 3 baths per week and Resident # 24 was satisfied with the stated resolution on 02/08/16. The "Resident Concern" form was signed by the Director of Nursing (DON) and the Administrator. Interview with Resident #24 on 02/23/16 at 3:02 PM revealed that he was waiting to get his bath for the day. Resident #24 stated that he had not been washed up at all and was waiting on the nursing assistant to come and wash him. Resident #24 also stated that he did not take showers due to chronic pain, so he took bed baths on Tuesdays and Thursdays when the hospice staff came and assisted him. Resident #24 stated that on the days that hospice is not there, the facility staff is "supposed to wash me up and they do not." Resident #24 further stated that he would be happy with 3 bed baths per week. Resident #24 stated the he remembered the grievance filed by his friend and RP on his behalf and the resolution was fine if he was actually receiving the 3 bed baths per week but he was not. Interview with Social Worker Assistant (SWA) on 02/24/16 at 4:36 PM stated the resident concern forms are located outside her office and on admission residents and families are notified where they are located. When a resident or family has a concern it is placed on the "Resident Concern" form and then she routed it to the	{F 166}	Any areas of concern were addressed immediately. 3) On 3/1/16 the administrator initiated an in-service for the administrative staff on Follow Up to Resident Concerns which included: 1) When addressing resident concerns, you must include detailed information for resolution of concern to include a date. 2) Any needed audits or observations to support monitoring should be documented. 4) The administrator and/or DON will review resident concerns weekly utilizing a "Resident Concern" monitoring tool to ensure concern have been addressed and the resolution reviewed with the resident/RP in a timely manner to include a written response on the concern form and details of the follow up that occurred with a date. The administrator and/or DON will present all findings at the monthly QI committee meeting. The QI committee will review the minutes of the resident council meeting monthly and "Resident Concern" audit tool for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly	

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{F 166}	Continued From page 8 appropriate department for resolution. The SWA recalled the grievance filed by Resident #24 and stated that he was in agreement with the resolution of adding the 3 bath per week but that no other follow up was done to determine if Resident #24 was receiving the bath or not, that would be up the manager for the department that concern was routed too. Interview with the interim Director of Nursing (DON) on 02/24/16 at 5:51 PM revealed that she had received the grievance from the DON and had spoken with the shower team and an extra bath was scheduled so that Resident #24 would receive 3 bath per week and he was in agreement with this. The interim DON stated that no further follow up had been done to determine if Resident #24 had received 3 baths per week, she further stated that she should have went back a week or 2 later to see if Resident #24 was satisfied with the resolution at that point.	{F 166}	executive QA committee for further recommendations and oversight.	
{F 223} SS=D	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 staff interviews and record review, the facility failed to protect a resident's right to be free from physical abuse with immediate intervention when a resident became combative during	{F 223}	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion	3/18/16

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{F 223}	Continued From page 9 nursing care. A resident was physically abused twice when a staff member slapped her on the face and then on the right thigh for 1 of 1 sampled residents reviewed for abuse. (Resident #6). Immediate Jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped a combative resident on the face and again on the right thigh (Resident #6). Each incident of physical abuse occurred on the secure unit and was witnessed by NA #2. NA #2 did not immediately intervene or report to administrative staff that she witnessed physical abuse against Resident #6 and failed to protect this Resident and other residents on the secure unit from further abuse. Resident #6 was assessed with reddened discoloration to her right thigh. The immediate jeopardy is present and ongoing. The facility provided the State Agency and Centers for Medicare and Medicaid an acceptable allegation of compliance (AOC) on 03/08/16. A revisit survey was conducted on 03/14/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following: Skin audits for all cognitively impaired residents dated 02/16/16 Documentation of interviews regarding abuse for all cognitively intact residents dated 02/16/16 Documentation of in-services (identifying/reporting abuse, caring for residents with dementia) for all currently employed staff completed by 03/07/16 Documentation of abuse monitoring on each shift which began on 02/26/16 and remained ongoing 24 hour/5 day reports for an allegation of abuse	{F 223}	F 223 1) On 2/16/16, Resident #6 was assessed by the Medical Director. No new orders were received. On 2/16/16 Resident #6 was assessed by Nurse #1 which included a head to toe assessment. The findings revealed a reddened area on upper right thigh and small healing bruises. Resident #6 still resides in the facility. On 2/16/16 NA #1 was suspended from employment for physically abusing Resident #6 and terminated on 2/22/16. 2) Because all residents have the potential to be affected by verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion on 2/16/16 staff nurses completed 100% body audit on all cognitively impaired residents in the facility for evidence of abuse. No negative findings were identified. On 2/16/16, the social worker interviewed all alert and oriented residents related to abuse and resulted in no negative responses. On 2/19/16 NA#2 was disciplined for failure to report immediately allegation of abuse according to the Abuse policy and on 2/25/16 NA #2 was terminated for not providing safety for Resident #6. 3) On 2/16//16 all facility staff including Administrative and current contract staff present were re-educated either by Administrator or Director of Nursing (DON) on the Abuse Policy and what constitute abuse. Abuse will not be tolerated, to ensure immediate safety of	

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{F 223}	Continued From page 10 on 03/03/16 and an allegation of neglect on 02/27/16 A 24 hour/5 day report for Resident #6 for the 8:00 AM incident of abuse which had not previously been reported to the Health Care Personnel Registry (HCPR). Both reports were faxed the the HCPR on 02/25/16 Personnel files for all staff hired since 02/16/16 to include criminal background checks, reference checks, Nurse Aide Registry checks, license checks, and abuse training The facility's Abuse Policy Observations of nursing care, interviews with cognitively intact residents, interviews with family, interviews with all staff present in the facility on 03/14/16, review of all documentation to support the AOC and interviews with the facility's Administrator, Director of Nursing and the Nurse Practitioner provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F-223. The immediate jeopardy was removed on 03/14/16 at 7:15 PM. The facility remained out of compliance at F-223 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of their corrective action. The findings included: Resident #6 was admitted to the facility on 04/10/14. Diagnoses included dementia with behaviors, mood affective disorder, cognitive communicative deficit, paranoid delusional beliefs and psychosis. Resident #6 was currently being treated and followed by ongoing psychiatric	{F 223}	all residents and removing the accused from resident care area immediately. On 2/18/16 staff facilitator started a video in-service for all staff entitled Being with a Person with Dementia: Actions and Reactions." On 2/26/16, 2/29/16, 3/1/16 and/or 3/2/16 all staff and contract staff attended a Directed in-service presented by the Regional Ombudsman Area Agency on Aging. Titled: Identification and Prevention of Elder Abuse. On 3/1/16 Staff facilitator started an in-service for all nurses and nursing assistants on following resident care plans and care guides. No staff will take an assignment until these in-services has been completed. On 3/4/16 an in-service was held for all staff by The Geriatric and Adult Mental Health Specialty Team titled "Managing Challenging Behaviors." Quarterly in-services will be offered to all staff by the Specialty Team. All newly hired employees will continue to receive training on the Abuse policy through written, video, and verbal education. New hires, prior to taking an assignment will watch the video series "Hand in Hand," a series providing training on caring for residents with dementia and on preventing abuse. 4) The DON, ADON, Department Heads and administrative staff on administrative staff rounds will continue to monitor and complete abuse observations on 10 residents per shift to be completed seven days a week three times a day to include each shift per week x4 weeks, 10	

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{F 223}	Continued From page 11 services. Medical record review revealed Resident #6 had physician orders dated 08/31/15 for Ativan (antianxiety) 2 milligrams (mg) IM (intramuscular) injection as needed for pain and 11/16/15 Ativan 1 mg every 8 hours as needed for agitation. A quarterly Minimum Data Set dated 12/29/15 assessed Resident #6 with severely impaired cognition, required extensive staff assistance of 2 persons for activities of daily living (ADL) to include mobility, transfers, dressing and toileting, physically and verbally abusive and without impairments in range of motion. A care plan dated 12/29/15 recorded that Resident #6 had problematic behavior characterized by ineffective coping behaviors of verbal and physical abuse, resistive to treatment/care as evidenced by yelling, cursing, swinging arms and delusional behavior. The care plan's goal specified that staff were to ensure the resident's safety. The care plan's interventions included the following: approach calmly and slowly from the front, respect personal space, provide diversion activity, allow for flexibility in ADL routine to accommodate mood, and when care is refused, leave and return in 5-10 minutes. Review of the "Resident care guide" revealed staff were encouraged to approach Resident #6 in a calm, reassuring manner and if care was refused, to approach the Resident later. A progress note dated 02/05/16 by the nurse practitioner (NP) revealed Resident #6 was referred by nursing for evaluation of morning agitation and persevering behaviors. Nursing reported that Resident #6 was noted increasingly	{F 223}	residents bi-weekly for 8 weeks and then 10 residents monthly x3 months using the Abuse/Neglect audit tool called "Watching For and Responding to an Incident." The monthly QI committee will review results of the Abuse/Neglect audit tool results monthly for 6 months for identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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agitated primarily in the morning. The progress note recorded that Resident #6 was noted by the NP to be very agitated, angry, and confused. Medications were adjusted and staff were to continue to monitor.

A Skin Monitoring Review for Resident #6 dated 02/15/16 did not record any changes or concern with skin integrity.

Review of a nursing progress note dated 02/16/16 at 4:49 PM written by Nurse #1 and the February 2016 Medication Administration Record recorded that Resident #6 was very combative towards staff that day. Nurse #1 documented that she administered Ativan 1 mg by mouth as needed for agitation at 7:40 AM with some positive effects and then Ativan 2 mg IM as needed for pain at 12:10 PM with slight positive effects.

A nursing progress note dated 02/16/16 at 4:56 PM by Nurse #1 recorded that nursing assistant (NA #1) verbalized she slapped Resident #6 during care when the Resident pulled her hair. The Medical Director was notified and assessed the Resident. Nurse #1 performed a full body assessment for Resident #6 and noted a deep reddened area to the Resident's right upper thigh.

A Skin Monitoring Review dated 02/16/16, completed by Nurse #1, recorded that Resident #6 had redness to her inner thighs and an irregular reddened area, approximately 3 inches long to the front of her upper right thigh.

An incident report dated 02/16/16 at 5:03 PM completed by the Director of Nursing (DON), recorded that NA #1 stated she struck Resident

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#6 on the leg and afterwards the Resident was noted with red marks across the right thigh.

A written statement by NA #1 dated 02/16/16 recorded that NA #1 struck Resident #6 on her leg on 02/16/16 around 10:00 AM when Resident #6 become combative and pulled the hair of NA #1.

Review of a Health Care Personnel Registry (HCPR) 24 Hour Initial Report dated 02/16/16 completed by the Administrator, recorded that on 02/16/16 at 10:00 AM, NA #1 stated she struck Resident #6 on her leg to stop the Resident from pulling her hair. Resident #6 was noted with a red mark on her upper right thigh.

Review of the facility's investigation revealed a written statement by the Administrator, dated 02/19/16, which recorded that she spoke to the Deputy Sheriff on 02/16/16 around 9:00 PM and was asked if she was aware that NA #2 also witnessed NA #1 slap Resident #6 on 02/16/16 about 8:00 AM. The written statement recorded that the Administrator was not aware. The Administrator documented that she spoke to NA #2 on 02/17/16 and was informed that NA #2 witnessed NA #1 slap Resident #6 on the face on 02/16/16 around 8:00 AM and again on the right thigh above her knee at 10:00 AM, when the Resident became combative.

Written statements by NA #2, dated 02/17/16, recorded that on 02/16/16 at 7:30 AM, NA #2 witnessed Resident #6 become combative during morning care and NA #1 slapped Resident #6 on the left side of her face. NA #2 witnessed NA #1 leave the Resident's room and make a statement at the nurse's station that she "popped" Resident

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#6. Later in the morning around 9:45 AM on 02/16/16, while in the shower room, NA #2 witnessed Resident #6 grab the hair of NA #1 and NA #1 slapped Resident #6 on the leg. NA #2 then witnessed NA #1 leave the shower room and report the incident to Nurse #1 and Nurse #2.

Review of a HCPR 5 Working Day Report dated 02/19/16, completed by the Administrator, recorded on 02/16/16 at 10:00 AM, NA #1 immediately reported that she slapped a combative resident on the leg during resident care. The physical abuse was witnessed, NA #1 was immediately suspended, the police was called at 6:00 PM, the allegation of abuse was substantiated and NA #1 was terminated.

An interview with NA #2 was conducted on 02/24/16 at 10:30 AM. NA #2 stated that she received a lot of abuse training recently and knew that if she witnessed abuse she should tell the nurse/supervisor, remove the resident from harm, watch the perpetrator and don't let the perpetrator go into any resident rooms. NA #2 stated that on 02/16/16 around 7:30 AM Resident #6 would not cooperate with staff and became combative during morning care (kicking, yelling and hitting). NA #2 stated she witnessed Resident #6 hit NA #1 twice, then witnessed NA #1 slap Resident #6 on the left side of her face and said "You are going to stop that." NA #2 stated the slap was more than just a pat on the face, but it wasn't a hard slap. NA #2 stated Resident #6 was already upset and remained upset. Both NAs continued getting Resident #6 dressed, placed her in her wheelchair and NA #1 took Resident #6 to the dining room. NA #1 stated that on the way to the dining room, NA #1 stopped at the nurse's station and told Nurse #1 "I popped (Resident #6)" and

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Nurse #1 said "Ok." NA #2 stated that she found out later that Nurse #1 did not hear NA #1's statement. NA #2 stated she felt that when NA #1 slapped Resident #6 that the incident fit the definition of abuse, but that she didn't know how to separate NA #1 from Resident #6. NA #2 further stated she did not think it would happen again and thought Nurse #1 heard NA #1 report the incident and would take care of it. NA #2 further stated that later that morning around 10:00 AM, both NA #1 and NA #2 were toileting Resident #6 in the shower room when the Resident became combative again. During care, NA #1 bent down to pull up the Resident's pants and Resident #6 grabbed NA #1's hair. That's when NA #1 slapped Resident #6 on her right thigh. NA #2 stated the slap was loud enough to hear, but she didn't know what to do. Resident #6 released her grip on NA #1 hair and they finished pulling up the Resident's pants, transferred her to the wheelchair and NA #2 took Resident #6 to the dining room. NA #2 stated that she observed NA #1 immediately go to the nurse's station and told Nurse #1 and Nurse #2 that she "popped" Resident #6 on the leg. Nurse #2 immediately left the unit and Nurse #2 and the DON returned to the unit. NA #2 observed NA #1 talk to the DON and then NA #1 was escorted off the unit. NA #2 stated the DON asked her on 02/16/16 what happened and she told the DON that NA #1 slapped Resident #6 on the left side of her face about 8:00 AM and then on her right thigh about 10:00 AM. NA #2 stated she also informed the police officer on 02/16/16 when he interviewed her that evening on the phone and the Administrator on 02/17/16 when she talked to her on the phone.

A telephone interview was conducted on 02/24/16

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at 12:55 PM with NA #1. She stated that she worked on the facility's secure unit as her permanent assignment and had recently received abuse training. NA #1 stated she was trained on how to identify abuse and if abuse was witnessed, she should remove the perpetrator from the resident, call law enforcement or the Administrator, and make sure the perpetrator and resident were both watched. NA #1 stated that on, 02/16/16 Resident #6 slapped her on the face and she responded by gently touching the Resident's face and said "Let's don't do that." NA #1 stated "I just touched her face with my hand" and NA #2 was present. NA #1 stated she went to the nurse's station after providing care to Resident #6 and told Nurse #1 that the Resident was a hand full, but she did not report touching her face because she did not think there was anything to it. NA #1 stated there was no mark left on the Resident's face. NA #1 stated later that morning around 10:00 AM, she and NA #2 were toileting Resident #6 in the shower room and the Resident became combative, worse this time. NA #1 stated that while she was pulling up the Resident's brief, the Resident grabbed her hair, pulling so hard "I was up on my tip toes", so "I smacked her on the right knee to get her to stop, I said stop and she stopped." NA #1 stated she struck her gently because it was not her nature to hurt anyone. Resident #6 continued yelling and hitting, we got her dressed and took her to the day room. NA #1 stated afterwards, she reported to Nurse #1 and Nurse #2 that she struck Resident #6 on the leg, the DON came and took a statement from her and she was suspended.

A telephone interview was conducted on 02/24/16 at 11:10 AM and a follow up interview was conducted on 02/25/16 at 3:30 PM with Nurse #1.

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During the interviews, Nurse #1 stated that on 02/16/16 there were 14 residents on the secure unit. Around 10:00 or 10:15 AM, NA #1 informed her that while NA #1 and NA #2 provided care to Resident #6 in the shower room, the Resident became combative and grabbed NA #1 by the hair. NA #1 stated she "popped" Resident #6 to get her to let go. Nurse #1 stated Nurse #2 (supervisor) was also present and heard the conversation. NA #1 stayed at the nurse's station with Nurse #1, while Nurse #2 reported the incident to the DON. The DON came to the unit, took a statement from NA #1 and she was suspended. Nurse #1 stated that NA #1 worked with all residents on the secure unit that day from 7:00 AM until she was suspended around 10:30 AM, but Nurse #1 was not aware of any prior incidents of abuse regarding NA #1. Nurse #1 stated she had not been informed that NA #2 witnessed NA #1 slap Resident #6 on the face earlier that morning. Nurse #1 stated Resident #6 was combative at times, usually required 2 staff to give her care. Nurse #1 stated that staff were trained that when residents became combative, staff should give the resident time to calm down, try to redirect and come back later to provide care. Nurse #1 stated Resident #6 was very combative that day and received Ativan (as needed) twice on her shift that day for agitation and later for pain. Nurse #1 stated Resident #6 did not cooperate initially with a skin assessment, and Ativan was given to calm her down. Once Resident #6 was calm, a full body skin assessment was completed, around 12:30 PM and she was noted with a reddened area to her right thigh about 3 inches long and irregular in shape. Nurse #1 stated there were no other changes noted to her skin or face.

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The Administrator was interviewed on 02/24/16 at 3:52 PM. She stated that the DON informed her around lunch time on 02/16/16 that NA #1 "popped" Resident #6 on the knee in the shower room and reported herself. The DON told the Administrator that NA #1 was suspended and that she had started completing interviews for the investigation. The Administrator called the police around 6:00 PM. The Administrator stated she went to see Resident #6 for the first time that day around 7:00 PM when the police officer arrived. Both she and the police officer observed Resident #6 without any marks to either thigh. The Administrator stated later that evening, around 9:00 PM, the police officer caller her and asked if she knew about another incident of abuse that happened earlier that day, but the Administrator stated she was not aware and she had not looked at the DON's investigation. The Administrator stated she called NA #2 sometime the next morning on 02/17/16 and obtained a statement from her over the phone regarding both incidents of physical abuse that were witnessed by NA #2 on 02/16/16 and reported to the DON. The Administrator asked NA #2 to provide written statements about what she saw.

Nurse #2 was interviewed on 02/25/16 at 10:28 AM. Nurse #2 stated she was the Nurse Supervisor on the 7AM - 3 PM shift on 02/16/16. Nurse #2 and Nurse #1 were both at the nurse's station on the secure unit on 02/16/16 around 10:00 AM when NA #1 said "I just want everybody to know that I just popped (named Resident)." NA #1 proceeded to say that she "popped" Resident #6 because the Resident pulled her hair. Nurse #2 stated she asked NA #1 to stay at the nurse's station. Nurse #2 went to find the DON and report what occurred. The DON came to the secure unit,

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{F 223}	Continued From page 19 obtained a statement from NA #1 and she was suspended. Nurse #2 stated she was not aware of any previous incidents of abuse between NA #1 and Resident #6. Attempts to interview the DON were unsuccessful. The administrator was notified of immediate jeopardy on 02/24/16 at 5:27 PM. An extended survey was conducted on 02/25/16.	{F 223}		
{F 225} SS=D	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 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	{F 225}		3/18/16

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{F 225}	Continued From page 20 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 staff interviews and record review, the staff failed to immediately notify administrative staff of a witnessed incident of physical abuse in which a resident was slapped on the face. Once notified, the facility failed to report the incident of physical abuse to the Health Care Personnel Registry in 24 hours and the investigative findings in 5 working days for 1 of 1 sampled residents. (Resident #6). Immediate Jeopardy began on 02/16/16 when Nurse Aide (NA) #2 failed to immediately report that she witnessed physical abuse to a combative resident (Resident #6) on the secure unit which resulted in further physical abuse. NA #2 witnessed NA #1 slap Resident #6 on the face, but did not immediately report the abuse or protect the Resident from further abuse. NA #1 remained on the secure unit, working unsupervised and was witnessed again on 02/16/16, by NA #2, to slap Resident #6 on the right thigh. The facility failed to report physical abuse to the Health Care Personnel Registry	{F 225}	F225 Investigation/Report allegations/individuals The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress and the results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with Stat law(including to the State Survey and certification agency) within 5 days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 1) On 2/16/16, Resident #6 was assessed by the Medical Director. No new orders were received. On 2/16/16, Resident #6 was assessed by Nurse #1 which included a head to toe assessment. The findings revealed a	

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{F 225}	Continued From page 21 within 24 hours and the investigation of the physical abuse within 5 working days. The immediate jeopardy is present and ongoing. The facility provided the State Agency and Centers for Medicare and Medicaid an acceptable allegation of compliance (AOC) on 03/08/16. A revisit survey was conducted on 03/14/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following: Skin audits for all cognitively impaired residents dated 02/16/16 Documentation of interviews regarding abuse for all cognitively intact residents dated 02/16/16 Documentation of in-services (identifying/reporting abuse, caring for residents with dementia) for all currently employed staff completed by 03/07/16 Documentation of abuse monitoring on each shift which began on 02/26/16 and remained ongoing 24 hour/5 day reports for an allegation of abuse on 03/03/16 and an allegation of neglect on 02/27/16 A 24 hour/5 day report for Resident #6 for the 8:00 AM incident of abuse which had not previously been reported to the Health Care Personnel Registry (HCPR). Both reports were faxed the the HCPR on 02/25/16 Personnel files for all staff hired since 02/16/16 to include criminal background checks, reference checks, Nurse Aide Registry checks, license checks, and abuse training The facility's Abuse Policy Observations of nursing care, interviews with cognitively intact residents, interviews with family,	{F 225}	reddened area on the upper right thigh and small healing bruises. Resident #6 still resides in the facility. On 2/16/16 NA #1 was suspended from employment and terminated on 2/22/16. On 2/16/16, staff nurses completed 100% body audit on all cognitively impaired residents in the facility for evidence of abuse. No negative findings were identified. On 2/16/16, the social worker interviewed all alert and oriented residents related to abuse and resulting in no negative responses. On 2/19/16 NA#2 was disciplined for failure to report immediately allegation of abuse according to the Abuse policy and on 2/25/16 NA #2 was terminated for not providing safety for Resident #6. 2) On 2/16/16 administrator submitted the 24 hour report to DHSR Health Care Registry. On 2/22/16 administrator submitted the 5 day report to DHSR Health Care Registry for initial abuse investigation of NA#1 striking Resident #6 on the thigh. On 2/25/16 administrator submitted a 24 hour report to DHSR Health Care Registry for NA#1 alleging slapping Resident #6 on the face. On 2/25/16 administrator submitted 5 day report to DHSR Health Care Registry for allegation identified during investigation of initial abuse involving NA#1 and NA#2 not reporting immediately 8:00 AM physical abuse slapping incident. 3) On 2/18/16 "The Hand in Hand: A Training Series for Nursing Homes", on	

