

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/13/2017
NAME OF PROVIDER OR SUPPLIER SILAS CREEK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103	
(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 A complaint investigation survey was conducted from 10/11/17 through 10/13/17. An extended survey was conducted. Immediate Jeopardy was identified at: CFR 483.25 at tag F323 at a scope and severity (J) The tag F323 at a J constituted Substandard Quality of Care. Immediate Jeopardy for tag F323 began on 9/15/17 and was removed on 10/13/17.	F 000		
F 323 SS=J	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with	F 323		11/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/31/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	<p>Continued From page 1</p> <p>the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interviews, staff interviews and record review the facility failed to provide supervision for 1 of 3 sampled residents (Resident #2) reviewed for supervision to prevent accidents (Resident #2). The facility failed to supervise Resident #2, to prevent him from entering another resident's room and choking Resident #1 and then failed to respond timely to Resident # 1's verbal calls for help and the activation of her call light to request staff assistance while she was being assaulted by Resident #2.</p> <p>Immediate jeopardy began on 9/15/17 when Resident #2 entered Resident #1's room, placed his hands around Resident #1's neck and verbally yelled at her to get out of the bed. The staff did not respond to Resident #1's verbal requests for help and when she turned on her call light to request help which resulted in Resident #1 being left alone for a reported 15 to 20 minutes trying to convince Resident #2 to let go of her neck and to get out of bed unassisted in order to get to her room's doorway to try to find someone to help her. As a result of the incident Resident #1 experienced neck pain when turning her head and voiced feeling fear about sleeping at the facility. She left the facility 2 days after the incident. The immediate jeopardy was removed on 10/13/17 at 4:39 pm when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a</p>	F 323	<p>The statements included in this allegation of compliance are not an admission and do not constitute an agreement with the alleged deficiencies herein. The allegation of compliance is completed in compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following allegation of compliance.</p> <p>F323</p> <p>PROVIDE SUPERVISION TO PREVENT ACCIDENTS;</p> <p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;</p> <p>On 9/15/17 at approximately 9:45PM, Resident #1 entered Resident #2 's room, unobserved by staff. Per resident #2, Resident #1 attempted to "choke" resident #2. Once staff became aware of incident, staff responded to resident #2's room and resident #1 assisted away from the area. Between 9:18PM and 9:35PM, two nursing staff members were on meal break. During this time frame three</p>		

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F 323	<p>Continued From page 2</p> <p>scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective.</p> <p>Findings Included:</p> <p>Resident #2 was admitted to the facility on 8/11/17 and his diagnoses included fracture of the pelvis, history of falls, mild cognitive impairment and depressive disorder.</p> <p>A care plan dated 8/14/17 for Resident #2 identified him as an elopement risk, wanderer as evidenced by impaired safety awareness. Interventions included identify patterns of wandering, intervene as appropriate, provide re-orientation strategies and structured activities.</p> <p>A review of the admission comprehensive Minimum Data Set (MDS) dated 8/25/17 for Resident #2 revealed his cognition was severely impaired, required supervision one person assist with mobility on and off the unit and demonstrated no behaviors during the look back period.</p> <p>A review of a nursing progress note dated 9/14/17 at 8:07 pm for Resident #2 revealed he was self-propelling in his wheelchair in the hallway. Resident #2 stated he was in a hotel and his wife was missing and she had all of his money. Resident #2 was brought to the nurse's station and called his wife so that resident could speak with her. Resident #2 calmed down after speaking to his wife.</p> <p>A review of a nursing progress note for Resident #2 dated 9/16/17 at 1:20 am (referencing the incident on 9/15/17), written by Nurse #1</p>	F 323	<p>nursing staff members remained to provide care for the 34 residents on the unit. There were no incidents or grievances outside of this event.</p> <p>Resident # 1 was discharged to the emergency room after the incident on 9/15/17 and did not return to the facility. Resident #2 was discharged from the facility on 9/18/17.</p> <p>An initial investigation began on 9-16-17, into the incident between Resident #1 and Resident #2, was conducted by the Director of Nursing to include interview of staff who were assigned to resident # 1 and resident #2 and all other staff working second shift (3:00PM – 11:00PM) on unit "A", on 9-15-17. The investigation revealed that resident #2 stated she "felt safe" in the facility as long as resident #1 was not in the facility. Interviews by the Director of Nursing and Social Services with Resident #2 and her family member revealed there were no concerns regarding the timeliness of call light response. There was no reasonable foreseeability that the incident would occur based on the assessment of resident #1 prior to the incident.</p> <p>An additional investigation was initiated on 10/12/17 due to new information that was relayed to the nursing home administrator and director of nursing by the state surveyor. State surveyor stated that resident #2 stated her call light was on for twenty minutes, resident# 2's roommate stated the call light was on for fifteen</p>		