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{F 225}	Continued From page 22 interviews with all staff present in the facility on 03/14/16, review of all documentation to support the AOC and interviews with the facility's Administrator, Director of Nursing and the Nurse Practitioner provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F-225. The immediate jeopardy was removed on 03/14/16 at 7:15 PM. The facility remained out of compliance at F-225 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of their corrective action. The findings included: Resident #6 was admitted to the facility on 04/10/14. Diagnoses included dementia with behaviors, mood affective disorder, cognitive communicative deficit, paranoid delusional beliefs and psychosis. Resident #6 was currently being followed and treated by ongoing psychiatric services. A quarterly Minimum Data Set dated 12/29/15 assessed Resident #6 with severely impaired cognition, required extensive staff assistance of 2 persons for activities of daily living (ADL) to include mobility, transfers, dressing and toileting, physically and verbally abusive and without impairments in range of motion. A nursing progress note dated 02/16/16 at 4:56 PM written by Nurse #1 recorded that nursing assistant (NA #1) verbalized she slapped Resident #6 on her right thigh during care when the Resident pulled her hair.	{F 225}	Person-Centered Care of Persons with Dementia and Prevention of Abuse, Module Four- Being with a Person with Dementia: Actions and Reactions was viewed by all staff. On 2/26/16, 2/29/16, 2/1/16 or 3/2/16 all staff and contract staff attended a Directed-in-service presented by the Regional Ombudsman Area Agency on Aging Title: Identification and Prevention of Elder Abuse. On 2/25/16 administrator received an in-service from the corporate Vice President of Operations. The in-service included the following: The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and 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/her 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	

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{F 225}	Continued From page 23 A Skin Monitoring Review dated 02/16/16, completed by Nurse #1, and an incident report dated 02/16/16 completed by the Director of Nursing (DON) recorded that Resident #6 had redness to her inner thighs and an irregular reddened area, approximately 3 inches long to the front of her upper right thigh. A written statement by NA #1 dated 02/16/16 recorded that NA #1 struck Resident #6 on her leg on 02/16/16 around 10:00 AM when Resident #6 become combative and pulled the hair of NA #1. A Consultation Report dated 02/16/16, completed by the DON, recorded a concern that NA #2 did not report abuse immediately, remove the employee from an abuse situation and report to another supervisor when the charge nurse was advised of abuse, but did not respond. Review of a Health Care Personnel Registry (HCPR) 24 Hour Initial Report dated 02/16/16 completed by the Administrator, recorded that on 02/16/16 at 10:00 AM, NA #1 stated she struck Resident #6 on her leg to stop the Resident from pulling her hair. NA #1 was immediately suspended. The report did not include the physical abuse that occurred on 02/16/16 at 8:00 AM. Review of the facility's investigation revealed a written statement by the Administrator, dated 02/19/16, which recorded that she spoke to the Deputy Sheriff on 02/16/16 around 9:00 PM and was asked if she was aware that NA #2 also witnessed NA #1 slap Resident #6 on the face on 02/16/16 at about 8:00 AM. The written statement	{F 225}	must be taken. A 24 hour and 5 day report is required for each allegation, including allegations identified during an investigation and/or additional allegations occurring on the same day and/or involving the same employee/resident. 4) The Corporate staff, i.e. corporate nursing consultant and/or regional vice president will continue to review all allegations of abuse and interventions when reported to the administrator in accordance with the abuse policy and Elder Justice Act including appropriate agencies notifications. The monthly QI committee will review results of any allegations of abuse i.e. 24 hour/5 day report monthly for 6 months for identification of trends, actions taken and determine the need for and /or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendation to the quarterly executive QA committee for further recommendations and oversight.	

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recorded that the Administrator was not aware. The Administrator documented that she spoke to NA #2 on 02/17/16 and was informed that NA #2 witnessed NA #1 slap Resident #6 on the face on 02/16/16 around 8:00 AM and again on the right thigh above her knee at 10:00 AM, when the Resident became combative.

Written statements by NA #2, dated 02/17/16, recorded that on 02/16/16 at 7:30 AM, NA #2 witnessed Resident #6 become combative during morning care and NA #1 slapped Resident #6 on the left side of her face. NA #2 witnessed NA #1 leave the Resident's room and make a statement at the nurse's station that she "popped" Resident #6. NA #2 stated that she did not report the witnessed physical abuse against Resident #6 because she thought the nursing staff heard NA #1's statement. Later in the morning around 9:45 AM on 02/16/16, while in the shower room, NA #2 witnessed Resident #6 grab the hair of NA #1 and NA #1 slapped Resident #6 on the leg. NA #2 then witnessed NA #1 leave the shower room and report the incident to Nurse #1 and Nurse #2. NA #2 stated she did not report the witnessed incident of staff to resident physical abuse at this time.

Written statements by Nurse #1 dated 02/16/16 and the Administrator dated 02/19/16 both recorded that Nurse #1 stated she was not made aware that NA #2 witnessed NA #1 slap Resident #6 on the left side of her face on 02/16/16 at 8:00 AM. NA #1 did self -report that she "popped" Resident #6 on the right thigh on 02/16/16 around 10:00 AM.

Review of a HCPR 5 Working Day Report dated

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02/19/16, completed by the Administrator, recorded on 02/16/16 at 10:00 AM, NA #1 immediately reported that she slapped a combative resident on the leg during resident care. The physical abuse was witnessed, NA #1 was immediately suspended, the police was called at 6:00 PM, the allegation of abuse was substantiated and NA #1 was terminated. The report did not include the witnessed physical abuse that occurred on 02/16/16 around 8:00 AM.

An interview with NA #2 was conducted on 02/24/16 at 10:30 AM. NA #2 stated that she received a lot of abuse training recently and knew that if she witnessed abuse she should tell the nurse/supervisor, remove the resident from harm, watch the perpetrator and don't let the perpetrator go into any resident rooms. NA #2 stated that on 02/16/16 around 7:30 AM Resident #6 would not cooperate with staff and became combative during morning care (kicking, yelling and hitting). NA #2 stated she witnessed Resident #6 hit NA #1 twice, then witnessed NA #1 slap Resident #6 on the left side of her face and said "You are going to stop that." NA #2 stated the slap was more than just a pat on the face, but it wasn't a hard slap. NA #2 stated Resident #6 was already upset and remained upset. Both NAs continued getting Resident #6 dressed, placed her in her wheelchair and NA #1 took Resident #6 to the dining room. NA #1 stated that on the way to the dining room, NA #1 stopped at the nurse's station and told Nurse #1 "I popped (Resident #6)" and Nurse #1 said "Ok." NA #2 stated that she found out later that Nurse #1 did not hear NA #1's statement. NA #2 stated she felt that when NA #1 slapped Resident #6 that the incident fit the definition of abuse, but that she didn't know how to separate NA #1 from Resident #6. NA #2

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further stated she did not think it would happen again and thought Nurse #1 heard NA #1 report the incident and would take care of it. NA #2 further stated that later that morning around 10:00 AM, both NA #1 and NA #2 were toileting Resident #6 in the shower room when the Resident became combative again. During care, NA #1 bent down to pull up the Resident's pants and Resident #6 grabbed NA #1's hair. That's when NA #1 slapped Resident #6 on her right thigh. NA #2 stated the slap was loud enough to hear, but she didn't know what to do. Resident #6 released her grip on NA #1 hair and they finished pulling up the Resident's pants, transferred her to the wheelchair and NA #2 took Resident #6 to the dining room. NA #2 stated that she observed NA #1 immediately go to the nurse's station and told Nurse #1 and Nurse #2 that she "popped" Resident #6 on the leg. Nurse #2 immediately left the unit and returned to the unit with the DON. NA #2 observed NA #1 talk to the DON and then NA #1 was escorted off the unit. NA #2 stated the DON asked her on 02/16/16 what happened and she told the DON that NA #1 slapped Resident #6 on the left side of her face about 8:00 AM and then on her right thigh about 10:00 AM. NA #2 stated she also informed the police officer on 02/16/16 when he interviewed her that evening on the phone and the Administrator on 02/17/16 when she talked to her on the phone.

A telephone interview was conducted on 02/24/16 at 12:55 PM with NA #1. She stated that she worked on the facility's secure unit as her permanent assignment and had recently received abuse training. NA #1 stated she was trained on how to identify abuse and if abuse was witnessed, she should remove the perpetrator

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from the resident, call law enforcement or the Administrator, and make sure the perpetrator and resident were both watched. NA #1 stated that on, 02/16/16 Resident #6 slapped her in the face and she responded by gently touching the Resident's face and said "Let's don't do that." NA #1 stated "I just touched her face with my hand" and NA #2 was present. NA #1 stated she went to the nurse's station after providing care to Resident #6 and told Nurse #1 that the Resident was a hand full, but she did not report touching her face because she did not think there was anything to it. NA #1 stated there was no mark left on the Resident's face. NA #1 stated later that morning around 10:00 AM, she and NA #2 were toileting Resident #6 in the shower room and the Resident became combative, worse this time. NA #1 stated that while she was pulling up the Resident's brief, the Resident grabbed her hair, pulling so hard "I was up on my tip toes", so "I smacked her on the right knee to get her to stop, I said stop and she stopped." NA #1 stated she struck her gently because it was not her nature to hurt anyone. Resident #6 continued yelling and hitting, we got her dressed and took her to the day room. NA #1 stated afterwards, she reported to Nurse #1 and Nurse #2 that she struck Resident #6 on the leg, the DON came and took a statement from her and she was suspended.

A telephone interview was conducted on 02/24/16 at 11:10 AM and a follow up interview was conducted on 02/25/16 at 3:30 PM with Nurse #1. During the interviews, Nurse #1 stated that on 02/16/16 there were 14 residents on the secure unit. Around 10:00 or 10:15 AM, NA #1 informed her that while NA #1 and NA #2 provided care to Resident #6 in the shower room, the Resident became combative and grabbed NA #1 by the

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hair. NA #1 stated she "popped" Resident #6 to get her to let go. Nurse #1 stated Nurse #2 (supervisor) was also present and heard the conversation. NA #1 stayed at the nurse's station with Nurse #1, while Nurse #2 reported the incident to the DON. The DON came to the unit, took a statement from NA #1 and she was suspended. Nurse #1 stated that NA #1 worked with all residents on the secure unit that day from 7:00 AM until she was suspended around 10:30 AM, but Nurse #1 was not aware of any prior incidents of abuse regarding NA #1. Nurse #1 stated she had not been informed that NA #2 witnessed NA #1 slap Resident #6 on the face earlier that morning.

The Administrator was interviewed on 02/24/16 at 3:52 PM. She stated that the DON informed her around lunch time on 02/16/16 that NA #1 "popped" Resident #6 on the knee in the shower room and reported herself. The DON told the Administrator that NA #1 was suspended and that she had started completing interviews for the investigation. The Administrator continued working in her office and sometime before 4:00 PM she obtained the necessary information from the DON to complete the HCPR 24 Hour Initial Report. The DON left for the day around 4:00 PM, but informed the Administrator before she left that she had obtained all the written statements and interviews. The Administrator did not review the investigation before the DON left because she thought the DON had done everything. The Administrator called law enforcement around 6:00 PM. The Administrator stated she went to see Resident #6 for the first time that day around 7:00 PM when law enforcement arrived. Both she and the law enforcement observed Resident #6 without any marks to either thigh. The

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Administrator stated later that evening, around 9:00 PM, law enforcement called her and asked if she knew about another incident of abuse that happened earlier that day, but the Administrator stated she was not aware and she had not looked at the DON's investigation. The Administrator stated she called NA #2 sometime the next morning on 02/17/16 and obtained a statement from her over the phone regarding both incidents of physical abuse that were witnessed by NA #2 on 02/16/16 and reported to the DON. The Administrator asked NA #2 to provide written statements about what she saw. The Administrator stated she completed/faxed the HCPR 24 Hour Initial Report on 02/17/16 and the 5 Day Working Report on 02/22/16, but she did not report the incident of physical abuse that occurred on 02/16/16 around 8:00 AM because it was included in her investigation. The Administrator further said that now she realized that both incidents of physical abuse should have been reported to the HCPR.

Nurse #2 was interviewed on 02/25/16 at 10:28 AM. Nurse #2 stated she was the Nurse Supervisor on the 7AM - 3PM shift on 02/16/16. Nurse #2 and Nurse #1 were both at the nurse's station on the secure unit on 02/16/16 around 10:00 AM when NA #1 said "I just want everybody to know that I just popped (named Resident)." NA #1 proceeded to say that she "popped" Resident #6 because the Resident pulled her hair. Nurse #2 stated she asked NA #1 to stay at the nurse's station. Nurse #2 went to find the DON and report what occurred. The DON came to the secure unit, obtained a statement from NA #1 and she was suspended. Nurse #2 stated she was not aware of any previous incidents of abuse between NA #1 and Resident #6.

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{F 225}	Continued From page 30 Attempts to interview the DON were unsuccessful. The administrator was notified of immediate jeopardy on 02/24/16 at 5:27 PM. An extended survey was conducted on 02/25/16.	{F 225}		
{F 226} SS=D	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 staff interviews and record review, the facility failed to immediately stop nursing care when a resident (Resident #6) became combative to protect the resident and prevent an incident of physical abuse, intervene when physical abuse was observed, and immediately remove the perpetrator from a combative resident on a secure unit. The facility failed to report a witnessed incident of physical abuse to the Health Care Personnel Registry in 24 hours and the investigation in 5 working days. The facility failed to follow their abuse policy and procedures in the areas of prevention, protection, identification, training and reporting of physical abuse for 1 of 1 abuse investigation reviewed. Immediate Jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped Resident #6 on the	{F 226}	F226 Development/Implementation Policies for Abuse/Neglect 1)On 2/16/16, Resident #6 was assessed by the Medical Director. No new orders were received. On 2/16/16 Resident #6 was assessed by Nurse #1 which included a head to toe assessment. The findings revealed a reddened area on upper right thigh and small healing bruises. Resident #6 still resides in the facility. On 2/16/16 NA #1 was suspended from employment for physically abusing Resident #6 and terminated on 2/22/16. On 2/16/16 NA #2 was re-educated on the Abuse Policy to include immediately intervene and stop abuse, remove the perpetrator and	3/18/16

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{F 226}	Continued From page 31 face when the Resident became combative during nursing care. NA #2 witnessed the physical abuse but did not immediately intervene or report to administrative staff. This resulted in a lack of protection to Resident #6 and other residents which led to a second incident of physical abuse toward Resident #6. NA #2 witnessed NA #1 slap Resident #6 on the face during morning care, but did not immediately report the abuse. NA #1 remained on the secure unit, working unsupervised and several hours later on 02/16/16, NA #2 witnessed NA #1 slap Resident #6 on the right thigh during the provision of care. The facility failed to report physical abuse to the Health Care Personnel Registry within 24 hours and the investigation of the physical abuse within 5 working days. The immediate jeopardy is present and ongoing. The facility provided the State Agency and Centers for Medicare and Medicaid an acceptable allegation of compliance (AOC) on 03/08/16. A revisit survey was conducted on 03/14/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following: Skin audits for all cognitively impaired residents dated 02/16/16 Documentation of interviews regarding abuse for all cognitively intact residents dated 02/16/16 Documentation of in-services (identifying/reporting abuse, caring for residents with dementia) for all currently employed staff completed by 03/07/16 Documentation of abuse monitoring on each shift which began on 02/26/16 and remained ongoing 24 hour/5 day reports for an allegation of abuse	{F 226}	immediately report. 2) Because all residents have the potential to be affected by verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion on 2/16/16 staff nurses completed 100% body audit on all cognitively impaired residents in the facility for evidence of abuse. No negative findings were identified. On 2/16/16, the social worker interviewed all alert and oriented residents related to abuse and resulted in no negative responses. On 2/19/16 NA#2 was disciplined for failure to report immediately allegation of abuse according to the Abuse policy and on 2/25/16 NA #2 was terminated for not providing safety for Resident #6. 3) On 2/16//16 all facility staff including Administrative and contract staff present were re-educated either by Administrator or DON on the Abuse Policy and what constitute abuse. Abuse will not be tolerated, to ensure immediate safety of all residents and removing the accused from resident care area immediately. On 2/18/16 Staff facilitator started a video in-service for all staff entitled "Being with a Person with Dementia: Actions and Reactions." On 2/26/16, 2/29/16, 3/1/16 or 3/2/16 all staff and contract staff attended a Direct □in-service presented by the Regional Ombudsman Area Agency on Aging. Titled: Identification and Prevention of Elder Abuse. On 3/1/16 Staff facilitator in-serviced all	

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{F 226}	Continued From page 32 on 03/03/16 and an allegation of neglect on 02/27/16 A 24 hour/5 day report for Resident #6 for the 8:00 AM incident of abuse which had not previously been reported to the Health Care Personnel Registry (HCPR). Both reports were faxed the the HCPR on 02/25/16 Personnel files for all staff hired since 02/16/16 to include criminal background checks, reference checks, Nurse Aide Registry checks, license checks, and abuse training The facility's Abuse Policy Observations of nursing care, interviews with cognitively intact residents, interviews with family, interviews with all staff present in the facility on 03/14/16, review of all documentation to support the AOC and interviews with the facility's Administrator, Director of Nursing and the Nurse Practitioner provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F-226. The immediate jeopardy was removed on 03/14/16 at 7:15 PM. The facility remained out of compliance at F-226 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of their corrective action. The findings included: The facility's policy "Abuse, Neglect, or Misappropriation of Resident Property Policy", revised 11/01/06, included in part: The facility will do whatever is in its control to prevent mistreatment, neglect, and abuse of our residents or misappropriation of their property. Any	{F 226}	nurses and nursing assistants on following resident care plans and care guides. On 3/4/16 an in-service was offered for all staff by The Geriatric and Adult Mental Health Specialty Team titled "Managing Challenging Behaviors." Quarterly in-services will be provided to all staff by the Specialty Team. Staff Facilitator will continue to provide ongoing annual abuse and neglect education through written, video and verbal education. All newly hired employees will continue to receive training on the Abuse policy through written, video, and verbal education. Prior to taking an assignment new hires will watch the video series "Hand in Hand:" a series providing training on caring for residents with dementia and on preventing abuse. 4) The DON, ADON, Department Heads and administrative staff on administrative staff rounds will continue to monitor and complete abuse observations on 10 residents per shift to be completed seven days a week three times a day to include each shift. per week x4 weeks, 10 residents bi-weekly for 8 weeks and then 10 residents monthly x3 months using the Abuse/Neglect audit tool called "Watching for and responding to an Incident." The monthly QI committee will review results of the Abuse/Neglect audit tool results monthly for 6 months for identification of	

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{F 226}	Continued From page 33 employee who witnesses or suspects that abuse, neglect, or misappropriation of property has occurred, will immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator. Measures will be initiated to prevent any further potential abuse while the investigation is in progress. The Administrator is responsible to review the results of the investigation and report the alleged incident to the appropriate agencies in accordance with State and Federal regulations. The Administrator is responsible to direct the investigation process to ensure that appropriate agencies are notified, as indicated. Training: Training programs may include: Indicators of resident vulnerability to abuse and related interventions. Prevention: The facility will provide supervision to staff to identify inappropriate behaviors, such as rough handling. The facility will assess, care plan, and monitor residents with needs and behaviors that might lead to abuse, neglect, or misappropriation of property. Protection: Employees accused of being directly involved in allegations of abuse, neglect, or misappropriation of property will be suspended immediately from employment pending the outcome of the investigation. Review of the facility's Abuse, Neglect or Misappropriation of Resident Property policy revealed a definition of physical abuse was not included. Resident #6 was admitted to the facility on 04/10/14. Diagnoses included dementia with behaviors, mood affective disorder, cognitive communicative deficit, paranoid delusional beliefs and psychosis. Resident #6 was currently being treated and followed by ongoing psychiatric services.	{F 226}	trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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Medical record review revealed Resident #6 had physician orders dated 08/31/15 for Ativan (antianxiety) 2 milligrams (mg) IM (intramuscular) injection as needed for pain and another physician's order dated 11/16/15 for Ativan 1 mg every 8 hours as needed for agitation.

A quarterly Minimum Data Set dated 12/29/15 assessed Resident #6 with severely impaired cognition, required extensive staff assistance of 2 persons for activities of daily living (ADL) to include mobility, transfers, dressing and toileting, physically and verbally abusive and without impairments in range of motion.

A progress note dated 02/05/16 by the nurse practitioner (NP) revealed Resident #6 was referred by nursing for evaluation of morning agitation and persevering behaviors. Nursing reported that Resident #6 was noted increasingly agitated primarily in the morning. The progress note recorded that Resident #6 was noted by the NP to be very agitated, angry, and confused. Medications were adjusted and staff were to continue to monitor.

A Skin Monitoring Review for Resident #6 dated 02/15/16 did not record any changes or concerns with skin integrity.

Review of a nursing progress note dated 02/16/16 at 4:49 PM by Nurse #1 and the February 2016 Medication Administration Record recorded that Resident #6 was very combative towards staff that day. Nurse #1 documented that she administered Ativan 1 mg by mouth as needed for agitation at 07:40 AM with some positive effects and then Ativan 2 mg IM as

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needed for pain at 12:10 PM with slight positive effects.

A nursing progress note dated 02/16/16 at 4:56 PM by Nurse #1 recorded that nursing assistant (NA #1) verbalized she slapped Resident #6 during care when the Resident pulled her hair. The Medical Director was notified and assessed the Resident. Nurse #1 performed a full body assessment for Resident #6 and noted a deep reddened area to the Resident's right upper thigh.

A Skin Monitoring Review dated 02/16/16, completed by Nurse #1, recorded that Resident #6 had redness to her inner thighs and an irregular reddened area, approximately 3 inches long to the front of her upper right thigh.

An incident report dated 02/16/16 at 5:03 PM completed by the Director of Nursing (DON), recorded that NA #1 stated she struck Resident #6 on the leg and afterwards the Resident was noted with red marks on the right thigh.

A written statement by NA #1 dated 02/16/16 recorded that NA #1 struck Resident #6 on her leg on 02/16/16 around 10:00 AM when Resident #6 become combative and pulled the hair of NA #1. A Disciplinary Warning Notice dated 02/16/16, completed by the DON and signed by NA #1, recorded that NA #1 was suspended for an inappropriate way of dealing with a resident behavior.

A Consultation Report dated 02/16/16, completed by the DON, recorded a concern that NA #2 did not report abuse immediately, remove the employee from an abuse situation and report to another supervisor when the charge nurse was

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advised of abuse, but did not respond.

Review of a Health Care Personnel Registry (HCPR) 24 Hour Initial Report dated 02/16/16 completed by the Administrator, recorded that on 02/16/16 at 10:00 AM, NA #1 stated she struck Resident #6 on her leg to stop the Resident from pulling her hair. Resident #6 was noted with a red mark on her upper right thigh. NA #1 was immediately suspended. The report did not include the incident of physical abuse that occurred on 02/16/16 at 8:00 AM.

Review of the facility's investigation revealed a written statement by the Administrator, dated 02/19/16, which recorded that she spoke to the law enforcement on 02/16/16 around 9:00 PM and was asked if she was aware that NA #2 also witnessed NA #1 slap Resident #6 on 02/16/16 about 8:00 AM. The written statement recorded that the Administrator was not aware. The Administrator documented that she spoke to NA #2 on 02/17/16 and was informed that NA #2 witnessed NA #1 slap Resident #6 on the face on 02/16/16 around 8:00 AM and again on the right thigh above her knee at 10:00 AM, when the Resident became combative.

Written statements by NA #2, dated 02/17/16, recorded that on 02/16/16 at 7:30 AM, NA #2 witnessed Resident #6 become combative during morning care and NA #1 slapped Resident #6 on the left side of her face. NA #2 witnessed NA #1 leave the Resident's room and make a statement at the nurse's station that she "popped" Resident #6. NA #2 did not report the witnessed physical abuse against Resident #6 because she thought the nursing staff heard NA #1's statement. Later in the morning around 9:45 AM on 02/16/16, while

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in the shower room, NA #2 witnessed Resident #6 grab the hair of NA #1 and NA #1 slapped Resident #6 on the leg. NA #2 then witnessed NA #1 leave the shower room and report the incident to Nurse #1 and Nurse #2.

Written statements by Nurse #1 dated 02/16/16 and the Administrator dated 02/19/16 both recorded that Nurse #1 stated she was not made aware that NA #2 witnessed NA #1 slap Resident #6 on the left side of her face on 02/16/16 at 8:00 AM. NA #1 did self-report that she "popped" Resident #6 on the right thigh on 02/16/16 around 10:00 AM.

Review of a HCPR 5 Working Day Report dated 02/19/16, completed by the Administrator, recorded on 02/16/16 at 10:00 AM, NA #1 immediately reported that she slapped a combative resident on the leg during resident care and immediately knew what she did was wrong. The physical abuse was witnessed, NA #1 was immediately suspended, law enforcement was called at 6:00 PM, the allegation of abuse was substantiated and NA #1 was terminated. The report did not include the witnessed physical abuse that occurred on 02/16/16 at 8:00 AM.

An interview with NA #2 was conducted on 02/24/16 at 10:30 AM. NA #2 stated that she received a lot of abuse training recently and knew that if she witnessed abuse she should tell the nurse/supervisor, remove the resident from harm, watch the perpetrator and don't let the perpetrator go into any resident rooms. NA #2 stated that on 02/16/16 around 7:30 AM Resident #6 would not cooperate with staff and became combative during morning care (kicking, yelling and hitting). NA #2 stated she witnessed Resident #6 hit NA

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#1 twice, then witnessed NA #1 slap Resident #6 on the left side of her face and said "You are going to stop that." NA #2 stated the slap was more than just a pat on the face, but it wasn't a hard slap. NA #2 stated Resident #6 was already upset and remained upset. Both NAs continued getting Resident #6 dressed, placed her in her wheelchair and NA #1 took Resident #6 to the dining room. NA #1 stated that on the way to the dining room, NA #1 stopped at the nurse's station and told Nurse #1 "I popped (Resident #6)" and Nurse #1 said "Ok." NA #2 stated that she found out later that Nurse #1 did not hear NA #1's statement. NA #2 stated she felt that when NA #1 slapped Resident #6 that the incident fit the definition of abuse, but that she didn't know how to separate NA #1 from Resident #6. NA #2 further stated she did not think it would happen again and thought Nurse #1 heard NA #1 report the incident and would take care of it. NA #2 further stated that later that morning around 10:00 AM, both NA #1 and NA #2 were toileting Resident #6 in the shower room when the Resident became combative again. During care, NA #1 bent down to pull up the Resident's pants and Resident #6 grabbed NA #1's hair. That's when NA #1 slapped Resident #6 on her right thigh. NA #2 stated the slap was loud enough to hear, but she didn't know what to do. Resident #6 released her grip on NA #1 hair and they finished pulling up the Resident's pants, transferred her to the wheelchair and NA #2 took Resident #6 to the dining room. NA #2 stated that she observed NA #1 immediately go to the nurse's station and told Nurse #1 and Nurse #2 that she "popped" Resident #6 on the leg. Nurse #2 immediately left the unit and returned to the unit with the DON. NA #2 observed the DON talk to NA #1 and NA #1 was escorted off the unit. NA

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#2 stated the DON asked her on 02/16/16 what happened and she told the DON that NA #1 slapped Resident #6 on the left side of her face about 8:00 AM and then on her right thigh about 10:00 AM. NA #2 stated she also informed law enforcement on 02/16/16 when he interviewed her that evening on the phone and the Administrator on 02/17/16 when she talked to her on the phone.

A telephone interview was conducted on 02/24/16 at 12:55 PM with NA #1. She stated that she worked on the facility's secure unit as her permanent assignment and had recently received abuse training. NA #1 stated she was trained on how to identify abuse and if abuse was witnessed, she should remove the perpetrator from the resident, call law enforcement or the Administrator, and make sure the perpetrator and resident were both watched. NA #1 stated that on, 02/16/16 Resident #6 slapped her on the face and she responded by gently touching the Resident's face and said "Let's don't do that." NA #1 stated "I just touched her face with my hand" and NA #2 was present. NA #1 stated she went to the nurse's station after providing care to Resident #6 and told Nurse #1 that the Resident was a hand full, but she did not report touching her face because she did not think there was anything to it. NA #1 stated there was no mark left on the Resident's face. NA #1 stated later that morning around 10:00 AM, she and NA #2 were toileting Resident #6 in the shower room and the Resident became combative, worse this time. NA #1 stated that while she was pulling up the Resident's brief, the Resident grabbed her hair, pulling so hard "I was up on my tip toes", so "I smacked her on the right knee to get her to stop, I said stop and she stopped." NA #1 stated she

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struck her gently because it was not her nature to hurt anyone. Resident #6 continued yelling and hitting, we got her dressed and took her to the day room. NA #1 stated afterwards, she reported to Nurse #1 and Nurse #2 that she struck Resident #6 on the leg, the DON came and took a statement from her and she was suspended.

A telephone interview was conducted on 02/24/16 at 11:10 AM and a follow up interview was conducted on 02/25/16 at 3:30 PM with Nurse #1. During the interviews, Nurse #1 stated that on 02/16/16 there were 14 residents on the secure unit. Around 10:00 or 10:15 AM, NA #1 informed her that while NA #1 and NA #2 provided care to Resident #6 in the shower room, the Resident became combative and grabbed NA #1 by the hair. NA #1 stated she "popped" Resident #6 to get her to let go. Nurse #1 stated Nurse #2 (supervisor) was also present and heard the conversation. NA #1 stayed at the nurse's station with Nurse #1, while Nurse #2 reported the incident to the DON. The DON came to the unit, took a statement from NA #1 and she was suspended. Nurse #1 stated that NA #1 worked with all residents on the secure unit that day from 7:00 AM until she was suspended around 10:30 AM, but Nurse #1 was not aware of any prior incidents of abuse regarding NA #1. Nurse #1 stated she had not been informed that NA #2 witnessed NA #1 slap Resident #6 on the face earlier that morning. Nurse #1 stated Resident #6 was combative at times, usually required 2 staff to give her care. Nurse #1 stated that staff were trained that when residents became combative, staff should give the resident time to calm down, try to redirect and come back later to provide care. Nurse #1 stated Resident #6 was very combative that day and received Ativan (as

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needed) twice on her shift that day for agitation and later for pain. Nurse #1 stated Resident #6 did not cooperate initially with a skin assessment, and Ativan was given to calm her down. Once Resident #6 was calm, a full body skin assessment was completed, around 12:30 PM and she was noted with a reddened area to her right thigh about 3 inches long and irregular in shape. Nurse #1 stated there were no other changes noted to her skin or face.

The Administrator was interviewed on 02/24/16 at 3:52 PM. She stated that the DON informed her around lunch time on 02/16/16 that NA #1 "popped" Resident #6 on the knee in the shower room and reported herself. The DON told the Administrator that NA #1 was suspended and that she had started completing interviews for the investigation. The Administrator continued working in her office and sometime before 4:00 PM she obtained the necessary information from the DON to complete the HCPR 24 Hour Initial Report. The DON left for the day around 4:00 PM, but informed the Administrator before she left that she had obtained all the written statements and interviews. The Administrator did not review the investigation before the DON left because she thought the DON had done everything. The Administrator called law enforcement around 6:00 PM. The Administrator stated she went to see Resident #6 for the first time that day around 7:00 PM when law enforcement arrived. Both she and law enforcement observed Resident #6 without any marks to either thigh. The Administrator stated later that evening, around 9:00 PM, law enforcement called her and asked if she knew about another incident of abuse that happened earlier that day, but the Administrator stated she was not aware and she had not looked at the

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DON's investigation. The Administrator stated she called NA #2 sometime the next morning on 02/17/16 and obtained a statement from her over the phone regarding both incidents of physical abuse that were witnessed by NA #2 and reported to the DON. The Administrator asked NA #2 to provide written statements about what she saw. The Administrator stated she completed/faxed the HCPR 24 Hour Initial Report on 02/17/16 and the 5 Day Working Report on 02/22/16, but she did not complete a separate report for the incident of physical abuse that occurred on 02/16/16 around 8:00 AM because it was included in her investigation. The Administrator further said that now she realized that both incidents of physical abuse should have been reported to the HCPR.

Nurse #2 was interviewed on 02/25/16 at 10:28 AM. Nurse #2 stated she was the Nurse Supervisor on the 7AM - 3PM shift on 02/16/16. Nurse #2 and Nurse #1 were both at the nurse's station on the secure unit on 02/16/16 around 10:00 AM when NA #1 said "I just want everybody to know that I just popped (named Resident)." NA #1 proceeded to say that she "popped" Resident #6 because the Resident pulled her hair. Nurse #2 stated she asked NA #1 to stay at the nurse's station. Nurse #2 went to find the DON and report what occurred. The DON came to the secure unit, obtained a statement from NA #1 and she was suspended. Nurse #2 stated she was not aware of any previous incidents of abuse between NA #1 and Resident #6.

Attempts to interview the DON were unsuccessful.

The administrator was notified of immediate jeopardy on 02/24/16 at 5:27 PM

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LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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{F 226}	Continued From page 43	{F 226}		
{F 242} SS=D	An extended survey was conducted on 02/25/16. 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based record reviews, resident and staff interviews the facility failed to assess and honor the choice of bathing frequency for 1 of 3 residents sampled for choices. (Resident #24) The findings included: Resident #24 was readmitted to the facility on 12/18/15 with diagnoses that included hypertension, anxiety, depression, dysphagia, and weakness. Review of the most recent comprehensive significant change minimum data set (MDS) dated 11/06/15 indicated that it was very important to Resident #24 to choose between a tub bath, shower, bed bath, or sponge bath. This MDS also indicated Resident #24 required total assistance of two person for bathing. The MDS further indicated no behaviors were identified. Review of Resident #24's care guide dated 12/2015 that was kept in his closet in his room did not identify his bathing schedule or preferences. Review of a care plan dated 12/18/15 read in part that Resident #24 required assistance to restore	{F 242}	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care, interact with members of the community both inside and outside the facilt5iy, and make choices about aspects of this or her life in the facility that are significant to the resident. F 242 Self-Determination-Right to Make Choices 1) On 2/25/16, the Director of Nursing (DON) spoke with resident # 24 to assess and confirm his choice of bathing frequency in order to honor his right to make a choice. The DON then updated resident # 24□s bathing preference schedule to include Saturday a full bed bath in addition to being provided a full bed bath by Hospice services on	3/18/16

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{F 242}	Continued From page 44	{F 242}		

maximum function of self-sufficiency for bathing related to impaired mobility and physical limitations. The goal of said care plan stated that Resident #24 would be neat, clean, and odor free through the next review period. Interventions included: one person to provide some physical assistance with bathing and encourage Resident #24 to participate in self-care as ability permitted.
Review of the facility's master shower schedule revealed Resident #24's bed baths were scheduled on Wednesdays and Saturdays on second shift.
Review of the facility's bathing log dated 01/28/16 through 02/24/16 for Resident #24 revealed that Resident #24 had received no type of bathing or bathing assistance for 21 of the last 30 days.
Interview with Resident #24 on 02/23/16 at 3:02 PM revealed that he was waiting to get his bath for the day. Resident #24 stated that he had not been washed up at all and was waiting on the nursing assistant (NA) to come and wash him. Resident #24 also stated that he did not take showers due to chronic pain, so he took bed baths on Tuesdays and Thursdays when the hospice staff came and assisted him. Resident #24 stated that on the days that hospice is not there, the facility staff is "supposed to wash me up and they do not." Resident #24 further stated that he would be happy with 3 bed baths per week.
Interview with NA #4 on 02/24/16 at 8:49 AM revealed she was taking care of Resident #24 and that hospice staff completed his bed baths on Tuesdays and Fridays she believed but was not sure. NA #4 stated that Resident #24 was scheduled to receive a bed bath today but she was not sure if he would get one because he was on hospice services. NA #4 was not aware of Resident #24's bathing preference in regards to Tuesdays and Thursdays.

2) On 2/26/16, the social worker completed a 100% audit of all interviewable residents to assess their choice of bathing frequency. The results of the 100% audit was given to the DON to update the bathing preference schedule on 2/26/16.

3) On 2/26/16 the administrator in-serviced the admissions coordinator regarding asking the resident and/or resident□'s family about the resident□'s bathing preference as part of the admission□s process by utilizing a "Bathing Preference" questionnaire. The admission coordinator will then give a copy of the Bathing Preference questionnaire to the nursing department so the shower team can schedule the resident'□s bathing preference in order to honor his/her choice.

On 3/14/16, the Staff facilitator and social worker in-serviced regarding Self-Determination for all licensed nurses and certified nursing assistants. The Self-Determination in-service included: 1. Residents have the right to make choices about aspects of his or her life in the facility that are significant to the resident. 2. Each resident has the right to make choices about his or her bathing preference. All future employees will be in-serviced during their orientation process.

4) On 3/10/16, the DON and/or Social

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{F 242}	Continued From page 45 frequency, NA #4 just knew that hospice provided bed baths twice a week. In a follow up interview with Resident #24 on 02/24/16 at 8:57 AM he stated that he had finally received his bed bath yesterday at 4:00 PM when the hospice staff came to do it. Resident #24 also stated that the NA had shaved him yesterday while doing his bed bath, and that he had trimmed his own nails. Resident #24 stated that the only bed baths he received were the ones that hospice staff provided for him on Tuesdays and Thursdays, and this really bothered him because when he was able he took a shower once a day. Interview with NA #5 on 02/24/16 at 9:48 AM revealed that she was a part of the shower team and that Resident #24 was showered once a week on Saturday and that hospice staff came on Tuesdays and Thursdays but was not aware of whether Resident #24 received a bed bath or a shower. NA #5 was not aware of whether Resident #24 was actually showered on Saturdays, she was aware that was his scheduled shower day, NA#5 was not aware of Resident #24's bathing preferences in regards to frequency or preference of bed bath due to severe pain. Interview with the interim Director of Nursing (DON) on 02/24/16 at 5:51 PM revealed that on admission showers/bed baths are assigned by room number and if the resident wanted something different they needed to let the staff know and they would rearrange their shower schedule. The interim DON stated she thought the Admissions Director asked choices for laundry and hair services but that bathing preferences were not obtained to her knowledge. She further stated the resident could request a change in the shower/bathing schedule but if they did not request a change then the resident would stay on the schedule that was assigned by room	{F 242}	Service utilized a Bathing Preference Audit Tool to ensure residents are receiving their choice of bathing preference. The "Bathing Preference Audit Tool" will be completed weekly x twelve weeks, then monthly x three months. Any negative findings will be addressed immediately. The monthly QI committee will review results of the "Bathing Preference Audit Tool" monthly for 6 months for identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight	

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{F 242}	Continued From page 46 number. The interim DON was new to this role and was not aware that preferences on activities and care needed to be obtained from each resident. Interview with the Admission Director on 02/25/16 at 10:46 AM revealed bathing preferences were obtained every quarter when they interviewed 10% of the residents for satisfaction on facility practices. Admission Director was unable to provide any record of Resident #24's satisfaction survey being completed in the last year which would have included bathing preferences.	{F 242}		
{F 253} SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain clean wheelchairs for 7 of 11 wheelschairs on the 200 and 300 halls, for 2 of 6 halls (Rooms 201 B, 202 A, 202 B, 203 A, 204 B, 300 and 305 B). The findings included: On 2/22/2016 at 10:25 AM and on 2/24/2016 at 9:55 AM, tour of the facility's 200 and 300 halls was conducted. The wheel chairs of the residents in rooms 201 B, 202 A, 202 B, 203 A, 204 B, 300 and 305 B were observed to be dirty with dried food particles, food crumbs and dark colored spots. On 2/22/2016 at 10:25 AM, an observation of the wheelchair, which belonged to the resident who resided in room 204 B revealed the wheelchair's	{F 253}	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. F 253 Housekeeping & Maintenance Services 1) On 2/25/16,the housekeeping staff cleaned the wheelchairs for Rooms 201B, 202A, 202B, 203A, 204B, 300, and 305B. 2) On 2/26/16,the housekeeping supervisor completed a 100% audit of all resident wheelchairs for cleanliness. Any	3/18/16

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{F 253}	Continued From page 47 seat and frame was dirty with food particles and dirt and dust. Spots of dirt and food observed on the wheelchair were dried and dusty. On 2/22/2016 at 10:27 AM, an observation of the wheelchair, which belonged to the resident who resided in room 202 A revealed the wheelchair's seat and frame was dirty with food particles, dirt and dust. Spots of dirt and food observed on the wheelchair were dried and dusty. On 2/22/2016 at 10:27 AM, an observation of the wheelchair, which belonged to the resident who resided in room 202 B revealed the wheelchair's seat and frame was dirty with food particles, dirt and dust. Spots of dirt and food observed on the wheelchair were dried and dusty. On 2/22/2016 at 11: 32 AM, an observation of the wheelchair, which belonged to the resident who resided in room 300 revealed the wheelchair's seat and frame was dirty with food particles, dirt and dust. Spots of dirt and food observed on the wheelchair were dried and dusty. On 2/22/2016 at 11:40 AM, an observation of the wheel chair which belonged to the resident who resided in room 203 A revealed dried hard dirt along the wheelchair's frame and food particles in the seat of the wheelchair. On 2/22/2016 at 11:53 AM, an observation of the wheelchair which belonged to the resident who resided in room 305 B revealed the wheelchair's seat and frame was dirty with food particles, dirt and dust. Spots of dirt and food observed on the wheelchair were dried and dusty. On 2/24/2016 at 9:56 AM, an observation of the wheelchair which belonged to the resident who resided in room 201 B revealed the wheelchair's frame and seat cushion was dirty with dried dirt, dust and food particles along the edges of the seat cushion. On 2/24/2016 at 9: 56 AM, an observation of the	{F 253}	wheelchairs that were identified as not being clean were immediately scheduled for cleaning by the housekeeping staff. 3) On 2/26/16, a system was put in place by the housekeeping supervisor for cleaning wheelchairs. All resident wheelchairs are to be cleaned weekly and as needed during first and second shift by the housekeeping staff. A Wheel Chair Log will be completed by the housekeeping staff after wheelchairs are cleaned. The completed Wheel Chair Log will then be given to the facility administrator and the regional housekeeping director. On 2/26/16, the housekeeping supervisor in-serviced the housekeeping staff on cleaning wheelchairs. 4) On 3/1/16, the Maintenance Director began auditing the Wheel Chair Log on a weekly basis and ongoing. The Maintenance director will monitor for proper completion and follow up of the Wheel Chair Log tool by initialing the bottom right hand corner of the audit tool. The Environmental Supervisor will present findings of the Wheel Chair Log at the monthly QI committee meeting. The monthly QI committee will review the results of the monitoring for continued compliance. The monthly QI committee will review the results monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or	

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{F 253}	Continued From page 48 wheelchair which belonged to the resident who resided in room 203 A revealed the wheelchair's seat and frame was dirty with food particles, dirt and dust. Spots of dirt and food observed on the wheelchair were dried and dusty. On 2/24/2016 at 9:58 AM, an observation of the wheelchair which belonged to the resident who resided in room 300 revealed the wheelchair's seat and frame was dirty with food particles, dirt and dust. Spots of dirt and food observed on the wheelchair were dried and dusty. On 2/24/2016 at 9:58 AM, an observation of the wheelchair which belonged to the resident who resided in room 305 B revealed the wheelchair's seat and frame was dirty with food particles, dirt and dust. Spots of dirt and food observed on the wheelchair were dried and dusty. On 2/25/2016 at 8:41 AM, environmental rounds were conducted with the maintenance director and the housekeeping supervisor on the 200 and 300 halls to observe the wheelchairs for rooms 201 B, 202 A, 202 B, 203 A, 204 B, 300 and 305 B. The housekeeping supervisor stated that housekeeping was responsible for cleaning wheelchairs. He stated that wheel chairs were to be cleaned on a routine schedule every Tuesday. He stated that the wheelchairs were to be brought out to the rear of the building by the nursing staff and then the housekeeping staff would high power wash them and sanitize them and return them to the resident's room. The housekeeping supervisor stated that he had no specific cleaning schedules for specific halls or rooms and no specific notification of a wheelchair cleaning schedule was in place.	{F 253}	frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	{F 282}		3/18/16

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{F 282}	Continued From page 49 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to follow the plan of care when a resident became combative during nursing care. Staff failed to immediately stop nursing care when the resident became combative and approach the resident at a later time. This resulted in 2 incidents of physical abuse for 1 of 3 sampled residents reviewed with care plans which addressed problematic behaviors (Resident #6). Immediate Jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped a combative resident on the face and again on the right thigh (Resident #6). Each incident of physical abuse occurred on the secure unit and was witnessed by NA #2. NA #2 did not immediately intervene to protect Resident #6 and other residents on the secure unit from physical abuse. Resident #6 was assessed with reddened discoloration to her right thigh. The immediate jeopardy is present and ongoing. The facility provided the State Agency and Centers for Medicare and Medicaid an acceptable allegation of compliance (AOC) on 03/08/16. A revisit survey was conducted on 03/14/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following:	{F 282}	F282 Services by Qualified persons/per care plan The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident□s written plan of care 1) On 2/1/16 and 2/22/16 Resident #6□s care plan and care guide were reviewed by the Minimum Data Set Nurse (MDS) and found to be accurate and up to date without any concerns. The resident care plan includes problematic behavior characterized by ineffective coping behaviors of verbal and physical abuse, resistant to care/treatment as evidenced by yelling, cursing, swinging arms and delusional behavior. The care plan goals specify staff are to ensure resident safety. The care plans interventions include: approach resident calmly and slowly from the front, respect personal space, provide diversional activity, allow for flexibility in Activity of Daily Living (ADL) routine to accommodate mood, and when care is refused, leave and return in 5-10 minutes. 2) On 3/4/16, the MDS nurse reviewed 100% of the care plans and care guides for all residents identified through the MDS process with behaviors to ensure	

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{F 282}	Continued From page 50 Skin audits for all cognitively impaired residents dated 02/16/16 Documentation of interviews regarding abuse for all cognitively intact residents dated 02/16/16 Documentation of in-services (identifying/reporting abuse, caring for residents with dementia) for all currently employed staff completed by 03/07/16 Documentation of abuse monitoring on each shift which began on 02/26/16 and remained ongoing 24 hour/5 day reports for an allegation of abuse on 03/03/16 and an allegation of neglect on 02/27/16 A 24 hour/5 day report for Resident #6 for the 8:00 AM incident of abuse which had not previously been reported to the Health Care Personnel Registry (HCPR). Both reports were faxed the the HCPR on 02/25/16 Personnel files for all staff hired since 02/16/16 to include criminal background checks, reference checks, Nurse Aide Registry checks, license checks, and abuse training The facility's Abuse Policy Observations of nursing care, interviews with cognitively intact residents, interviews with family, interviews with all staff present in the facility on 03/14/16, review of all documentation to support the AOC and interviews with the facility's Administrator, Director of Nursing and the Nurse Practitioner provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F-282. The immediate jeopardy was removed on 03/14/16 at 7:15 PM. The facility remained out of compliance at F-282 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the	{F 282}	those behaviors were addressed on the care plan and care guide to include interventions needed during staff interaction with the resident. Ongoing, the MDS nurse will continue to identify resident with behaviors through the MDS process. Care plans and care guides are updated with each resident MDS assessment or a resident change in status. 3) On 3/1/16, the staff facilitator in-serviced at 100% all nurses and nursing assistants related to following resident care guides and care plans to ensure each resident is provided quality care and safety is maintained. During orientation of new employees nurses and nursing assistants will continue to be educated on the importance of following residents care plans and care guides and locations of each form. 4) The administrative nurses, DON, staff facilitator, and or MDS nurse began utilizing on 3/4/16 the audit tool "Following Care Guide" to ensure care guides are being followed to include interventions required to assist with management of residents identified with behaviors. Random audit of 20% of residents with identified behaviors will be reviewed weekly x 4 weeks, biweekly x8 weeks then monthly x 3 months. The monthly QI committee will review results of the "Following Care Guide" for any trends, actions taken and determine	

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{F 282}	Continued From page 51 implementation of their corrective action. The findings included: Resident #6 was admitted to the facility on 04/10/14. Diagnoses included dementia with behaviors, mood affective disorder, cognitive communicative deficit, paranoid delusional beliefs and psychosis. Resident #6 was currently being treated and followed by ongoing psychiatric services. Medical record review revealed Resident #6 had physician orders dated 08/31/15 for Ativan (antianxiety) 2 milligrams (mg) IM (intramuscular) injection as needed for pain. The resident had another physician's order dated 11/16/15 for Ativan 1 mg every 8 hours as needed for agitation. A quarterly Minimum Data Set dated 12/29/15 assessed Resident #6 with severely impaired cognition, required extensive staff assistance of 2 persons for activities of daily living (ADL) to include mobility, transfers, dressing and toileting, physically and verbally abusive and without impairments in range of motion. A care plan dated 12/29/15 recorded that Resident #6 had problematic behavior characterized by ineffective coping behaviors of verbal and physical abuse, resistive to treatment/care as evidenced by yelling, cursing, swinging arms and delusional behavior. The care plan's goal specified that staff were to ensure the resident's safety. The care plan's interventions included the following: approach calmly and slowly from the front, respect personal space,	{F 282}	the need for and /or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendation to the quarterly executive QA committee for further recommendations and oversight.	

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{F 282}	Continued From page 52	{F 282}		

provide diversion activity, allow for flexibility in ADL routine to accommodate mood, and when care is refused, leave and return in 5-10 minutes. Review of the "Resident care guide" revealed staff were encouraged to approach Resident #6 in a calm, reassuring manner and if care was refused, to approach the Resident later.

A progress note dated 02/05/16 by the nurse practitioner (NP) revealed Resident #6 was referred by nursing for evaluation of morning agitation and persevering behaviors. Nursing reported that Resident #6 was noted increasingly agitated primarily in the morning. The progress note recorded that Resident #6 was noted by the NP to be very agitated, angry, and confused. Medications were adjusted and staff were to continue to monitor.

Review of a nursing progress note dated 02/16/16 at 4:49 PM written by Nurse #1 and the February 2016 Medication Administration Record revealed that Resident #6 was very combative towards staff that day. Nurse #1 documented that she administered Ativan 1 mg by mouth as needed for agitation at 7:40 AM with some positive effects and then Ativan 2 mg IM as needed for pain at 12:10 PM with slight positive effects.

A nursing progress note dated 02/16/16 at 4:56 PM written by Nurse #1 recorded that nursing assistant (NA #1) verbalized she slapped Resident #6 during care when the Resident pulled her hair. The Medical Director was notified and assessed the Resident. Nurse #1 performed a full body assessment for Resident #6 and noted a deep reddened area to the Resident's right upper thigh.

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An incident report dated 02/16/16 at 5:03 PM completed by the Director of Nursing (DON), recorded that NA #1 stated she struck Resident #6 on the leg and afterwards the Resident was noted with red marks across the right thigh.

A written statement by NA #1 dated 02/16/16 recorded that NA #1 struck Resident #6 on her leg on 02/16/16 around 10:00 AM when Resident #6 become combative and pulled her hair.

Review of a written statement by the Administrator, dated 02/19/16, documented that she became aware on 02/16/16 around 9:00 PM that NA #2 also witnessed NA #1 slap Resident #6 on the face on 02/16/16 about 8:00 AM. The written statement recorded that the Administrator was not previously aware. The Administrator documented that she spoke to NA #2 on 02/17/16 and was informed that NA #2 witnessed NA #1 slap Resident #6 on the face on 02/16/16 around 8:00 AM and again on the right thigh above her knee at 10:00 AM, when the Resident became combative.

Written statements by NA #2, dated 02/17/16, recorded that on 02/16/16 at 7:30 AM, NA #2 witnessed Resident #6 become combative during morning care and struck NA #1 twice. Nursing care continued and Resident #6 continued to be combative. During the care, NA #1 slapped Resident #6 on the left side of her face. Later in the morning around 9:45 AM on 02/16/16, while in the shower room, Resident #6 again became combative and struck NA #1. Nursing care continued and NA #2 witnessed Resident #6 grab the hair of NA #1 and NA #1 slapped Resident #6 on the leg.

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An interview with NA #2 was conducted on 02/24/16 at 10:30 AM. NA #2 stated that on 02/16/16 around 7:30 AM Resident #6 would not cooperate with staff and became combative during morning care, kicking, yelling and hitting. NA #2 stated she witnessed Resident #6 hit NA #1 twice, then witnessed NA #1 slap Resident #6 on the left side of her face and said "You are going to stop that." NA #2 stated Resident #6 was already upset and remained upset. Both NAs continued getting Resident #6 dressed, placed her in her wheelchair and NA #1 took Resident #6 to the dining room. NA #2 stated she felt that when NA #1 slapped Resident #6 that the incident fit the definition of abuse, but that she didn't know how to separate NA #1 from Resident #6. NA #2 further stated she did not think it would happen again. NA #2 further stated that later that morning around 10:00 AM, both NA #1 and NA #2 were toileting Resident #6 in the shower room when the Resident became combative again and struck NA #1. During care, NA #1 bent down to pull up the Resident's pants and Resident #6 grabbed NA #1's hair. That's when NA #1 slapped Resident #6 on her right thigh. NA #2 stated she didn't know what to do. Resident #6 released her grip on NA #1 hair and they finished pulling up the Resident's pants, transferred her to the wheelchair and NA #2 took Resident #6 to the dining room.

A telephone interview was conducted on 02/24/16 at 12:55 PM with NA #1. She stated that she worked on the facility's secure unit as her permanent assignment. NA #1 stated that on, 02/16/16 Resident #6 slapped her on the face and she responded by gently touching the Resident's face and said "Let's don't do that." NA

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#1 stated "I just touched her face with my hand" and NA #2 was present. NA #1 stated she went to the nurse's station after providing care to Resident #6 and told Nurse #1 that the Resident was a hand full. NA #1 stated later that morning around 10:00 AM, she and NA #2 were toileting Resident #6 in the shower room and the Resident became combative, worse this time. NA #1 stated that while she was pulling up the Resident's brief, the Resident grabbed her hair, pulling so hard "I was up on my tip toes", so "I smacked her on the right knee to get her to stop, I said stop and she stopped." NA #1 stated she struck her gently because it was not her nature to hurt anyone. Resident #6 continued yelling and hitting, we got her dressed and took her to the day room. NA #1 stated she was trained to allow a combative resident time to calm down and come back later, but Resident #6 usually worked well with her. NA #1 stated that Resident #6 liked chocolate milk and this often worked to calm her down, but offering her chocolate milk did not work on 02/16/16. NA #1 confirmed that she did not stop providing nursing care to Resident #6 when the Resident became agitated, as she had been trained, but rather continued and completed the Resident care. NA #1 stated she knew striking Resident #6 was not the right thing to do, but NA #2 was not much help and so striking Resident #6, when she became combative, was just a reaction.

A telephone interview was conducted on 02/24/16 at 11:10 AM and a follow up interview was conducted on 02/25/16 at 3:30 PM with Nurse #1. During the interviews, Nurse #1 stated that on 02/16/16 around 10:00 or 10:15 AM, NA #1 informed her that while NA #1 and NA #2 provided care to Resident #6 in the shower room,

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the Resident became combative and grabbed NA #1 by the hair. NA #1 stated she "popped" Resident #6 to get her to let go. Nurse #1 stated that NA #1 worked with all residents on the secure unit that day from 7:00 AM until she was suspended around 10:30 AM, but Nurse #1 was not aware of any prior incidents of abuse regarding NA #1. Nurse #1 stated she had not been informed that NA #2 witnessed NA #1 slap Resident #6 on the face earlier that morning. Nurse #1 stated Resident #6 was combative at times, usually required 2 staff to give her care. Nurse #1 stated that staff were trained that when residents became combative, staff should give the resident time to calm down, try to redirect and come back later to provide care. Nurse #1 stated Resident #6 was very combative that day and Nurse #1 heard Resident #6 yelling at staff during care both around 8:00 AM and 10:00 AM. Nurse #1 stated Resident #6 received Ativan (as needed) twice on her shift that day for agitation and later for pain. Nurse #1 stated she did not assist the NAs with nursing care as it was only reported to her that Resident #6 was a hand full and thought the prn Ativan Resident #6 received for agitation was effective.

The Administrator was interviewed on 02/24/16 at 3:52 PM. The Administrator stated that it was her expectation that staff ensure the safety of combative residents during nursing care and if Resident #6 required the assistance of 2 nursing staff, then depending on whether or not the staff could get to the call bell would determine whether or not staff could call for additional assistance when Resident #6 became combative.

The Medical Director was interviewed on 02/25/16 at 3:36 PM. The Medical Director stated

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{F 282}	Continued From page 57 he was in the facility on 02/16/16 and was informed that Resident #6 was combative that day, struck a staff member and the staff member was witnessed to strike back. The Medical Director stated that he was very familiar with Resident #6 and knew that at times she was quite combative, resistive to care and would strike out and try to hit at staff. The Medical Director stated he expected nursing staff to immediately stop nursing care if a resident became combative, allow the resident time to calm down, to notify the supervisor for assistance, to continue to monitor and approach later. Attempts to interview the DON were unsuccessful. The administrator was notified of immediate jeopardy on 02/24/16 at 5:27 PM. An extended survey was conducted on 02/25/16.	{F 282}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review, the facility failed to position a resident in her wheel chair with foot/leg	{F 309}	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the	3/18/16

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{F 309}	Continued From page 58 support to prevent a decline in range of motion for 1 of 3 sampled residents reviewed for well-being (Resident #80). The findings included: Resident #80 was admitted to the facility on 02/01/12. Diagnoses included rhabdomyolysis, difficulty walking, general muscle weakness, abnormality of gait and mobility, history of falling, and dementia without behavioral disturbances, among others. An annual Minimum Data Set, dated 12/10/15 assessed Resident #80 with severely impaired cognition, delirium, disorganized thinking, extensive staff assistance of 1 person for mobility, extensive staff assistance of 2 persons for transfers and locomotion, not steady, only able to stabilize with staff assistance when moving from seated to standing and surface to surface, and a wheelchair for mobility. A care plan dated 03/01/16 and Resident Care Guide identified Resident #80 with chronic progressive decline in intellectual function, at risk for functional decline and falls characterized by deficit in memory and judgement due to her diagnosis of dementia. Interventions included to assist with transfers/mobility, use of a low wheelchair, a raised front wedge cushion, dycem (non-slip material) under top cushion, personal alarm, anti-tippers, anti-roll back brakes, and to elevate legs when in wheelchair. Resident #80 was observed without her legs elevated while in her wheel chair on the following dates/times:	{F 309}	highest practicable physical, mental and psychosocial well-being in accordance with the compressive assessment and plan of care. F309 1) On 2/25/16, the administrator directed the nursing assistant to place foot rests on Resident #80'□s wheelchair so the resident□s legs were no longer dangling and her feet were not pointing towards the floor. On 2/25/16, the MDS nurse reviewed Resident #80□'s care plan. The care plan already included having Resident #80'□s legs elevated. The MDS nurse on 3/3/16 added to the care plan on and care guide to have leg rests on wheelchair with feet placed on pedals. The MDS nurse placed the updated care guide in Resident #80□s closet. 2) On 2/29/16, the Director of Nursing (DON) completed a 100% audit of all residents, using a resident roster, to identify any resident in need of leg rests with foot pedals added to their wheelchair. Any residents in need of leg rests and/or foot pedals were addressed. 3) On 3/1/16, 100% of nursing staff were in-serviced to follow the resident care plans and care guides. On 3/14/16, staff facilitator in-serviced all nurses and nursing assistants regarding positioning of resident□s feet while in a wheelchair.	

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{F 309}	Continued From page 59 02/22/16 10:52 AM Resident #80 was in her wheelchair, seated on a thick cushion, in her room while receiving water from a staff member, facing the television, wheelchair positioned parallel to her bed, both feet crossed at the ankle, hanging approximately 4 inches off the floor. When her feet were relaxed, both feet pointed downward towards the floor. 02/23/16 4:36 PM Resident #80 was in her wheelchair, seated on a thick cushion, in her room, facing the television, wheelchair positioned parallel to her bed, both feet hung approximately 4 inches off the floor. When her feet were relaxed, both feet pointed downward towards the floor. 02/24/16 6:39 AM Resident #80 was in her wheelchair, seated on a thick cushion, at the nurse's station, both feet crossed at the ankles, hanging approximately 4 inches off the floor. When her feet were relaxed, both feet pointed downward towards the floor. On 02/24/16 at 06:39 AM, Nurse #6 stated he worked routinely with Resident #80 on the 11PM - 7 AM shift. Nurse #6 stated that Resident #80 had "happy feet" because she kicked her feet all the time when in her wheelchair. Nurse #6 stated he had not observed Resident #80 with foot/leg rests to her wheelchair as long as he had worked with her, but sometimes staff placed a chair in front of her to elevate her legs, so she did not kick her feet. Nurse #6 stated staff were concerned that she would kick her feet so hard that she might overturn in her wheelchair. Nurse #6 asked Resident #80 to relax her feet and noted that both feet pointed in a downward direction, he stated " Her feet are starting to	{F 309}	4) The audit tool for Privacy/ Choices/ADL□s/Wheelchairs will be monitored by administrative staff/nursing staff during rounds to ensure residents□ legs are not dangling, feet rest are in place if needed and feet are not pointing down while sitting in their wheelchair. The audit will be completed daily 5x a week x4 weeks, 1x a week x8 weeks and 1x per month x3 months. The Administrator, DON and/or ADON will review each Privacy/Choices/ADL□s/Wheelchair Audit tool weekly to verify completion and correct any identified concerns. The monthly QI committee will review results of the Privacy/Choices/ADL□s/ Wheelchair audit tool results monthly for 6 months for identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA	

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drop," but stated he had not noticed that before nor had he referred her to therapy due to a lack of foot/leg support when she was in her wheelchair.

An interview on 02/24/16 at 06:41 AM with Nurse Aide (NA) #6 revealed she worked with Resident #80 routinely on the 11PM - 7AM shift, occasionally on other shifts and assisted Resident #80 to her wheelchair that morning. NA #6 stated she was not aware that Resident #6 was to have her legs elevated while in the wheelchair. NA #6 further stated that the Resident's feet/legs either hung while she was seated in the wheelchair or she kicked her feet. NA #6 stated she never saw Resident #80 use foot/leg rests in her wheelchair.

An interview on 02/24/16 at 11:53 AM with the Therapy Manager revealed she was aware that Resident #80 used a low seated wheel chair without foot/leg rests and had observed Resident in her wheel chair with her feet hanging above the floor. The Therapy Manager stated that Resident #80 liked to put her feet up on a chair, on foot/leg rests or on her bed. The Therapy Manager stated that Resident #80 could elevate her legs herself and staff should position her to allow her to elevate her legs. The Therapy Manager stated that Resident #80 should have a chair, leg/foot rests or be positioned such that she could prop her feet up on a bed in a low position while seated in her wheelchair to prevent a decline in range of motion. The Therapy Manager stated that the family of Resident #80 declined therapy services since admission and Resident #80 was on the facility's list of residents that could not receive therapy services due the family's request. The Therapy Manager stated that Resident #80 was in the best wheelchair for her, with the seat

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{F 309}	Continued From page 61 as low as it could go, but staff had not tried a thinner cushion to see if that would allow her feet to reach the floor. An interview on 02/25/16 at 08:48 AM with the Interim Director of Nursing (DON) revealed Resident #80 kicked her feet routinely when in her wheel chair, but liked to prop her feet up. The Interim DON stated that she expected Resident #80 to be positioned in her wheel chair such that her feet reached the floor or to have her feet elevated when in her wheel chair for safety and to prevent a decline in range of motion.	{F 309}		
{F 312} SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, and staff interviews the facility failed to provide bed baths and failed to keep fingernails clean for 2 of 5 residents sampled for activities of daily living (ADL) (Residents #24 and #112). The findings included: 1. Resident #24 was readmitted to the facility on 12/18/15 with diagnosis that included: hypertension, anxiety, depression, dysphagia, and weakness. Review of the most recent quarterly Minimum Data Set (MDS) dated 01/25/16 indicated that Resident #24 was cognitively intact and required total assistance of	{F 312}	F 312 ADL Care Provided for Dependent Residents 1) On 2/25/16, Resident #24 was provided a bed bath, shave, clothing change. On 2/25/16, Resident #112 was provided assistance with nail care. 2) On 2/26/16 a 100% audit of all residents shower reviews for the past three days were completed by the Director of Nursing.	3/18/16

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{F 312}	Continued From page 62 one person for bathing. The MDS further indicated no behaviors were identified. Review of a care plan dated 12/18/15 read in part that Resident #24 required assistance to restore maximum function of self-sufficiency for bathing related to impaired mobility and physical limitations. The goal of said care plan stated that Resident #24 would be neat, clean, and odor free through the next review period. Interventions included: one person to provide some physical assistance with bathing and encourage Resident #24 to participate in self-care as ability permitted. Review of the facility's master shower schedule revealed Resident #24's bed baths were scheduled on Wednesdays and Saturdays on second shift. Review of the facility's bathing log dated 01/28/16 through 02/24/16 for Resident #24 revealed that Resident #24 had received no type of bathing or bathing assistance for 21 of the last 30 days. Observation of Resident #24 on 02/23/16 at 3:02 PM revealed Resident #24 was lying in the bed with eyes open, he had not been shaved with whiskers approximately a quarter inch long and Resident #24 was wearing the same red t-shirt that had his initial's embroidered on the lower left corner of the shirt that he was wearing the previous day. Interview with Resident #24 on 02/23/16 at 3:02 PM revealed that he was waiting to get his bath for the day. Resident #24 stated that he had not been washed up at all and was waiting on the nursing assistant (NA) to come and wash him. Resident #24 also stated that he does not take showers due to chronic pain, so he took bed baths on Tuesdays and Thursdays when the hospice staff came and assisted him. Resident #24 stated that on the days that hospice is not there, the facility staff is "supposed to wash me	{F 312}	On 2/26/16 a 100% audit of all residents fingernails was completed by the Director of Nursing and staff nurse. Any resident requiring assistance with a bath, shower, shaving, fingernail care, activity of daily living (ADL)care was provided at time of audit. 3) On 3/10/16 the staff facilitator in-serviced nurses and nursing assistants regarding assistance with ADL care. 4) The "Privacy/Choice/ADLs/Wheelchair Audit Tool" will be monitored by the administrative staff team. Administrative staff team (administrator, DON, ADON, staff facilitator, MDS, admissions, social worker, activity director, dietary manager, housekeeping supervisor, maintenance director) will notify assigned nursing staff of any ADL care needed. Nursing staff will provide ADL care at the time the need for care is identified. To make sure ADL solutions are sustained, monitoring will be done 5x a week x4 weeks, 1x a week x 8 weeks and 1x per month x 3 months. The administrator, DON, ADON, and/or staff facilitator will review the ADL audit tools at least once weekly to verify completion, ensure residents are receiving bathing, shaving, nail care, and clothing change and solutions are sustained. The monthly QI committee will review results of the audit tools results monthly for 6 months for identification of trends, actions taken and to determine the need	

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{F 312}	Continued From page 63 up and they do not." Interview with NA #4 on 02/24/16 at 8:49 AM revealed she was taking care of Resident #24 and that hospice staff completed his bed baths on Tuesdays and Fridays she believed but was not sure. NA #4 stated that Resident #24 was scheduled to receive a bed bath today but she was not sure if he would get one because he was on hospice services. In a follow up interview with Resident #24 on 02/24/16 at 8:57 AM he stated that he had finally received his bed bath yesterday at 4:00 PM when the hospice staff came to do it. Resident #24 also stated that the NA had shaved him yesterday while doing his bed bath, and that he had trimmed his own nails. Resident #24 stated that the only bed baths he received were the ones that hospice staff provided for him on Tuesdays and Thursdays, and this really bothered him because when he was able he took a shower once a day. Interview with NA #5 on 02/24/16 at 9:48 AM revealed that she was a part of the shower team and that Resident #24 was showered once a week on Saturday and that hospice staff came on Tuesdays and Thursdays but was not aware of whether Resident #24 received a bed bath or a shower. Interview with the Interim Director of Nursing (Interim DON) on 02/24/16 at 5:51 PM revealed that on admission showers/bed baths are assigned by room number and if the resident wanted something different they needed to let the staff know and they would rearrange their shower schedule. The Interim DON stated that it was her expectation that if hospice performed bed baths on Tuesdays and Thursdays the staff is expected to do partial bed baths on the other days of the week and record them on the bathing log in their computer system. The Interim DON	{F 312}	for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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{F 312}	Continued From page 64	{F 312}		

further stated that she was not aware that the staff was not performing the bed baths like she expected.

2. Resident #112 was admitted to the facility on 10/23/15 with diagnoses of peripheral vascular disease, Cerebrovascular Accident and hemiplegia.
Review of the quarterly Minimum Data Set dated 01/22/16 revealed Resident #112 was moderately cognitively impaired and required extensive assistance with personal hygiene and was dependent for bathing.
Review of the care plan dated 01/28/16 revealed Resident #112 required assistance to restore or maintain maximum function of self-sufficiency for personal hygiene characterized by the following functions; shaving, mouth care, daily maintaining of appearance related to impaired mobility. The goal was for Resident #112 to be neat, clean and odor free through the next review. The interventions included providing constant supervision with physical assistance.
Observations of Resident #112's fingernails revealed the following:
· 02/22/16 at 12:15 PM Fingernails on both hands were approximately ¼ inch long with brown debris under all fingernails.
· 02/23/16 at 3:45 PM Fingernails on both hands were approximately ¼ inch long with brown debris under all fingernails.
· 02/24/16 at 2:56 PM Fingernails on both hands were approximately ¼ inch long with brown debris under all fingernails.
· 02/25/16 at 10:12 AM Fingernails on both hands were approximately ¼ inch long with brown debris under all fingernails.
During an interview with Resident #112's

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{F 312}	Continued From page 65 Responsible Party (RP) on 02/22/16 at 12:45 she stated she would like for the facility to keep Resident #112's fingernails cleaned and trimmed. She stated she could not recall staff cleaning or trimming Resident #112's fingernails. An interview conducted with nurse aide (NA) #3 on 02/25/16 at 10:27 AM revealed nail care was to be done during resident showers and as needed. NA #3 stated she gave Resident #112 his shower and cleaned under his fingernails with a wash cloth. She stated she could not trim his fingernails because he was a diabetic and the NAs were not allowed to trim nails on a resident with diabetes. She stated the nurses did nail care on residents with diabetes. An interview conducted with Nurse #3 on 02/25/16 at 10:29 AM revealed nail care was to be provided by the NAs during showers and as needed unless the resident had diabetes and then the nurse should provide nail care as needed. Nurse #3 and NA#3 were accompanied to Resident #112's room on 02/25/16 at 10:30 AM to observe Resident fingernails and confirmed there was brown debris underneath each nail and his fingernails should have been cleaned and trimmed. During an interview conducted on 02/25/16 at 3:09 PM the Interim Director of Nursing stated it was her expectation for nail care to be performed with showers and as needed by NAs and as needed by nurses for residents with diabetes.	{F 312}		
{F 315} SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the	{F 315}		3/18/16

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{F 315}	Continued From page 66 resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and Physician and staff interviews the facility failed to change an indwelling urinary Foley catheter per physician order for 1 of 1 resident reviewed for catheter care (Resident #112). The findings included: Resident #112 was admitted to the facility on 10/23/15 with diagnoses of peripheral vascular disease, cerebrovascular accident, hemiplegia and neurogenic bladder. Review of the quarterly Minimum Data Set dated 01/22/16 revealed Resident #112 was moderately cognitively impaired and had an indwelling urinary catheter. Review of the care plan dated 01/28/16 revealed Resident #112 had an altered pattern of urinary elimination with an indwelling Foley catheter and was at risk for infection. The goal was for Resident #112 to be free from urinary tract infection through the next review. Interventions included catheter care per facility protocol and change Foley catheter per physician orders and/or facility protocol. Review of physician order's dated 11/08/15 revealed Resident #112's indwelling urinary Foley catheter was to be changed every 30 days. Review of the treatment records (TAR) for	{F 315}	F 315 No Catheter, Prevent UTI, Restore Bladder 1) On 2/25/16, the staff nurse contacted Resident #112'□s physician and obtained an updated Foley catheter order. On 2/25/16, Resident #112'□s Foley catheter was changed according to the Foley catheter order dated 2/25/16. 2) On 3/7/16, the Director of Nursing (DON) audited all residents with a foley catheter to ensure they were being changed as ordered. No negative findings. 3) On 3/7/16 the DON initiated an in-service for 100% of nurses regarding the timely and accurate transcription of physician orders to the medication administration records(MAR) or the treatment administration records(TAR),to include orders to change a Foley catheter. 4) On 3/7/16, the DON, QI nurse, staff facilitator, and/or evening charge nurse will utilize the "Foley Catheter Audit Tool" to validate Foley catheter orders are transferred over from the current month to	

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{F 315}	Continued From page 67 Resident #112 revealed the following: · 11/01/15 through 11/30/15 - change the Foley catheter every 30 days. Documented on TAR as changed on 11/08/15. · 12/01/15 through 12/31/15 - no order to change the Foley catheter every 30 days on TAR. · 01/01/16 through 01/31/16 - no order to change the Foley catheter every 30 days on TAR. · 02/01/16 through 02/25/16 - no order to change the Foley catheter every 30 days on TAR. Review of the nurse's notes from 10/23/15 through 02/25/16 revealed no note that Resident #112's urinary Foley catheter had been changed. Review of the nurse's note dated 01/14/16 at 6:25 AM revealed Nurse #5 deflated the balloon of Resident #112's urinary Foley catheter and retracted the Foley catheter out some due to bleeding around the external urethra. Review of nurse's note dated 01/15/16 at 11:36 PM revealed Resident #112 had an episode of vomiting and an anti-nausea medication was administered. Vital signs were as follows: blood pressure - 140/78, pulse - 54, respirations - 18, temperature - 103 axillary. Nurse's note dated 01/16/16 at 12:20 AM revealed Resident #112 was sent to the emergency room via emergency management system. Review of the hospital discharge summary revealed Resident #112 was admitted to the hospital for severe sepsis most likely due to catheter associated urinary tract infection from his indwelling Foley catheter. Resident #112 was managed in the intensive care unit with sepsis being gradually resolved at discharge back to the facility on 01/21/16. An observation made on 02/22/16 at 11:30 AM revealed Resident #112 had an indwelling urinaryfoley catheter draining clear, yellow urine. An interview conducted with Nurse #4 on	{F 315}	the new months. The audit will be completed within 5 days of the end-of-month MAR and TAR reconciliation and continue monthly for 6 months. The DON/ADON, nursing supervisor, and/or staff facilitator will review the completed "Foley Catheter Audit Tool" to ensure proper transcription of Foley catheter orders are completed. The DON/ADON and/or nursing supervisor will initial the bottom right corner of the "Foley Catheter Audit Tool" with the date for a period of six months. The DON/ADON, nursing supervisor, and/or staff facilitator, will monitor the TARs using the "Foley Catheter Audit Tool" to ensure catheter changes have been completed as ordered. The audit will be completed weekly x 4 weeks, biweekly times 8 weeks,then monthly x 3 months. The DON will present all findings from the "Foley Catheter Audit Tools" to the monthly QI committee meetings for recommendations as appropriate to maintain continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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{F 315}	Continued From page 68 02/24/16 at 9:40 AM revealed she did not know when Resident #112's urinary Foley catheter had last been changed. She stated the last documented urinary foley catheter change on the TAR was 11/08/15 and there were no orders on the TAR for 12/2015, 01/2016 and 02/2016 to change the urinary Foley catheter every 30 days. Nurse #5 stated the order to change the urinary Foley catheter every 30 days did not get transcribed to the TAR after 11/2015 so she wouldn't have known it needed to be changed. An interview conducted with Nurse #3 on 02/25/16 at 10:15 AM revealed she normally worked the 3:00 PM to 11:00 PM shift with Resident #112. She reviewed the February 2016 TAR for Resident #112 with the surveyor and confirmed there was no order to change Resident #112's urinary Foley catheter every 30 days. She stated she did not know when Resident #112's urinary Foley catheter had last been changed because it had not been documented on the TAR for February 2016 and stated it should have been written on the TAR what day of the month and what shift Resident #112's urinary Foley catheter was to be changed. Nurse #5 further stated each nurse on the floor was assigned a couple of charts each month to transcribe orders from the previous month to the next month to the TAR and was not sure if anyone checked the orders behind the person that transcribed them. An interview conducted with the facility Physician on 02/25/16 at 1:41 PM revealed he was not aware the urinary Foley catheter order had not been placed on the TAR for 12/2015, 01/2016 and 02/2016. He stated he expected the urinary catheters to be changed every 30 days as ordered. The physician further stated there was always the risk of infection from an indwelling urinary Foley catheter and not changing the	{F 315}		

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{F 315}	Continued From page 69 catheter as ordered could have caused the infection leading to Resident #112's hospitalization on 01/16/16. A phone call was attempted on 02/25/16 at 2:45 PM with Nurse #5 due to her no longer being employed by the facility. A message was left but Nurse #5 did not return surveyors call. During an interview conducted with the Interim Director of Nursing (DON) on 02/25/16 at 3:00 PM she revealed the order to change Resident #112's urinary catheter every 30 days had not been transcribed to the TAR in 12/2015, 01/2016 and 02/2016 and she could not find any documentation in the medical record of the urinary Foley catheter being changed since 11/08/15. The Interim DON further stated she had interviewed nurses that provided care to Resident #112 and none of them recalled changing Resident #112's urinary Foley catheter. The DON stated Resident #112's urinary Foley catheter should have been changed every 30 days and the order to change the catheter should have been documented on the TAR.	{F 315}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	{F 441}		3/18/16

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{F 441}	Continued From page 70 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to follow contact precautions while setting up a meal tray for a resident on contact isolation for 1 of 1 resident on contact isolation observed for dining on the 700 hall (Resident #137). The findings included: Resident #137 was admitted to the facility on 01/20/16 with diagnoses of clostridium difficile (c diff), bacteria that can cause severe diarrhea to life-threatening inflammation of the colon. Review of the facility Infection Control Policy	{F 441}	F 441 Infection Control 1) On 2/26/2016 the Director of Nursing (DON) reviewed resident # 137□'s chart and physician□s order to ensure correct isolation precautions were implemented, correct signage for contact precautions was on the resident□s door, and the over the door storage bin for personal protective equipment (PPE) was stocked with needed supplies to include gowns and gloves.	

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{F 441}	Continued From page 71 dated 09/2014 revealed contact isolation precautions were to be followed by all staff. An observation made on 02/22/16 at 12:30 PM revealed Resident #137's room had a red Contact Isolation sign on the door that read in part: wear gloves when entering room. Wear a gown if expected to be soiled in any way. An observation made of Nurse #4 setting up the lunch tray for Resident #137 on 02/22/16 at 12:40 PM revealed Nurse #4 taking the lunch tray from the cart, knock on Resident #137's door and enter her room with her lunch tray. Nurse #4 did not don gloves when entering Resident #137's room. Nurse #4 placed the meal tray on Resident #137's over bed table and positioned the over bed table for Resident #137 to reach her tray. Nurse #4 took the lid off of the plate, removed silverware from the packet and opened the straw for Resident #137. Nurse #4 then exited Resident #137's room without washing her hands. Nurse #4 used hand sanitizer from her pocket when she came out into the hall and proceeded to take another tray from the lunch cart to give to another resident. An interview conducted with Nurse #4 on 12/22/16 at 12:55 PM revealed she did not wear gloves during the set-up of Resident #137's lunch tray because she did not touch anything but the tray while she was in the room. Nurse #4 stated she used hand sanitizer between passing meal trays instead of handwashing because it took less time. During an interview conducted with the Interim Director of Nursing (DON) on 02/23/16 at 11:30 AM she stated she expected staff to wear gloves when setting up meal trays for residents on contact isolation precautions and staff had been trained to wash their hands before leaving the room of a resident on isolation precautions. The	{F 441}	2) On 2/26/16 the DON reviewed all residents with isolation precautions including contact precautions to ensure the correct isolation precautions were implemented with the appropriate signage and over the door storage bin for PPE were in place for each identified resident. No negative findings were identified. 3) On 3/2/16 the DON and Staff facilitator in-serviced all facility staff on Infection Control. The Infection Control in-service included the following: 1. The facility must establish an infection control program under which it----Decides what procedures, such as isolation should be applied to an individual resident. Contact precautions help prevent transmission of infectious agents 2. All employees must follow the signage for precautions to include contact precaution when entering a resident□s room. 3. This includes wearing gloves when entering a resident□s room who is on contact precautions to set up a resident□s meal tray. 4. Each employee must wash their hands after glove use to include when exiting a resident□s room who is on contact precautions to prevent the spread of infection to another resident□s room. For example, when you are exiting a resident□s room who is on contact precautions, you must remove your gloves and wash your hands before delivering a meal tray to another resident□s room. No	

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{F 441}	Continued From page 72 Interim DON further stated hand sanitizer did not kill c diff and that was why it was important to use soap and water for handwashing before leaving the residents room.	{F 441}	employee will work until in-service is completed. All future employees will continue to be in-serviced during their orientation process. 4) On 2/26/16 the DON and/or staff facilitator utilized a "Resident Care Audit Tool" to ensure staff follows isolation precautions for residents who are on contact precautions. The "Resident Care Audit Tool" will be completed five times weekly x 4 weeks, twice weekly x 4 weeks, weekly x 4 weeks, and monthly x 12 weeks. Any negative findings will be addressed immediately by the DON and/or staff facilitator by providing retraining. The DON will present all findings at the monthly QI committee meeting. The monthly QI committee will review the results of the "Resident Care Audit Tool" monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight	
{F 490} SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	{F 490}		3/18/16

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{F 490}	Continued From page 73 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of facility records, the facility administrative staff failed to create and impose a culture that all residents would be protected from abuse and that staff would implement the facility's abuse policy and procedures to intervene, protect and immediately report abuse when witnessed. A combative resident experienced 2 episodes of physical abuse without immediate facility intervention, protection and implementation of abuse policies and procedures for 1 of 1 sampled residents reviewed for abuse (Resident #6). Immediate jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped Resident #6 on the face and the witness, NA #2 did not intervene and did not immediately report to administrative staff for protection of Resident #6 and other residents. A second incident of physical abuse occurred on 02/16/16 when NA #1 slapped Resident #6 on the right thigh and the witness, NA #2 did not intervene for the protection of Resident #6. Immediate jeopardy is present and ongoing. The facility provided the State Agency and Centers for Medicare and Medicaid an acceptable allegation of compliance (AOC) on 03/08/16. A revisit survey was conducted on 03/14/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for	{F 490}	A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. F490 1) On 2/16/16, Resident#6 was assessed by the Medical Director. No new orders were received. On 2/16/16, Resident#6 was assessed by Nurse #1 which included a head to toe assessment. The findings revealed a reddened area on the upper right thigh and small healing bruises. Resident #6 still resides in the facility. On 2/16/16 NA #1 was suspended from employment and terminated on 2/22/16. 2) On 2/16/16, staff nurses completed 100% body audit on all cognitively impaired residents in the facility for evidence of abuse. No negative findings were identified. On 2/16/16, the social worker interviewed all alert and oriented residents related to abuse and resulting in no negative responses.	

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{F 490}	Continued From page 74 review of the following: Skin audits for all cognitively impaired residents dated 02/16/16 Documentation of interviews regarding abuse for all cognitively intact residents dated 02/16/16 Documentation of in-services (identifying/reporting abuse, caring for residents with dementia) for all currently employed staff completed by 03/07/16 Documentation of abuse monitoring on each shift which began on 02/26/16 and remained ongoing 24 hour/5 day reports for an allegation of abuse on 03/03/16 and an allegation of neglect on 02/27/16 A 24 hour/5 day report for Resident #6 for the 8:00 AM incident of abuse which had not previously been reported to the Health Care Personnel Registry (HCPR). Both reports were faxed the the HCPR on 02/25/16 Personnel files for all staff hired since 02/16/16 to include criminal background checks, reference checks, Nurse Aide Registry checks, license checks, and abuse training The facility's Abuse Policy Observations of nursing care, interviews with cognitively intact residents, interviews with family, interviews with all staff present in the facility on 03/14/16, review of all documentation to support the AOC and interviews with the facility's Administrator, Director of Nursing and the Nurse Practitioner provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F-490. The immediate jeopardy was removed on 03/14/16 at 7:15 PM. The facility remained out of compliance at F-490 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the	{F 490}	On 2/19/16 NA#2 was disciplined for failure to report immediately allegation of abuse according to the Abuse Policy. On 2/25/16 NA #2 was terminated for not providing safety for Resident#6. 3) On 2/25/16, the administrator received an in-service from the corporate Vice President of Operations on F Tags 225 and 490. The in-service included the following: The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and 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/her 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. A 24 hour and 5 day report is required for each allegation, including allegations identified during an investigation and/or	

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{F 490}	Continued From page 75 facility continues the process of monitoring the implementation of their corrective action. The findings included: Cross refer to F 223 - Based on staff interviews and record review, the facility failed to protect a resident's right to be free from physical abuse with immediate intervention when a resident became combative during nursing care. A resident was physically abused twice when a staff member slapped her across the face and then on the right thigh for 1 of 1 sampled residents reviewed for abuse. (Resident #6). Cross refer to F225 - Based on staff interviews and record review, the staff failed to immediately notify administrative staff of a witnessed incident of physical abuse in which a resident was slapped on the face. Once notified, the facility failed to report the incident of physical abuse to the Health Care Personnel Registry in 24 hours and the investigative findings in 5 working days for 1 of 1 sampled residents. (Resident #6). Cross refer to F 226 - Based on staff interviews and record review, the facility failed to immediately stop nursing care when a resident (Resident #6) became combative to prevent an incident of physical abuse, intervene when physical abuse was observed, and immediately remove the perpetrator from a combative resident on a secure unit. The facility failed to report a witnessed incident of physical abuse to the Health Care Personnel Registry in 24 hours and the investigation in 5 working days. The facility failed to follow their abuse policy and procedures in the areas of prevention, protection, identification, training and reporting of physical abuse for 1 of 1 abuse investigation reviewed. During an interview with the Administrator on	{F 490}	additional allegations occurring on the same day and/or involving the same employee/resident. The facility must ensure staff effectively and consistently communicate through the chain of command, verbally and in documentation, to attain and maintain resident□s well-being. Staff have been trained to effectively and consistently communicate through the chain of command, verbally and in documentation, to attain and maintain residents□ safety from abuse. On 2/26/16, 2/29/16, 3/1/16 or 3/2/16 all staff and contract staff attended a Directed □in-service presented by the Regional Ombudsman Area Agency on Aging Titled: Identification and Prevention of Elder Abuse. 4) The Corporate Staff, i.e. clinical nursing consultant and/or regional VP will continue to review all allegations of abuse and interventions when reported to the administrator in accordance with the Abuse Policy including notification of appropriate agencies for 6 months. The monthly QI committee will review results of the Administrative Audit Tool for abuse and continue to review any allegations of abuse i.e. 24 hour/5/day report monthly for 6 months for identification of trends, actions taken and to determine the need for and/or frequency of continued interviews/monitoring and make recommendations for monitoring for	

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{F 490}	Continued From page 76 02/24/16 at 3:52 PM, she revealed she was informed by the Director of Nursing (DON) on 02/16/16 around lunch time that abuse occurred in the facility on 02/16/16 around 10:00 AM. The Administrator stated that the DON told her that she had begun the investigation, so the Administrator continued working in her office. The Administrator stated that around 4:00 PM, before leaving for the day, the DON came back to the Administrator's office and told her that she had written statements and interviews, but the Administrator did not review the investigation conducted by the DON and assumed the DON had it all together. The Administrator stated that later she realized that the DON had not been thorough in her investigation and that as the "captain of the ship" it was her responsibility to make sure all parts of the investigation was completed. The Administrator stated that it was her expectation that staff ensure the safety of combative residents during nursing care and if Resident #6 required the assistance of 2 nursing staff, then depending on whether or not the staff could get to the call bell would determine whether or not staff could call for additional assistance when Resident #6 became combative. The Administrator stated she attributed the failure of staff to immediately report abuse and protect a combative resident from further abuse was due to a lack of training that provided staff with the necessary tools to know how to respond to a combative resident and what to do when a combative resident was abused. The Medical Director was interviewed on 02/25/16 at 3:36 PM. The Medical Director stated he was in the facility on 02/16/16 and was informed that Resident #6 was combative that day, struck a staff member and the staff member	{F 490}	continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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{F 490}	Continued From page 77 was witnessed to strike back. The Medical Director stated that he was very familiar with Resident #6 and knew that at times she was quite combative, resistive to care and would strike out and try to hit at staff. The Medical Director stated he was involved in developing the plan of correction when abuse occurred in the facility in January 2016. He stated that staff were re-educated to report abuse immediately, if it occurred or was witnessed. If abuse was reported to administrative staff, the Medical Director stated he expected the facility to follow the abuse protocol for reporting to the proper authorities and continued monitoring to make sure abuse did not continue to occur. The Administrator was informed of immediate jeopardy on 02/24/2016 at 5:27 PM. An extended survey was conducted on 02/25/16.	{F 490}		
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	{F 514}		3/18/16

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{F 514}	Continued From page 78 This REQUIREMENT is not met as evidenced by: Based on an observation, staff interviews and review of medical and facility records, the facility failed to transcribe a physician order for 3 months to the treatment record regarding the change of a resident's indwelling urinary catheter every 30 days (Resident #112) and document the correct time of administration of an enteral feeding product (Resident #36) for 2 of 31 medical records reviewed. The findings included: 1. Resident #112 was admitted to the facility on 10/23/15 with diagnoses of peripheral vascular disease, cerebrovascular accident and hemiplegia. Review of the quarterly Minimum Data Set dated 01/22/16 revealed Resident #112 was moderately cognitively impaired and had an indwelling Foley catheter. Review of the care plan dated 01/28/16 revealed Resident #112 had an altered pattern of urinary elimination with an indwelling catheter and was at risk for infection. The goal was for Resident #112 to be free from urinary tract infection through the next review. Interventions included Foley catheter care per facility protocol and change Foley catheter per physician orders and/or facility protocol. Review of the treatment records (TAR) for Resident #112 revealed the following: · 10/23/15 through 10/31/15 - urinary catheter care once every shift. · 11/01/15 through 11/30/15 - Change urinary catheter every 30 days. Documented on TAR as changed on 11/08/15. No mention of urinary catheter care every shift.	{F 514}	F 514 Resident Records 1) On 2/25/16, the staff nurse contacted Resident #112'□s physician and obtained an updated Foley catheter order. On 2/25/16, Resident #112□'s Foley catheter was changed according to the Foley catheter order dated 2/25/16. On 2/25/16, the staff nurse started the Glucema 1.2 enteral feeding at 50 cc/hour as ordered. On 2/25/16 the staff nurse contacted Resident #36□'s physician regarding the resident not getting the Glucema 1.2 as ordered, the resident did not have 35 minutes of the tube feeding product (29.05 cc). No new orders were received. On 2/25/16, the Director of Nursing (DON)reviewed Resident #36□'s weights for the past 3 months with no negative findings. 2) On 2/26/16, DON audited all other residents with a foley catheter and residents receiving enteral feedings for accurate record documentation. There were no negative findings. 3) On 2/26/16, DON initiated an in-service for 100% of nurses regarding documenting the correct time of administration of enteral feeding products, to include continuous feedings. The in-service was completed on 3/7/16.	

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{F 514}	Continued From page 79 · 12/01/15 through 12/31/15 - No mention of urinary catheter care every shift or change urinary catheter every 30 days on TAR. · 01/01/16 through 01/31/16 - No mention of urinary catheter care every shift or change urinary catheter every 30 days. · 02/01/16 through 02/25/16 - No mention of urinary catheter care every shift or change urinary catheter every 30 days. Review of the nurse's notes from 10/23/15 through 02/25/16 revealed no note that Resident #112's urinary catheter had been changed. Review of the nurse's note dated 01/14/16 at 6:25 AM revealed Nurse #5 deflated the balloon of Resident #112's urinary catheter and retracted the catheter out some due to bleeding around the external urethra. An interview conducted with Nurse #4 on 02/24/16 at 9:40 AM revealed she did not know when Resident #112's urinary catheter had last been changed. She stated the last documented catheter change on the TAR was 11/08/15 and there were no orders on the TAR for 12/2015, 01/2016 and 02/2016 to change the urinary catheter every 30 days. Nurse #5 stated the order to change the urinary catheter every 30 days did not get transcribed to the TAR after 11/2015 so she wouldn't have known it needed to be changed. An interview conducted with Nurse #3 on 02/25/16 at 10:15 AM revealed she normally worked the 3:00 PM to 11:00 PM shift with Resident #112. She reviewed the February 2016 TAR for Resident #112 with the surveyor and confirmed there was no order to change Resident #112's urinary catheter every 30 days. She stated she knew the nurse aides provided catheter care during incontinence care but she did not know when the urinary catheter had last been changed	{F 514}	On 3/7/16, DON initiated an in-service for 100% of nurses regarding the timely and accurate transcription of physician orders to the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) to include orders to change a Foley catheter on the TAR. The in-service was completed on 3/14/16. 4) On 3/7/16, DON, QI nurse, staff facilitator, and/or evening charge nurse will utilize the "Foley Catheter Audit Tool" to validate Foley catheter orders are transferred over from the current month to the new month. The audit will be completed within 5 days of the end-of-month MAR and TAR reconciliation. This audit will be completed for 6 months. On 3/7/16,DON, QI nurse, staff facilitator, and/or evening charge nurse will utilize the "Enteral Feeding Audit Tool" to validate the enteral feeding is being administered according to physician orders, to include nurses writing accurate start times on the enteral feeding bottles. The audits will be completed 5 days a week for 4 weeks, then 2 days a week for 4 weeks, then 1 time a week for 4 months. The DON and/or the QI nurse, and/or the staff facilitator will monitor the "Foley Catheter Audit Tool" results to ensure proper transcription of Foley catheter	

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{F 514}	Continued From page 80 because it had not been documented on the TAR for February 2016 and stated it should have been written on the TAR what day of the month and what shift Resident #112's urinary catheter was to be changed. Nurse #5 further stated each nurse on the floor was assigned a couple of charts each month to transcribe orders from the previous month to the next month to the TAR and was not sure if anyone checked the orders behind the person that transcribed them. A phone call was attempted on 02/25/16 at 2:45 PM with Nurse #5 due to her no longer being employed by the facility. A message was left but Nurse #5 did not return surveyors call. During an interview conducted with the Interim Director of Nursing (DON) on 02/25/16 at 3:00 PM she revealed the order to change Resident #112's urinary catheter every 30 days had not been transcribed to the TAR in 12/2015, 01/2016 and 02/2016 and she could not find any documentation in the medical record of the urinary catheter being changed since 11/08/15. The Interim DON stated it was her expectation that all orders be transcribed correctly to the TAR each month. She stated the nurse's should have been checking behind each other for transcription mistakes. 2. Resident #36 was admitted to the facility on 09/17/14. Diagnoses included cognitive deficit, artificial opening of digestive tract, intestinal obstruction, and peritonitis. A physician's order dated 02/12/16 was written for Glucerna 1.2 (enteral feeding product) to infuse at 50 cc per hour, continuously. The physician's order included to provide Resident #36 with a water flush of 500 cc every 4 hours at 2AM, 6AM,	{F 514}	orders onto the TAR. The DON and/ or QI nurse, or staff facilitator will initial the bottom right corner of the audit tool with the date to acknowledge completion and follow-up The DON and/or the QI nurse,or staff facilitator will monitor the "Enteral Feeding Audit Tool" results to ensure proper administration of enteral feedings. The administrator and/or DON will present the findings from the "Foley Catheter Audit and Enteral Feeding Audit" to the monthly QI committee for recommendations as appropriate to maintain continued compliance and to the quarterly executive QA committee for further recommendations and oversight.	

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{F 514}	Continued From page 81	{F 514}		

10AM, 2PM, 6PM and 10PM. The physician's order also indicated that staff could cocktail medications (provided all together) and give via the percutaneous endoscopic gastrostomy (PEG) tube.

On 02/24/16 at 05:35 AM Resident #36 was in her bed with the head of the bed elevated to approximately 30 degrees. On 02/24/16 at 05:48 AM, the enteral feeding bottle of Glucerna 1.2 was empty and the enteral feeding pump was noted beeping. Nurse #7 was observed to turn off the enteral feeding pump per the request of Nurse #6. Nurse #6 was noted to gather supplies and medications for Resident #36 which included an enteral feeding bottle of Glucerna 1.2. On 02/24/16 at 06:01 AM, Nurse #6 was observed to record the date of 02/24/16, time of 05:30 AM, and rate of 50 cc on the enteral feeding bottle for Resident #36. On 02/24/16 at 06:05 AM, Nurse #6 administered medications and a water flush to Resident #36 via the PEG tube and started the enteral feeding product.

Nurse #6 was interviewed on 02/24/16 at 6:10 AM and stated he wrote 05:30 AM on the enteral feeding bottle as the administration time because he typically recorded the time he prepared the medications and that was the time he prepared medications for Resident #36. Nurse #6 stated he realized that by recording an administration time of 05:30 AM, Resident #36 missed 35 minutes of TF product.

The Interim Director of Nursing (DON) was interviewed on 02/25/16 at 8:48 AM. During the interview she stated that for accuracy, staff should document the actual time medications were given and enteral feeding products infused

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{F 514}	Continued From page 82 so that the medical record would document the correct amount of enteral feeding product infused. The Interim DON stated that based on the hang time Nurse #6 documented for the enteral feeding product, Resident #36 missed 35 minutes of enteral feeding product.	{F 514}		
{F 520} SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of facility	{F 520}	F 520 QAA Committee	3/18/16

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{F 520}	Continued From page 83 records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place on February 05, 2016. This was for 4 recited deficiencies that were originally cited during a Complaint survey conducted on January 15, 2016 and subsequently recited during a Recertification, Complaint and Follow up Complaint survey conducted on February 25, 2016. The deficiencies were in the areas of a resident's right to be free from abuse, the facility's implementation of abuse policies and procedures, administration and accuracy of the clinical record. Immediate jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped Resident #6 on the face and the witness, NA #2 did not intervene and did not immediately report to administrative staff for protection of Resident #6. A second incident of physical abuse occurred on 02/16/16 when NA #1 slapped Resident #6 on the right thigh and the witness, NA #2 did not intervene for the protection of Resident #6. Immediate jeopardy is present and ongoing. The facility provided the State Agency and Centers for Medicare and Medicaid an acceptable allegation of compliance (AOC) on 03/08/16. A revisit survey was conducted on 03/14/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following: Skin audits for all cognitively impaired residents dated 02/16/16 Documentation of interviews regarding abuse for all cognitively intact residents dated 02/16/16 Documentation of in-services (identifying/reporting abuse, caring for residents	{F 520}	1) On 3/1/2016, the monthly QI Committee held a meeting. The administrator, DON, QI nurse, MDS nurse, treatment nurse, staff facilitator, maintenance director, social workers, medical records, dietary manager and housekeeping supervisor will attend monthly QI Committee meetings on an ongoing basis and will assign additional team members as appropriate. 2) On 3/3/2016 the regional facility consultant in-serviced the facility administrator, DON, MDS nurse, treatment nurse, maintenance director, dietary manager, social workers, medical records, dietary manager and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identifying issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns to include F 223, F225, F226, F282, F490 and F520 all of which are immediate jeopardy level. 3) As of 3/3/2016, after the facility consultant in-service, the monthly QI Committee began identifying other areas of quality concern through the QA review process, for example: review of administrative rounds tools, resident council minutes, and resident concern log. Corrective action has been taken for the identified concerns related to the repeated	

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{F 520}	Continued From page 84 with dementia) for all currently employed staff completed by 03/07/16 Documentation of abuse monitoring on each shift which began on 02/26/16 and remained ongoing 24 hour/5 day reports for an allegation of abuse on 03/03/16 and an allegation of neglect on 02/27/16 A 24 hour/5 day report for Resident #6 for the 8:00 AM incident of abuse which had not previously been reported to the Health Care Personnel Registry (HCPR). Both reports were faxed the the HCPR on 02/25/16 Personnel files for all staff hired since 02/16/16 to include criminal background checks, reference checks, Nurse Aide Registry checks, license checks, and abuse training The facility's Abuse Policy Observations of nursing care, interviews with cognitively intact residents, interviews with family, interviews with all staff present in the facility on 03/14/16, review of all documentation to support the AOC and interviews with the facility's Administrator, Director of Nursing and the Nurse Practitioner provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F-520. The immediate jeopardy was removed on 03/14/16 at 7:15 PM. The facility remained out of compliance at F-520 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of their corrective action. The findings included: 1a. Cross refer to F 223 - Based on staff interviews and record review, the facility failed to protect a resident's right to be free from physical	{F 520}	deficiency. 4) The Committee will continue to meet monthly with oversight by the Vice President of Operations or Vice President of Clinical Services or the facility Clinical Consultant. The QI Committee meeting agenda and minutes with resulting plans of correction and audit results will be reviewed as a component of this oversight after each QI Committee meeting. The Executive QI Committee, including the Medical Director, will review monthly the compiled QI report information, review trends and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in the correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or DON will report back to the Executive QI Committee at the next scheduled quarterly meeting.	

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abuse with immediate intervention when a resident became combative during nursing care. A resident was physically abused twice when a staff member slapped her on the face and then on the right thigh for 1 of 1 sampled residents reviewed for abuse. (Resident #6).
During a Complaint survey conducted on January 15, 2016, the facility was cited for failure to protect a resident from sexual abuse. During a Recertification, Complaint and Follow up to Complaint survey conducted on February 25, 2016, the facility was cited for failure to protect a resident from physical abuse.
1b. Cross refer to F 226 - Based on staff interviews and record review, the facility failed to immediately stop nursing care when a resident (Resident #6) became combative to protect the resident and prevent an incident of physical abuse, intervene when physical abuse was observed, and immediately remove the perpetrator from a combative resident on a secure unit. The facility failed to report a witnessed incident of physical abuse to the Health Care Personnel Registry in 24 hours and the investigation in 5 working days. The facility failed to follow their abuse policy and procedures in the areas of prevention, protection, identification, training and reporting of physical abuse for 1 of 1 abuse investigation reviewed.
During a Complaint survey conducted on January 15, 2016, the facility was cited for failure to implement their abuse policy/procedures and have a policy that included assessment of a resident after abuse. During a Recertification, Complaint and Follow up to Complaint survey conducted on February 25, 2016, the facility was cited for failure to implement their abuse policy/procedures.
1c. Cross refer to F 490 - Based on staff

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interviews and review of facility records, the facility administrative staff failed to create and impose a culture that all residents would be protected from abuse and that staff would implement the facility's abuse policy and procedures to intervene, protect and immediately report abuse when witnessed. A combative resident experienced 2 episodes of physical abuse without immediate facility intervention, protection and implementation of abuse policies and procedures for 1 of 1 sampled residents reviewed for abuse (Resident #6).
During a Complaint conducted on January 15, 2016 the facility was cited for failure of administration to impose the expectation for implementation of the facility's abuse policy/procedures. During a Recertification, Complaint and Follow up survey of February 25, 2016, the facility was cited for failure of administration to create and impose a culture that protected residents from physical abuse.
1d. Cross refer to F 514 - Based on an observation, staff interviews and review of medical and facility records, the facility failed to transcribe a physician order for 3 months to the treatment record regarding the change of a resident's indwelling Foley catheter every 30 days (Resident #112) and document the correct time of administration of an enteral feeding product (Resident #36) for 2 of 31 medical records reviewed.
During a Complaint survey conducted on January 15, 2016 the facility was cited for failure to document an incident of sexual abuse in the medical record. During a Recertification, Complaint and Follow up to Complaint survey of February 25, 2016, the facility was cited for failure to transcribe a physician's order to the treatment record for 3 months and document the correct

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time of administration of an enteral feeding product.
During an interview with the Administrator on 02/25/16 at 4:29 PM and a follow up interview on 02/25/16 at 7:00 PM, she revealed that the facility's QAA met monthly and quarterly. She stated that the monthly QAA meetings focused on the same agenda each month, and the quarterly QAA meetings' agenda focused on unresolved or new concerns. The Administrator stated that since abuse was cited in January 2016 during a Federal Complaint survey, all department heads were responsible for monitoring for abuse on all shifts. The Administrator stated that staff had no observations of abuse noted or brought for discussion to the morning staff meetings since the January 2016 Federal Complaint survey. The Administrator stated that during these rounds, nursing staff were able to communicate the correct responses when quizzed regarding implementation of the facility's abuse policy/procedures. The Administrator stated that she attributed a repeat deficiency at F 223 to some nursing staff did not know how to respond when a resident became combative during care and that administration needed to provide more interactive in-services. The Administrator stated she attributed a repeat deficiency at F226 to staff not having the right understanding of the abuse policy/procedures or not getting enough information on how to implement the facility's abuse policy and procedures regarding what to report as abuse and when to report abuse. The Administrator also stated that she took responsibility for implementing the facility's abuse policy as it related to reporting abuse to the Health Care Personnel Registry (HCPR), as she did not initially identify the 2 incidents of abuse as 2 separate incidents. The Administrator further

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stated that she attributed a repeat deficiency at F490 to staff not feeling safe to report abuse, it was administration's responsibility to reassure staff that it was okay to report abuse and that administrative staff should have reported to the HCPR both incidents of abuse once administration became aware. The Administrator stated she attributed a repeat deficiency at F514 to a lack of staff training and a need for re-education on accuracy when documenting the medical record.

The Medical Director was interviewed on 02/25/16 at 3:36 PM and stated he was involved in developing the plan of correction when abuse occurred in the facility in January 2016. He stated that staff were re-educated to report abuse immediately, if it occurred or was witnessed. If abuse was reported to administrative staff, the Medical Director stated he expected the facility to follow the abuse protocol for reporting to the proper authorities and continued monitoring to make sure abuse did not continue to occur.

The Administrator was informed of immediate jeopardy on 02/24/2016 at 5:27 PM.

An extended survey was conducted on 02/25/16.

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{F 000}	INITIAL COMMENTS	{F 000}		

A recertification, complaint and followup complaint survey was conducted on 02/22/16 to 02/25/16. The facility was notified of ongoing immediate jeopardy on 02/24/16 at F-223 (J), F-226 (J), and F-490 (J), which began on 01/06/16. An extended survey was conducted on 02/25/16. Immediate jeopardy was present and remained ongoing at the completion of the survey.

483.13 (F 223) at J
Immediate Jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped a combative resident on the face and again on the right thigh (Resident #6). Each incident of physical abuse occurred on the secure unit and was witnessed by NA #2. NA #2 did not immediately intervene or report to administrative staff that she witnessed physical abuse against Resident #6 and failed to protect this Resident and other residents on the secure unit from further abuse. Resident #6 was assessed with reddened discoloration to her right thigh.

483.13 (F 226) at J
Immediate Jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped Resident #6 on the face when the Resident became combative during nursing care. NA #2 witnessed the physical abuse but did not immediately intervene or report to administrative staff. This resulted in a lack of protection to Resident #6 and other residents which led to a second incident of physical abuse toward Resident #6. NA #2 witnessed NA #1 slap Resident #6 on the face during morning care, but did not immediately report the abuse. NA #1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/21/2016

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remained on the secure unit, working unsupervised and several hours later on 02/16/16, NA #2 witnessed NA #1 slap Resident #6 on the right thigh during the provision of care. The facility failed to report physical abuse to the Health Care Personnel Registry within 24 hours and the investigation of the physical abuse within 5 working days.

483.75 (F 490) at J
Immediate jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped Resident #6 on the face and the witness, NA #2 did not intervene and did not immediately report to administrative staff for protection of Resident #6 and other residents. A second incident of physical abuse occurred on 02/16/16 when NA #1 slapped Resident #6 on the right thigh and the witness, NA #2 did not intervene for the protection of Resident #6.

The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance on 03/08/16.

A revisit survey was conducted on 03/14/16 for verification of the facility's allegation of compliance and to determine the status of the ongoing Immediate Jeopardy. Immediate Jeopardy was removed on 03/14/16 at 7:15 PM. At the time of the exit on 03/14/16, the facility remained out of compliance at F-223, F-226, and F-490 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of their corrective actions.

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{F 223}	Continued From page 2	{F 223}		
{F 223} SS=D	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 staff interviews and record review, the facility failed to protect a resident's right to be free from physical abuse with immediate intervention when a resident became combative during nursing care. A resident was physically abused twice when a staff member slapped her on the face and then on the right thigh for 1 of 1 sampled residents reviewed for abuse. (Resident #6). Immediate Jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped a combative resident on the face and again on the right thigh (Resident #6). Each incident of physical abuse occurred on the secure unit and was witnessed by NA #2. NA #2 did not immediately intervene or report to administrative staff that she witnessed physical abuse against Resident #6 and failed to protect this Resident and other residents on the secure unit from further abuse. Resident #6 was assessed with reddened discoloration to her right thigh. The immediate jeopardy is present and ongoing. The facility provided the State Agency and	{F 223}	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion F 223 1) On 2/16/16, Resident #6 was assessed by the Medical Director. No new orders were received. On 2/16/16 Resident #6 was assessed by Nurse #1 which included a head to toe assessment. The findings revealed a reddened area on upper right thigh and small healing bruises. Resident #6 still resides in the facility. On 2/16/16 NA #1 was suspended from employment for physically abusing Resident #6 and terminated on 2/22/16. 2) Because all residents have the potential to be affected by verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion on 2/16/16 staff nurses completed 100% body audit on all cognitively impaired residents in the facility for evidence of	3/18/16

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{F 223}	Continued From page 3 Centers for Medicare and Medicaid an acceptable allegation of compliance (AOC) on 03/08/16. A revisit survey was conducted on 03/14/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following: Skin audits for all cognitively impaired residents dated 02/16/16 Documentation of interviews regarding abuse for all cognitively intact residents dated 02/16/16 Documentation of in-services (identifying/reporting abuse, caring for residents with dementia) for all currently employed staff completed by 03/07/16 Documentation of abuse monitoring on each shift which began on 02/26/16 and remained ongoing 24 hour/5 day reports for an allegation of abuse on 03/03/16 and an allegation of neglect on 02/27/16 A 24 hour/5 day report for Resident #6 for the 8:00 AM incident of abuse which had not previously been reported to the Health Care Personnel Registry (HCPR). Both reports were faxed the the HCPR on 02/25/16 Personnel files for all staff hired since 02/16/16 to include criminal background checks, reference checks, Nurse Aide Registry checks, license checks, and abuse training The facility's Abuse Policy Observations of nursing care, interviews with cognitively intact residents, interviews with family, interviews with all staff present in the facility on 03/14/16, review of all documentation to support the AOC and interviews with the facility's Administrator, Director of Nursing and the Nurse Practitioner provided sufficient evidence to support corrective action by the facility to remove	{F 223}	abuse. No negative findings were identified. On 2/16/16, the social worker interviewed all alert and oriented residents related to abuse and resulted in no negative responses. On 2/19/16 NA#2 was disciplined for failure to report immediately allegation of abuse according to the Abuse policy and on 2/25/16 NA #2 was terminated for not providing safety for Resident #6. 3) On 2/16//16 all facility staff including Administrative and current contract staff present were re-educated either by Administrator or Director of Nursing (DON) on the Abuse Policy and what constitute abuse. Abuse will not be tolerated, to ensure immediate safety of all residents and removing the accused from resident care area immediately. On 2/18/16 staff facilitator started a video in-service for all staff entitled Being with a Person with Dementia: Actions and Reactions." On 2/26/16, 2/29/16, 3/1/16 and/or 3/2/16 all staff and contract staff attended a Directed □in-service presented by the Regional Ombudsman Area Agency on Aging. Titled: Identification and Prevention of Elder Abuse. On 3/1/16 Staff facilitator started an in-service for all nurses and nursing assistants on following resident care plans and care guides. No staff will take an assignment until these in-services has been completed. On 3/4/16 an in-service was held for all staff by The Geriatric and Adult Mental Health Specialty Team titled "Managing	

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{F 223}	Continued From page 4 the immediate jeopardy at F-223. The immediate jeopardy was removed on 03/14/16 at 7:15 PM. The facility remained out of compliance at F-223 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of their corrective action. The findings included: Resident #6 was admitted to the facility on 04/10/14. Diagnoses included dementia with behaviors, mood affective disorder, cognitive communicative deficit, paranoid delusional beliefs and psychosis. Resident #6 was currently being treated and followed by ongoing psychiatric services. Medical record review revealed Resident #6 had physician orders dated 08/31/15 for Ativan (antianxiety) 2 milligrams (mg) IM (intramuscular) injection as needed for pain and 11/16/15 Ativan 1 mg every 8 hours as needed for agitation. A quarterly Minimum Data Set dated 12/29/15 assessed Resident #6 with severely impaired cognition, required extensive staff assistance of 2 persons for activities of daily living (ADL) to include mobility, transfers, dressing and toileting, physically and verbally abusive and without impairments in range of motion. A care plan dated 12/29/15 recorded that Resident #6 had problematic behavior characterized by ineffective coping behaviors of verbal and physical abuse, resistive to treatment/care as evidenced by yelling, cursing,	{F 223}	Challenging Behaviors." Quarterly in-services will be offered to all staff by the Specialty Team. All newly hired employees will continue to receive training on the Abuse policy through written, video, and verbal education. New hires, prior to taking an assignment will watch the video series "Hand in Hand," a series providing training on caring for residents with dementia and on preventing abuse. 4) The DON, ADON, Department Heads and administrative staff on administrative staff rounds will continue to monitor and complete abuse observations on 10 residents per shift to be completed seven days a week three times a day to include each shift per week x4 weeks, 10 residents bi-weekly for 8 weeks and then 10 residents monthly x3 months using the Abuse/Neglect audit tool called "Watching For and Responding to an Incident." The monthly QI committee will review results of the Abuse/Neglect audit tool results monthly for 6 months for identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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swinging arms and delusional behavior. The care plan's goal specified that staff were to ensure the resident's safety. The care plan's interventions included the following: approach calmly and slowly from the front, respect personal space, provide diversion activity, allow for flexibility in ADL routine to accommodate mood, and when care is refused, leave and return in 5-10 minutes. Review of the "Resident care guide" revealed staff were encouraged to approach Resident #6 in a calm, reassuring manner and if care was refused, to approach the Resident later.

A progress note dated 02/05/16 by the nurse practitioner (NP) revealed Resident #6 was referred by nursing for evaluation of morning agitation and persevering behaviors. Nursing reported that Resident #6 was noted increasingly agitated primarily in the morning. The progress note recorded that Resident #6 was noted by the NP to be very agitated, angry, and confused. Medications were adjusted and staff were to continue to monitor.

A Skin Monitoring Review for Resident #6 dated 02/15/16 did not record any changes or concern with skin integrity.

Review of a nursing progress note dated 02/16/16 at 4:49 PM written by Nurse #1 and the February 2016 Medication Administration Record recorded that Resident #6 was very combative towards staff that day. Nurse #1 documented that she administered Ativan 1 mg by mouth as needed for agitation at 7:40 AM with some positive effects and then Ativan 2 mg IM as needed for pain at 12:10 PM with slight positive effects.

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A nursing progress note dated 02/16/16 at 4:56 PM by Nurse #1 recorded that nursing assistant (NA #1) verbalized she slapped Resident #6 during care when the Resident pulled her hair. The Medical Director was notified and assessed the Resident. Nurse #1 performed a full body assessment for Resident #6 and noted a deep reddened area to the Resident's right upper thigh.

A Skin Monitoring Review dated 02/16/16, completed by Nurse #1, recorded that Resident #6 had redness to her inner thighs and an irregular reddened area, approximately 3 inches long to the front of her upper right thigh.

An incident report dated 02/16/16 at 5:03 PM completed by the Director of Nursing (DON), recorded that NA #1 stated she struck Resident #6 on the leg and afterwards the Resident was noted with red marks across the right thigh.

A written statement by NA #1 dated 02/16/16 recorded that NA #1 struck Resident #6 on her leg on 02/16/16 around 10:00 AM when Resident #6 become combative and pulled the hair of NA #1.

Review of a Health Care Personnel Registry (HCPR) 24 Hour Initial Report dated 02/16/16 completed by the Administrator, recorded that on 02/16/16 at 10:00 AM, NA #1 stated she struck Resident #6 on her leg to stop the Resident from pulling her hair. Resident #6 was noted with a red mark on her upper right thigh.

Review of the facility's investigation revealed a written statement by the Administrator, dated 02/19/16, which recorded that she spoke to the Deputy Sheriff on 02/16/16 around 9:00 PM and

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was asked if she was aware that NA #2 also witnessed NA #1 slap Resident #6 on 02/16/16 about 8:00 AM. The written statement recorded that the Administrator was not aware. The Administrator documented that she spoke to NA #2 on 02/17/16 and was informed that NA #2 witnessed NA #1 slap Resident #6 on the face on 02/16/16 around 8:00 AM and again on the right thigh above her knee at 10:00 AM, when the Resident became combative.

Written statements by NA #2, dated 02/17/16, recorded that on 02/16/16 at 7:30 AM, NA #2 witnessed Resident #6 become combative during morning care and NA #1 slapped Resident #6 on the left side of her face. NA #2 witnessed NA #1 leave the Resident's room and make a statement at the nurse's station that she "popped" Resident #6. Later in the morning around 9:45 AM on 02/16/16, while in the shower room, NA #2 witnessed Resident #6 grab the hair of NA #1 and NA #1 slapped Resident #6 on the leg. NA #2 then witnessed NA #1 leave the shower room and report the incident to Nurse #1 and Nurse #2.

Review of a HCPR 5 Working Day Report dated 02/19/16, completed by the Administrator, recorded on 02/16/16 at 10:00 AM, NA #1 immediately reported that she slapped a combative resident on the leg during resident care. The physical abuse was witnessed, NA #1 was immediately suspended, the police was called at 6:00 PM, the allegation of abuse was substantiated and NA #1 was terminated.

An interview with NA #2 was conducted on 02/24/16 at 10:30 AM. NA #2 stated that she received a lot of abuse training recently and knew that if she witnessed abuse she should tell the

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nurse/supervisor, remove the resident from harm, watch the perpetrator and don't let the perpetrator go into any resident rooms. NA #2 stated that on 02/16/16 around 7:30 AM Resident #6 would not cooperate with staff and became combative during morning care (kicking, yelling and hitting). NA #2 stated she witnessed Resident #6 hit NA #1 twice, then witnessed NA #1 slap Resident #6 on the left side of her face and said "You are going to stop that." NA #2 stated the slap was more than just a pat on the face, but it wasn't a hard slap. NA #2 stated Resident #6 was already upset and remained upset. Both NAs continued getting Resident #6 dressed, placed her in her wheelchair and NA #1 took Resident #6 to the dining room. NA #1 stated that on the way to the dining room, NA #1 stopped at the nurse's station and told Nurse #1 "I popped (Resident #6)" and Nurse #1 said "Ok." NA #2 stated that she found out later that Nurse #1 did not hear NA #1's statement. NA #2 stated she felt that when NA #1 slapped Resident #6 that the incident fit the definition of abuse, but that she didn't know how to separate NA #1 from Resident #6. NA #2 further stated she did not think it would happen again and thought Nurse #1 heard NA #1 report the incident and would take care of it. NA #2 further stated that later that morning around 10:00 AM, both NA #1 and NA #2 were toileting Resident #6 in the shower room when the Resident became combative again. During care, NA #1 bent down to pull up the Resident's pants and Resident #6 grabbed NA #1's hair. That's when NA #1 slapped Resident #6 on her right thigh. NA #2 stated the slap was loud enough to hear, but she didn't know what to do. Resident #6 released her grip on NA #1 hair and they finished pulling up the Resident's pants, transferred her to the wheelchair and NA #2 took

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Resident #6 to the dining room. NA #2 stated that she observed NA #1 immediately go to the nurse's station and told Nurse #1 and Nurse #2 that she "popped" Resident #6 on the leg. Nurse #2 immediately left the unit and Nurse #2 and the DON returned to the unit. NA #2 observed NA #1 talk to the DON and then NA #1 was escorted off the unit. NA #2 stated the DON asked her on 02/16/16 what happened and she told the DON that NA #1 slapped Resident #6 on the left side of her face about 8:00 AM and then on her right thigh about 10:00 AM. NA #2 stated she also informed the police officer on 02/16/16 when he interviewed her that evening on the phone and the Administrator on 02/17/16 when she talked to her on the phone.

A telephone interview was conducted on 02/24/16 at 12:55 PM with NA #1. She stated that she worked on the facility's secure unit as her permanent assignment and had recently received abuse training. NA #1 stated she was trained on how to identify abuse and if abuse was witnessed, she should remove the perpetrator from the resident, call law enforcement or the Administrator, and make sure the perpetrator and resident were both watched. NA #1 stated that on, 02/16/16 Resident #6 slapped her on the face and she responded by gently touching the Resident's face and said "Let's don't do that." NA #1 stated "I just touched her face with my hand" and NA #2 was present. NA #1 stated she went to the nurse's station after providing care to Resident #6 and told Nurse #1 that the Resident was a hand full, but she did not report touching her face because she did not think there was anything to it. NA #1 stated there was no mark left on the Resident's face. NA #1 stated later that morning around 10:00 AM, she and NA #2 were

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toileting Resident #6 in the shower room and the Resident became combative, worse this time. NA #1 stated that while she was pulling up the Resident's brief, the Resident grabbed her hair, pulling so hard "I was up on my tip toes", so "I smacked her on the right knee to get her to stop, I said stop and she stopped." NA #1 stated she struck her gently because it was not her nature to hurt anyone. Resident #6 continued yelling and hitting, we got her dressed and took her to the day room. NA #1 stated afterwards, she reported to Nurse #1 and Nurse #2 that she struck Resident #6 on the leg, the DON came and took a statement from her and she was suspended.

A telephone interview was conducted on 02/24/16 at 11:10 AM and a follow up interview was conducted on 02/25/16 at 3:30 PM with Nurse #1. During the interviews, Nurse #1 stated that on 02/16/16 there were 14 residents on the secure unit. Around 10:00 or 10:15 AM, NA #1 informed her that while NA #1 and NA #2 provided care to Resident #6 in the shower room, the Resident became combative and grabbed NA #1 by the hair. NA #1 stated she "popped" Resident #6 to get her to let go. Nurse #1 stated Nurse #2 (supervisor) was also present and heard the conversation. NA #1 stayed at the nurse's station with Nurse #1, while Nurse #2 reported the incident to the DON. The DON came to the unit, took a statement from NA #1 and she was suspended. Nurse #1 stated that NA #1 worked with all residents on the secure unit that day from 7:00 AM until she was suspended around 10:30 AM, but Nurse #1 was not aware of any prior incidents of abuse regarding NA #1. Nurse #1 stated she had not been informed that NA #2 witnessed NA #1 slap Resident #6 on the face earlier that morning. Nurse #1 stated Resident #6

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was combative at times, usually required 2 staff to give her care. Nurse #1 stated that staff were trained that when residents became combative, staff should give the resident time to calm down, try to redirect and come back later to provide care. Nurse #1 stated Resident #6 was very combative that day and received Ativan (as needed) twice on her shift that day for agitation and later for pain. Nurse #1 stated Resident #6 did not cooperate initially with a skin assessment, and Ativan was given to calm her down. Once Resident #6 was calm, a full body skin assessment was completed, around 12:30 PM and she was noted with a reddened area to her right thigh about 3 inches long and irregular in shape. Nurse #1 stated there were no other changes noted to her skin or face.

The Administrator was interviewed on 02/24/16 at 3:52 PM. She stated that the DON informed her around lunch time on 02/16/16 that NA #1 "popped" Resident #6 on the knee in the shower room and reported herself. The DON told the Administrator that NA #1 was suspended and that she had started completing interviews for the investigation. The Administrator called the police around 6:00 PM. The Administrator stated she went to see Resident #6 for the first time that day around 7:00 PM when the police officer arrived. Both she and the police officer observed Resident #6 without any marks to either thigh. The Administrator stated later that evening, around 9:00 PM, the police officer caller her and asked if she knew about another incident of abuse that happened earlier that day, but the Administrator stated she was not aware and she had not looked at the DON's investigation. The Administrator stated she called NA #2 sometime the next morning on 02/17/16 and obtained a statement

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{F 223}	Continued From page 12 from her over the phone regarding both incidents of physical abuse that were witnessed by NA #2 on 02/16/16 and reported to the DON. The Administrator asked NA #2 to provide written statements about what she saw. Nurse #2 was interviewed on 02/25/16 at 10:28 AM. Nurse #2 stated she was the Nurse Supervisor on the 7AM - 3 PM shift on 02/16/16. Nurse #2 and Nurse #1 were both at the nurse's station on the secure unit on 02/16/16 around 10:00 AM when NA #1 said "I just want everybody to know that I just popped (named Resident)." NA #1 proceeded to say that she "popped" Resident #6 because the Resident pulled her hair. Nurse #2 stated she asked NA #1 to stay at the nurse's station. Nurse #2 went to find the DON and report what occurred. The DON came to the secure unit, obtained a statement from NA #1 and she was suspended. Nurse #2 stated she was not aware of any previous incidents of abuse between NA #1 and Resident #6. Attempts to interview the DON were unsuccessful. The administrator was notified of immediate jeopardy on 02/24/16 at 5:27 PM. An extended survey was conducted on 02/25/16.	{F 223}		
{F 226} SS=D	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.	{F 226}		3/18/16

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{F 226}	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to immediately stop nursing care when a resident (Resident #6) became combative to protect the resident and prevent an incident of physical abuse, intervene when physical abuse was observed, and immediately remove the perpetrator from a combative resident on a secure unit. The facility failed to report a witnessed incident of physical abuse to the Health Care Personnel Registry in 24 hours and the investigation in 5 working days. The facility failed to follow their abuse policy and procedures in the areas of prevention, protection, identification, training and reporting of physical abuse for 1 of 1 abuse investigation reviewed. Immediate Jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped Resident #6 on the face when the Resident became combative during nursing care. NA #2 witnessed the physical abuse but did not immediately intervene or report to administrative staff. This resulted in a lack of protection to Resident #6 and other residents which led to a second incident of physical abuse toward Resident #6. NA #2 witnessed NA #1 slap Resident #6 on the face during morning care, but did not immediately report the abuse. NA #1 remained on the secure unit, working unsupervised and several hours later on 02/16/16, NA #2 witnessed NA #1 slap Resident #6 on the right thigh during the provision of care. The facility failed to report physical abuse to the Health Care Personnel Registry within 24 hours and the investigation of the physical abuse within 5 working days.	{F 226}	F226 Development/Implementation Policies for Abuse/Neglect 1)On 2/16/16, Resident #6 was assessed by the Medical Director. No new orders were received. On 2/16/16 Resident #6 was assessed by Nurse #1 which included a head to toe assessment. The findings revealed a reddened area on upper right thigh and small healing bruises. Resident #6 still resides in the facility. On 2/16/16 NA #1 was suspended from employment for physically abusing Resident #6 and terminated on 2/22/16. On 2/16/16 NA #2 was re-educated on the Abuse Policy to include immediately intervene and stop abuse, remove the perpetrator and immediately report. 2) Because all residents have the potential to be affected by verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion on 2/16/16 staff nurses completed 100% body audit on all cognitively impaired residents in the facility for evidence of abuse. No negative findings were identified. On 2/16/16, the social worker interviewed all alert and oriented residents related to abuse and resulted in no negative responses. On 2/19/16 NA#2 was disciplined for failure to report immediately allegation of abuse according to the Abuse policy and on 2/25/16 NA #2	

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{F 226}	Continued From page 14 The immediate jeopardy is present and ongoing. The facility provided the State Agency and Centers for Medicare and Medicaid an acceptable allegation of compliance (AOC) on 03/08/16. A revisit survey was conducted on 03/14/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following: Skin audits for all cognitively impaired residents dated 02/16/16 Documentation of interviews regarding abuse for all cognitively intact residents dated 02/16/16 Documentation of in-services (identifying/reporting abuse, caring for residents with dementia) for all currently employed staff completed by 03/07/16 Documentation of abuse monitoring on each shift which began on 02/26/16 and remained ongoing 24 hour/5 day reports for an allegation of abuse on 03/03/16 and an allegation of neglect on 02/27/16 A 24 hour/5 day report for Resident #6 for the 8:00 AM incident of abuse which had not previously been reported to the Health Care Personnel Registry (HCPR). Both reports were faxed the the HCPR on 02/25/16 Personnel files for all staff hired since 02/16/16 to include criminal background checks, reference checks, Nurse Aide Registry checks, license checks, and abuse training The facility's Abuse Policy Observations of nursing care, interviews with cognitively intact residents, interviews with family, interviews with all staff present in the facility on 03/14/16, review of all documentation to support	{F 226}	was terminated for not providing safety for Resident #6. 3) On 2/16//16 all facility staff including Administrative and contract staff present were re-educated either by Administrator or DON on the Abuse Policy and what constitute abuse. Abuse will not be tolerated, to ensure immediate safety of all residents and removing the accused from resident care area immediately. On 2/18/16 Staff facilitator started a video in-service for all staff entitled "Being with a Person with Dementia: Actions and Reactions." On 2/26/16, 2/29/16, 3/1/16 or 3/2/16 all staff and contract staff attended a Direct □in-service presented by the Regional Ombudsman Area Agency on Aging. Titled: Identification and Prevention of Elder Abuse. On 3/1/16 Staff facilitator in-serviced all nurses and nursing assistants on following resident care plans and care guides. On 3/4/16 an in-service was offered for all staff by The Geriatric and Adult Mental Health Specialty Team titled "Managing Challenging Behaviors." Quarterly in-services will be provided to all staff by the Specialty Team. Staff Facilitator will continue to provide ongoing annual abuse and neglect education through written, video and verbal education. All newly hired employees will continue to	

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{F 226}	Continued From page 15 the AOC and interviews with the facility's Administrator, Director of Nursing and the Nurse Practitioner provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F-226. The immediate jeopardy was removed on 03/14/16 at 7:15 PM. The facility remained out of compliance at F-226 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of their corrective action. The findings included: The facility's policy "Abuse, Neglect, or Misappropriation of Resident Property Policy", revised 11/01/06, included in part: The facility will do whatever is in its control to prevent mistreatment, neglect, and abuse of our residents or misappropriation of their property. Any employee who witnesses or suspects that abuse, neglect, or misappropriation of property has occurred, will immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator. Measures will be initiated to prevent any further potential abuse while the investigation is in progress. The Administrator is responsible to review the results of the investigation and report the alleged incident to the appropriate agencies in accordance with State and Federal regulations. The Administrator is responsible to direct the investigation process to ensure that appropriate agencies are notified, as indicated. Training: Training programs may include: Indicators of resident vulnerability to abuse and related interventions. Prevention: The facility will provide supervision to staff to identify	{F 226}	receive training on the Abuse policy through written, video, and verbal education. Prior to taking an assignment new hires will watch the video series "Hand in Hand:" a series providing training on caring for residents with dementia and on preventing abuse. 4) The DON, ADON, Department Heads and administrative staff on administrative staff rounds will continue to monitor and complete abuse observations on 10 residents per shift to be completed seven days a week three times a day to include each shift. per week x4 weeks, 10 residents bi-weekly for 8 weeks and then 10 residents monthly x3 months using the Abuse/Neglect audit tool called "Watching for and responding to an Incident." The monthly QI committee will review results of the Abuse/Neglect audit tool results monthly for 6 months for identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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inappropriate behaviors, such as rough handling. The facility will assess, care plan, and monitor residents with needs and behaviors that might lead to abuse, neglect, or misappropriation of property. Protection: Employees accused of being directly involved in allegations of abuse, neglect, or misappropriation of property will be suspended immediately from employment pending the outcome of the investigation.

Review of the facility's Abuse, Neglect or Misappropriation of Resident Property policy revealed a definition of physical abuse was not included.

Resident #6 was admitted to the facility on 04/10/14. Diagnoses included dementia with behaviors, mood affective disorder, cognitive communicative deficit, paranoid delusional beliefs and psychosis. Resident #6 was currently being treated and followed by ongoing psychiatric services.

Medical record review revealed Resident #6 had physician orders dated 08/31/15 for Ativan (antianxiety) 2 milligrams (mg) IM (intramuscular) injection as needed for pain and another physician's order dated 11/16/15 for Ativan 1 mg every 8 hours as needed for agitation.

A quarterly Minimum Data Set dated 12/29/15 assessed Resident #6 with severely impaired cognition, required extensive staff assistance of 2 persons for activities of daily living (ADL) to include mobility, transfers, dressing and toileting, physically and verbally abusive and without impairments in range of motion.

A progress note dated 02/05/16 by the nurse

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practitioner (NP) revealed Resident #6 was referred by nursing for evaluation of morning agitation and persevering behaviors. Nursing reported that Resident #6 was noted increasingly agitated primarily in the morning. The progress note recorded that Resident #6 was noted by the NP to be very agitated, angry, and confused. Medications were adjusted and staff were to continue to monitor.

A Skin Monitoring Review for Resident #6 dated 02/15/16 did not record any changes or concerns with skin integrity.

Review of a nursing progress note dated 02/16/16 at 4:49 PM by Nurse #1 and the February 2016 Medication Administration Record recorded that Resident #6 was very combative towards staff that day. Nurse #1 documented that she administered Ativan 1 mg by mouth as needed for agitation at 07:40 AM with some positive effects and then Ativan 2 mg IM as needed for pain at 12:10 PM with slight positive effects.

A nursing progress note dated 02/16/16 at 4:56 PM by Nurse #1 recorded that nursing assistant (NA #1) verbalized she slapped Resident #6 during care when the Resident pulled her hair. The Medical Director was notified and assessed the Resident. Nurse #1 performed a full body assessment for Resident #6 and noted a deep reddened area to the Resident's right upper thigh.

A Skin Monitoring Review dated 02/16/16, completed by Nurse #1, recorded that Resident #6 had redness to her inner thighs and an irregular reddened area, approximately 3 inches long to the front of her upper right thigh.

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LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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An incident report dated 02/16/16 at 5:03 PM completed by the Director of Nursing (DON), recorded that NA #1 stated she struck Resident #6 on the leg and afterwards the Resident was noted with red marks on the right thigh.

A written statement by NA #1 dated 02/16/16 recorded that NA #1 struck Resident #6 on her leg on 02/16/16 around 10:00 AM when Resident #6 become combative and pulled the hair of NA #1. A Disciplinary Warning Notice dated 02/16/16, completed by the DON and signed by NA #1, recorded that NA #1 was suspended for an inappropriate way of dealing with a resident behavior.

A Consultation Report dated 02/16/16, completed by the DON, recorded a concern that NA #2 did not report abuse immediately, remove the employee from an abuse situation and report to another supervisor when the charge nurse was advised of abuse, but did not respond.

Review of a Health Care Personnel Registry (HCPR) 24 Hour Initial Report dated 02/16/16 completed by the Administrator, recorded that on 02/16/16 at 10:00 AM, NA #1 stated she struck Resident #6 on her leg to stop the Resident from pulling her hair. Resident #6 was noted with a red mark on her upper right thigh. NA #1 was immediately suspended. The report did not include the incident of physical abuse that occurred on 02/16/16 at 8:00 AM.

Review of the facility's investigation revealed a written statement by the Administrator, dated 02/19/16, which recorded that she spoke to the law enforcement on 02/16/16 around 9:00 PM

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and was asked if she was aware that NA #2 also witnessed NA #1 slap Resident #6 on 02/16/16 about 8:00 AM. The written statement recorded that the Administrator was not aware. The Administrator documented that she spoke to NA #2 on 02/17/16 and was informed that NA #2 witnessed NA #1 slap Resident #6 on the face on 02/16/16 around 8:00 AM and again on the right thigh above her knee at 10:00 AM, when the Resident became combative.

Written statements by NA #2, dated 02/17/16, recorded that on 02/16/16 at 7:30 AM, NA #2 witnessed Resident #6 become combative during morning care and NA #1 slapped Resident #6 on the left side of her face. NA #2 witnessed NA #1 leave the Resident's room and make a statement at the nurse's station that she "popped" Resident #6. NA #2 did not report the witnessed physical abuse against Resident #6 because she thought the nursing staff heard NA #1's statement. Later in the morning around 9:45 AM on 02/16/16, while in the shower room, NA #2 witnessed Resident #6 grab the hair of NA #1 and NA #1 slapped Resident #6 on the leg. NA #2 then witnessed NA #1 leave the shower room and report the incident to Nurse #1 and Nurse #2.

Written statements by Nurse #1 dated 02/16/16 and the Administrator dated 02/19/16 both recorded that Nurse #1 stated she was not made aware that NA #2 witnessed NA #1 slap Resident #6 on the left side of her face on 02/16/16 at 8:00 AM. NA #1 did self-report that she "popped" Resident #6 on the right thigh on 02/16/16 around 10:00 AM.

Review of a HCPR 5 Working Day Report dated 02/19/16, completed by the Administrator,

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recorded on 02/16/16 at 10:00 AM, NA #1 immediately reported that she slapped a combative resident on the leg during resident care and immediately knew what she did was wrong. The physical abuse was witnessed, NA #1 was immediately suspended, law enforcement was called at 6:00 PM, the allegation of abuse was substantiated and NA #1 was terminated. The report did not include the witnessed physical abuse that occurred on 02/16/16 at 8:00 AM.

An interview with NA #2 was conducted on 02/24/16 at 10:30 AM. NA #2 stated that she received a lot of abuse training recently and knew that if she witnessed abuse she should tell the nurse/supervisor, remove the resident from harm, watch the perpetrator and don't let the perpetrator go into any resident rooms. NA #2 stated that on 02/16/16 around 7:30 AM Resident #6 would not cooperate with staff and became combative during morning care (kicking, yelling and hitting). NA #2 stated she witnessed Resident #6 hit NA #1 twice, then witnessed NA #1 slap Resident #6 on the left side of her face and said "You are going to stop that." NA #2 stated the slap was more than just a pat on the face, but it wasn't a hard slap. NA #2 stated Resident #6 was already upset and remained upset. Both NAs continued getting Resident #6 dressed, placed her in her wheelchair and NA #1 took Resident #6 to the dining room. NA #1 stated that on the way to the dining room, NA #1 stopped at the nurse's station and told Nurse #1 "I popped (Resident #6)" and Nurse #1 said "Ok." NA #2 stated that she found out later that Nurse #1 did not hear NA #1's statement. NA #2 stated she felt that when NA #1 slapped Resident #6 that the incident fit the definition of abuse, but that she didn't know how to separate NA #1 from Resident #6. NA #2

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further stated she did not think it would happen again and thought Nurse #1 heard NA #1 report the incident and would take care of it. NA #2 further stated that later that morning around 10:00 AM, both NA #1 and NA #2 were toileting Resident #6 in the shower room when the Resident became combative again. During care, NA #1 bent down to pull up the Resident's pants and Resident #6 grabbed NA #1's hair. That's when NA #1 slapped Resident #6 on her right thigh. NA #2 stated the slap was loud enough to hear, but she didn't know what to do. Resident #6 released her grip on NA #1 hair and they finished pulling up the Resident's pants, transferred her to the wheelchair and NA #2 took Resident #6 to the dining room. NA #2 stated that she observed NA #1 immediately go to the nurse's station and told Nurse #1 and Nurse #2 that she "popped" Resident #6 on the leg. Nurse #2 immediately left the unit and returned to the unit with the DON. NA #2 observed the DON talk to NA #1 and NA #1 was escorted off the unit. NA #2 stated the DON asked her on 02/16/16 what happened and she told the DON that NA #1 slapped Resident #6 on the left side of her face about 8:00 AM and then on her right thigh about 10:00 AM. NA #2 stated she also informed law enforcement on 02/16/16 when he interviewed her that evening on the phone and the Administrator on 02/17/16 when she talked to her on the phone.

A telephone interview was conducted on 02/24/16 at 12:55 PM with NA #1. She stated that she worked on the facility's secure unit as her permanent assignment and had recently received abuse training. NA #1 stated she was trained on how to identify abuse and if abuse was witnessed, she should remove the perpetrator

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from the resident, call law enforcement or the Administrator, and make sure the perpetrator and resident were both watched. NA #1 stated that on, 02/16/16 Resident #6 slapped her on the face and she responded by gently touching the Resident's face and said "Let's don't do that." NA #1 stated "I just touched her face with my hand" and NA #2 was present. NA #1 stated she went to the nurse's station after providing care to Resident #6 and told Nurse #1 that the Resident was a hand full, but she did not report touching her face because she did not think there was anything to it. NA #1 stated there was no mark left on the Resident's face. NA #1 stated later that morning around 10:00 AM, she and NA #2 were toileting Resident #6 in the shower room and the Resident became combative, worse this time. NA #1 stated that while she was pulling up the Resident's brief, the Resident grabbed her hair, pulling so hard "I was up on my tip toes", so "I smacked her on the right knee to get her to stop, I said stop and she stopped." NA #1 stated she struck her gently because it was not her nature to hurt anyone. Resident #6 continued yelling and hitting, we got her dressed and took her to the day room. NA #1 stated afterwards, she reported to Nurse #1 and Nurse #2 that she struck Resident #6 on the leg, the DON came and took a statement from her and she was suspended.

A telephone interview was conducted on 02/24/16 at 11:10 AM and a follow up interview was conducted on 02/25/16 at 3:30 PM with Nurse #1. During the interviews, Nurse #1 stated that on 02/16/16 there were 14 residents on the secure unit. Around 10:00 or 10:15 AM, NA #1 informed her that while NA #1 and NA #2 provided care to Resident #6 in the shower room, the Resident became combative and grabbed NA #1 by the

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hair. NA #1 stated she "popped" Resident #6 to get her to let go. Nurse #1 stated Nurse #2 (supervisor) was also present and heard the conversation. NA #1 stayed at the nurse's station with Nurse #1, while Nurse #2 reported the incident to the DON. The DON came to the unit, took a statement from NA #1 and she was suspended. Nurse #1 stated that NA #1 worked with all residents on the secure unit that day from 7:00 AM until she was suspended around 10:30 AM, but Nurse #1 was not aware of any prior incidents of abuse regarding NA #1. Nurse #1 stated she had not been informed that NA #2 witnessed NA #1 slap Resident #6 on the face earlier that morning. Nurse #1 stated Resident #6 was combative at times, usually required 2 staff to give her care. Nurse #1 stated that staff were trained that when residents became combative, staff should give the resident time to calm down, try to redirect and come back later to provide care. Nurse #1 stated Resident #6 was very combative that day and received Ativan (as needed) twice on her shift that day for agitation and later for pain. Nurse #1 stated Resident #6 did not cooperate initially with a skin assessment, and Ativan was given to calm her down. Once Resident #6 was calm, a full body skin assessment was completed, around 12:30 PM and she was noted with a reddened area to her right thigh about 3 inches long and irregular in shape. Nurse #1 stated there were no other changes noted to her skin or face.

The Administrator was interviewed on 02/24/16 at 3:52 PM. She stated that the DON informed her around lunch time on 02/16/16 that NA #1 "popped" Resident #6 on the knee in the shower room and reported herself. The DON told the Administrator that NA #1 was suspended and that

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she had started completing interviews for the investigation. The Administrator continued working in her office and sometime before 4:00 PM she obtained the necessary information from the DON to complete the HCPR 24 Hour Initial Report. The DON left for the day around 4:00 PM, but informed the Administrator before she left that she had obtained all the written statements and interviews. The Administrator did not review the investigation before the DON left because she thought the DON had done everything. The Administrator called law enforcement around 6:00 PM. The Administrator stated she went to see Resident #6 for the first time that day around 7:00 PM when law enforcement arrived. Both she and law enforcement observed Resident #6 without any marks to either thigh. The Administrator stated later that evening, around 9:00 PM, law enforcement called her and asked if she knew about another incident of abuse that happened earlier that day, but the Administrator stated she was not aware and she had not looked at the DON's investigation. The Administrator stated she called NA #2 sometime the next morning on 02/17/16 and obtained a statement from her over the phone regarding both incidents of physical abuse that were witnessed by NA #2 and reported to the DON. The Administrator asked NA #2 to provide written statements about what she saw. The Administrator stated she completed/faxed the HCPR 24 Hour Initial Report on 02/17/16 and the 5 Day Working Report on 02/22/16, but she did not complete a separate report for the incident of physical abuse that occurred on 02/16/16 around 8:00 AM because it was included in her investigation. The Administrator further said that now she realized that both incidents of physical abuse should have been reported to the HCPR.

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{F 226}	Continued From page 25 Nurse #2 was interviewed on 02/25/16 at 10:28 AM. Nurse #2 stated she was the Nurse Supervisor on the 7AM - 3PM shift on 02/16/16. Nurse #2 and Nurse #1 were both at the nurse's station on the secure unit on 02/16/16 around 10:00 AM when NA #1 said "I just want everybody to know that I just popped (named Resident)." NA #1 proceeded to say that she "popped" Resident #6 because the Resident pulled her hair. Nurse #2 stated she asked NA #1 to stay at the nurse's station. Nurse #2 went to find the DON and report what occurred. The DON came to the secure unit, obtained a statement from NA #1 and she was suspended. Nurse #2 stated she was not aware of any previous incidents of abuse between NA #1 and Resident #6. Attempts to interview the DON were unsuccessful. The administrator was notified of immediate jeopardy on 02/24/16 at 5:27 PM An extended survey was conducted on 02/25/16.	{F 226}		
{F 490} SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of facility records, the facility administrative staff failed to	{F 490}	A facility must be administered in a manner that enables it to use its	3/18/16

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{F 490}	Continued From page 26 create and impose a culture that all residents would be protected from abuse and that staff would implement the facility's abuse policy and procedures to intervene, protect and immediately report abuse when witnessed. A combative resident experienced 2 episodes of physical abuse without immediate facility intervention, protection and implementation of abuse policies and procedures for 1 of 1 sampled residents reviewed for abuse (Resident #6). Immediate jeopardy began on 02/16/16 when Nurse Aide (NA) #1 slapped Resident #6 on the face and the witness, NA #2 did not intervene and did not immediately report to administrative staff for protection of Resident #6 and other residents. A second incident of physical abuse occurred on 02/16/16 when NA #1 slapped Resident #6 on the right thigh and the witness, NA #2 did not intervene for the protection of Resident #6. Immediate jeopardy is present and ongoing. The facility provided the State Agency and Centers for Medicare and Medicaid an acceptable allegation of compliance (AOC) on 03/08/16. A revisit survey was conducted on 03/14/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following: Skin audits for all cognitively impaired residents dated 02/16/16 Documentation of interviews regarding abuse for all cognitively intact residents dated 02/16/16 Documentation of in-services (identifying/reporting abuse, caring for residents with dementia) for all currently employed staff completed by 03/07/16 Documentation of abuse monitoring on each shift which began on 02/26/16 and remained ongoing 24 hour/5 day reports for an allegation of abuse	{F 490}	resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. F490 1) On 2/16/16, Resident#6 was assessed by the Medical Director. No new orders were received. On 2/16/16, Resident#6 was assessed by Nurse #1 which included a head to toe assessment. The findings revealed a reddened area on the upper right thigh and small healing bruises. Resident #6 still resides in the facility. On 2/16/16 NA #1 was suspended from employment and terminated on 2/22/16. 2) On 2/16/16, staff nurses completed 100% body audit on all cognitively impaired residents in the facility for evidence of abuse. No negative findings were identified. On 2/16/16, the social worker interviewed all alert and oriented residents related to abuse and resulting in no negative responses. On 2/19/16 NA#2 was disciplined for failure to report immediately allegation of abuse according to the Abuse Policy. On 2/25/16 NA #2 was terminated for not providing safety for Resident#6. 3) On 2/25/16, the administrator received an in-service from the corporate Vice President of Operations on F Tags 225 and 490. The in-service included the following:	

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{F 490}	Continued From page 27 on 03/03/16 and an allegation of neglect on 02/27/16 A 24 hour/5 day report for Resident #6 for the 8:00 AM incident of abuse which had not previously been reported to the Health Care Personnel Registry (HCPR). Both reports were faxed the the HCPR on 02/25/16 Personnel files for all staff hired since 02/16/16 to include criminal background checks, reference checks, Nurse Aide Registry checks, license checks, and abuse training The facility's Abuse Policy Observations of nursing care, interviews with cognitively intact residents, interviews with family, interviews with all staff present in the facility on 03/14/16, review of all documentation to support the AOC and interviews with the facility's Administrator, Director of Nursing and the Nurse Practitioner provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F-490. The immediate jeopardy was removed on 03/14/16 at 7:15 PM. The facility remained out of compliance at F-490 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of their corrective action. The findings included: Cross refer to F 223 - Based on staff interviews and record review, the facility failed to protect a resident's right to be free from physical abuse with immediate intervention when a resident became combative during nursing care. A resident was physically abused twice when a staff member slapped her across the face and then on	{F 490}	The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and 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/her 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. A 24 hour and 5 day report is required for each allegation, including allegations identified during an investigation and/or additional allegations occurring on the same day and/or involving the same employee/resident. The facility must ensure staff effectively and consistently communicate through the chain of command, verbally and in documentation, to attain and maintain resident□s well-being. Staff have been trained to effectively and consistently communicate through the chain of command, verbally and in documentation, to attain and maintain residents□ safety	

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{F 490}	Continued From page 28 the right thigh for 1 of 1 sampled residents reviewed for abuse. (Resident #6). Cross refer to F225 - Based on staff interviews and record review, the staff failed to immediately notify administrative staff of a witnessed incident of physical abuse in which a resident was slapped on the face. Once notified, the facility failed to report the incident of physical abuse to the Health Care Personnel Registry in 24 hours and the investigative findings in 5 working days for 1 of 1 sampled residents. (Resident #6). Cross refer to F 226 - Based on staff interviews and record review, the facility failed to immediately stop nursing care when a resident (Resident #6) became combative to prevent an incident of physical abuse, intervene when physical abuse was observed, and immediately remove the perpetrator from a combative resident on a secure unit. The facility failed to report a witnessed incident of physical abuse to the Health Care Personnel Registry in 24 hours and the investigation in 5 working days. The facility failed to follow their abuse policy and procedures in the areas of prevention, protection, identification, training and reporting of physical abuse for 1 of 1 abuse investigation reviewed. During an interview with the Administrator on 02/24/16 at 3:52 PM, she revealed she was informed by the Director of Nursing (DON) on 02/16/16 around lunch time that abuse occurred in the facility on 02/16/16 around 10:00 AM. The Administrator stated that the DON told her that she had begun the investigation, so the Administrator continued working in her office. The Administrator stated that around 4:00 PM, before leaving for the day, the DON came back to the Administrator's office and told her that she had written statements and interviews, but the Administrator did not review the investigation	{F 490}	from abuse. On 2/26/16, 2/29/16, 3/1/16 or 3/2/16 all staff and contract staff attended a Directed in-service presented by the Regional Ombudsman Area Agency on Aging Titled: Identification and Prevention of Elder Abuse. 4) The Corporate Staff, i.e. clinical nursing consultant and/or regional VP will continue to review all allegations of abuse and interventions when reported to the administrator in accordance with the Abuse Policy including notification of appropriate agencies for 6 months. The monthly QI committee will review results of the Administrative Audit Tool for abuse and continue to review any allegations of abuse i.e. 24 hour/5/day report monthly for 6 months for identification of trends, actions taken and to determine the need for and/or frequency of continued interviews/monitoring and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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{F 490}	Continued From page 29	{F 490}		

conducted by the DON and assumed the DON had it all together. The Administrator stated that later she realized that the DON had not been thorough in her investigation and that as the "captain of the ship" it was her responsibility to make sure all parts of the investigation was completed. The Administrator stated that it was her expectation that staff ensure the safety of combative residents during nursing care and if Resident #6 required the assistance of 2 nursing staff, then depending on whether or not the staff could get to the call bell would determine whether or not staff could call for additional assistance when Resident #6 became combative. The Administrator stated she attributed the failure of staff to immediately report abuse and protect a combative resident from further abuse was due to a lack of training that provided staff with the necessary tools to know how to respond to a combative resident and what to do when a combative resident was abused.

The Medical Director was interviewed on 02/25/16 at 3:36 PM. The Medical Director stated he was in the facility on 02/16/16 and was informed that Resident #6 was combative that day, struck a staff member and the staff member was witnessed to strike back. The Medical Director stated that he was very familiar with Resident #6 and knew that at times she was quite combative, resistive to care and would strike out and try to hit at staff. The Medical Director stated he was involved in developing the plan of correction when abuse occurred in the facility in January 2016. He stated that staff were re-educated to report abuse immediately, if it occurred or was witnessed. If abuse was reported to administrative staff, the Medical Director stated he expected the facility to follow the abuse

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{F 490}	Continued From page 30 protocol for reporting to the proper authorities and continued monitoring to make sure abuse did not continue to occur. The Administrator was informed of immediate jeopardy on 02/24/2016 at 5:27 PM. An extended survey was conducted on 02/25/16.	{F 490}		
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on an observation, staff interviews and review of medical and facility records, the facility failed to transcribe a physician order for 3 months to the treatment record regarding the change of a resident's indwelling Foley catheter every 30 days (Resident #112) and document the correct time of administration of an enteral feeding product (Resident #36) for 2 of 31 medical records reviewed.	{F 514}	F 514 Resident Records 1) On 2/25/16, the staff nurse contacted Resident #112'□s physician and obtained an updated Foley catheter order. On 2/25/16, Resident #112□'s Foley catheter was changed according to the Foley catheter order dated 2/25/16.	3/18/16

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{F 514}	Continued From page 31 The findings included: Resident #112 was admitted to the facility on 10/23/15 with diagnoses of peripheral vascular disease, cerebrovascular accident and hemiplegia. Review of the quarterly Minimum Data Set dated 01/22/16 revealed Resident #112 was moderately cognitively impaired and had an indwelling Foley catheter. Review of the care plan dated 01/28/16 revealed Resident #112 had an altered pattern of urinary elimination with an indwelling catheter and was at risk for infection. The goal was for Resident #112 to be free from urinary tract infection through the next review. Interventions included Foley catheter care per facility protocol and change Foley catheter per physician orders and/or facility protocol. Review of the treatment records (TAR) for Resident #112 revealed the following: · 10/23/15 through 10/31/15 - Foley catheter care once every shift. · 11/01/15 through 11/30/15 - Change Foley catheter every 30 days. Documented on TAR as changed on 11/08/15. No mention of Foley catheter care every shift. · 12/01/15 through 12/31/15 - No mention of Foley catheter care every shift or change Foley catheter every 30 days on TAR. · 01/01/16 through 01/31/16 - No mention of Foley catheter care every shift or change Foley catheter every 30 days. · 02/01/16 through 02/25/16 - No mention of Foley catheter care every shift or change Foley catheter every 30 days. Review of the nurse's notes from 10/23/15 through 02/25/16 revealed no note that Resident #112's Foley catheter had been changed. Review	{F 514}	On 2/25/16, the staff nurse started the Glucema 1.2 enteral feeding at 50 cc/hour as ordered. On 2/25/16 the staff nurse contacted Resident #36□'s physician regarding the resident not getting the Glucema 1.2 as ordered, the resident did not have 35 minutes of the tube feeding product (29.05 cc). No new orders were received. On 2/25/16, the Director of Nursing (DON)reviewed Resident #36□'s weights for the past 3 months with no negative findings. 2) On 2/26/16, DON audited all other residents with a foley catheter and residents receiving enteral feedings for accurate record documentation. There were no negative findings. 3) On 2/26/16, DON initiated an in-service for 100% of nurses regarding documenting the correct time of administration of enteral feeding products, to include continuous feedings. The in-service was completed on 3/7/16. On 3/7/16, DON initiated an in-service for 100% of nurses regarding the timely and accurate transcription of physician orders to the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) to include orders to change a Foley catheter on the TAR. The in-service was completed on 3/14/16. 4) On 3/7/16, DON, QI nurse, staff	

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{F 514}	Continued From page 32 of the nurse's note dated 01/14/16 at 6:25 AM revealed Nurse #5 deflated the balloon of Resident #112's Foley catheter and retracted the Foley catheter out some due to bleeding around the external urethra. An interview conducted with Nurse #4 on 02/24/16 at 9:40 AM revealed she did not know when Resident #112's Foley catheter had last been changed. She stated the last documented Foley catheter change on the TAR was 11/08/15 and there were no orders on the TAR for 12/2015, 01/2016 and 02/2016 to change the Foley catheter every 30 days. Nurse #5 stated the order to change the Foley catheter every 30 days did not get transcribed to the TAR after 11/2015 so she wouldn't have known it needed to be changed. An interview conducted with Nurse #3 on 02/25/16 at 10:15 AM revealed she normally worked the 3:00 PM to 11:00 PM shift with Resident #112. She reviewed the February 2016 TAR for Resident #112 with the surveyor and confirmed there was no order to change Resident #112's Foley catheter every 30 days. She stated she knew the nurse aides provided Foley catheter care during incontinence care but she did not know when the Foley catheter had last been changed because it had not been documented on the TAR for February 2016 and stated it should have been written on the TAR what day of the month and what shift Resident #112's Foley catheter was to be changed. Nurse #5 further stated each nurse on the floor was assigned a couple of charts each month to transcribe orders from the previous month to the next month to the TAR and was not sure if anyone checked the orders behind the person that transcribed them. A phone call was attempted on 02/25/16 at 2:45 PM with Nurse #5 due to her no longer being	{F 514}	facilitator, and/or evening charge nurse will utilize the "Foley Catheter Audit Tool" to validate Foley catheter orders are transferred over from the current month to the new month. The audit will be completed within 5 days of the end-of-month MAR and TAR reconciliation. This audit will be completed for 6 months. On 3/7/16,DON, QI nurse, staff facilitator, and/or evening charge nurse will utilize the "Enteral Feeding Audit Tool" to validate the enteral feeding is being administered according to physician orders, to include nurses writing accurate start times on the enteral feeding bottles. The audits will be completed 5 days a week for 4 weeks, then 2 days a week for 4 weeks, then 1 time a week for 4 months. The DON and/or the QI nurse, and/or the staff facilitator will monitor the "Foley Catheter Audit Tool" results to ensure proper transcription of Foley catheter orders onto the TAR. The DON and/ or QI nurse, or staff facilitator will initial the bottom right corner of the audit tool with the date to acknowledge completion and follow-up The DON and/or the QI nurse,or staff facilitator will monitor the "Enteral Feeding Audit Tool" results to ensure proper administration of enteral feedings. The administrator and/or DON will present	

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{F 514}	Continued From page 33 employed by the facility. A message was left but Nurse #5 did not return surveyors call. During an interview conducted with the Interim Director of Nursing (DON) on 02/25/16 at 3:00 PM she revealed the order to change Resident #112's Foley catheter every 30 days had not been transcribed to the TAR in 12/2015, 01/2016 and 02/2016 and she could not find any documentation in the medical record of the Foley catheter being changed since 11/08/15. The Interim DON stated it was her expectation that all orders be transcribed correctly to the TAR each month. She stated the nurse's should have been checking behind each other for transcription mistakes. 2. Resident #36 was admitted to the facility on 09/17/14. Diagnoses included cognitive deficit, artificial opening of digestive tract, intestinal obstruction, and peritonitis. A physician's order dated 02/12/16 was written for Glucerna 1.2 (enteral feeding product) to infuse at 50 cc per hour, continuously. The physician's order included to provide Resident #36 with a water flush of 500 cc every 4 hours at 2AM, 6AM, 10AM, 2PM, 6PM and 10PM. The physician's order also indicated that staff could cocktail medications (provided all together) and give via the percutaneous endoscopic gastrostomy (PEG) tube. On 02/24/16 at 05:35 AM Resident #36 was in her bed with the head of the bed elevated to approximately 30 degrees. On 02/24/16 at 05:48 AM, the enteral feeding bottle of Glucerna 1.2 was empty and the enteral feeding pump was noted beeping. Nurse #7 was observed to turn off the enteral feeding pump per the request of	{F 514}	the findings from the "Foley Catheter Audit and Enteral Feeding Audit" to the monthly QI committee for recommendations as appropriate to maintain continued compliance and to the quarterly executive QA committee for further recommendations and oversight.	

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Nurse #6. Nurse #6 was noted to gather supplies and medications for Resident #36 which included an enteral feeding bottle of Glucerna 1.2. On 02/24/16 at 06:01 AM, Nurse #6 was observed to record the date of 02/24/16, time of 05:30 AM, and rate of 50 cc on the enteral feeding bottle for Resident #36. On 02/24/16 at 06:05 AM, Nurse #6 administered medications and a water flush to Resident #36 via the PEG tube and started the enteral feeding product.

Nurse #6 was interviewed on 02/24/16 at 6:10 AM and stated he wrote 05:30 AM on the enteral feeding bottle as the administration time because he typically recorded the time he prepared the medications and that was the time he prepared medications for Resident #36. Nurse #6 stated he realized that by recording an administration time of 05:30 AM, Resident #36 missed 35 minutes of TF product.

The Interim Director of Nursing (DON) was interviewed on 02/25/16 at 8:48 AM. During the interview she stated that for accuracy, staff should document the actual time medications were given and enteral feeding products infused so that the medical record would document the correct amount of enteral feeding product infused. The Interim DON stated that based on the hang time Nurse #6 documented for the enteral feeding product, Resident #36 missed 35 minutes of enteral feeding product.