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F 323	<p>Continued From page 3</p> <p>revealed she was called to Resident #1's room by a staff member. Resident #1 reported to her that Resident #2 had come into her room and began to choke her, yelling that she was in his wife's bed and he paid for this room. Assigned nursing assistant (NA) reported when she attempted to remove Resident #2 from the room and take him to his room he pushed her and grabbed her arm. The MD for Resident #2 was notified and gave a verbal order to transfer Resident #2 to the emergency department. The Administrator on call was notified and reported that she would notify the Director of Nursing (DON). This nurse called 911 and Resident #2 was transferred via ambulance.</p> <p>Review of Resident #1's medical record revealed she was admitted to the facility on 9/15/17 following gallbladder surgery. A review of the facility admission assessment, resident data set dated 9/15/17 for Resident #1 revealed she was alert and cognition was intact. A review of the functional abilities and goals dated 9/15/17 for Resident #1 revealed she required supervision to moderate assistance with mobility, could walk but was not attempted due to health condition.</p> <p>A review of a nursing progress note for Resident #1 dated 9/16/17 at 1:51 am (referencing the incident on 9/15/17) written by Nurse #1 revealed Resident #1 had called for assistance and reported that Resident #2 came in her room and choked her. Resident #3 (the roommate of Resident #1) stated that Resident #2 had his hands around Resident #1's neck and was choking her. Resident #1 called her family and they arrived back at the facility. Resident #1 stated she was afraid. This nurse notified Resident #1's family that Resident #2 had been</p>	F 323	<p>minutes and nobody responded. This was the first time the facility was made aware of a delay in call light response time during the incident. Upon interviewing resident #2's roommate on 10/12/17, she stated the call light response time on the night of the incident was "five or ten minutes, but more like five". Roommate stated she has never had a concern with call light response during her stay.</p> <p>The procedure for implementing the acceptable plan of correction for the specific deficiency cited;</p> <p>An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted on 10/13/17 and included the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Social Worker and Primary Care Physician, to analyze incident occurring on 9-15-17 and developed a Quality Assurance Improvement Plan. The policy for abuse prohibition was reviewed with the QAPI committee on 10/13/17. F-323 and allegation of compliance with supporting documentation was reviewed by the QAPI committee on 10/13/17.</p> <p>All residents currently residing in the facility were assessed utilizing the Minimum Data Set (MDS) - Section C (cognition) and Section E (behaviors) by the facility MDS nurse(s), Social Service Director or Director of Nursing, by 10-13-17 to ensure there is no reasonable foreseeability of resident to resident</p>		

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F 323	<p>Continued From page 4 transferred out of the facility.</p> <p>A review of a nursing progress note dated 9/18/17 at 1:43 am for Resident #1 revealed "Resident was quiet and had no complaints of pain. Assisted to the bathroom. Resident was afraid at hours of sleep (HS)."</p> <p>A review of a nursing progress note dated 9/18/17 at 9:51 am, written by the DON, for Resident #1 revealed she saw Resident #1 and her daughter in with the Social Worker this morning. Writer walked into Social Worker's office to assess resident for mental anguish. Resident #1 stated she was fine, but her daughter stated that Resident #1 would be going home as she could provide care for her at home. Resident #1 reported that she ate and swallowed without issue. No bruising noted to neck. Observed full range of motion (ROM) of neck as resident turned to address writer. Daughter informed that resident would leave after her follow-up appointment with surgeon.</p> <p>A review of the physician's discharge summary dated 9/18/17 for Resident #1 stated "She suffered an assault by another resident who had dementia but no history of violence. We discussed the assault by another resident that occurred over the weekend. Resident #1 still has soreness with rotating her head. The police did speak to the resident and her family when they came to take Resident #2 to the emergency room."</p> <p>A phone interview was conducted with Resident #1 on 10/12/17 at 10:51 am. During this interview Resident #1 stated that on 9/15/17 at approximately 10:00 pm she was in her bed, but</p>	F 323	<p>altercation, based on those resident's assessed cognitive status and assessed patterns of behavior. After review, no residents were found to have reasonable foreseeability with regard to resident to resident altercations.</p> <p>A questionnaire to include 100% of all alert and oriented interviewable residents was conducted on 10/12/17 by Nursing Management asking each resident:</p> <p>Is your call light answered in a timely manner? Do you feel safe here in the facility? Has anyone ever wandered into your room and made you feel threatened? If you feel threatened do you know what to do?</p> <p>After review of all questionnaires, no patterns were identified that indicated lack of substantial compliance with regards to call light response, resident supervision and/or facility safety.</p> <p>In-servicing of 100% of all licensed and non-licensed staff to include; The Facility's Policy on Abuse, Call light response, Assigned staff break times, Rounding and supervision of assigned residents, and preventing aggressive resident injuries was completed by 10-13-17, by the Staff Development Coordinator, Social Services Director, and Human Resources Coordinator. The education consisted of the definition of abuse meaning; the willful infliction of injury, unreasonable confinement, intimidation, or punishment</p>		

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F 323	Continued From page 5 was not asleep. She stated she heard someone enter her room and then felt the person put their hands around the back of her neck and applied pressure to her neck. Resident #1 explained that Resident #2 was choking her and he kept yelling at her to get out of his wife's bed that he had paid for it. She stated this went on for 2 to 3 minutes and Resident #2 continued to apply pressure to her neck. She added that she was able to locate her call light and turned it on to request staff assistance to help her. She also called out to her roommate that a man was attacking her and to call for help. Resident #1 stated that about 5 minutes went by and no one responded to the call bell or her yells for help, so she decided she needed to try to get up on her own to find someone to help her. Resident #1 explained she was able to sit up in bed and at that time the man moved his hands to the sides of her neck. She was able to scoot to the end of her bed and she told Resident #2 that she was getting out of the bed, so they could go find his wife. Resident #2 then let go of her neck. She stated she was able to walk to the doorway of her room and feared that she would fall because she wasn't supposed to be getting up on her own. Resident #1 added she got into the hallway, but didn't see any nurses. She did see another male resident and yelled to him to get her help. She stated another 2 to 3 minutes went by and then a nurse came down the hall and tried to get Resident #1 out of her room. Resident #1 explained that Resident #2 pushed the nurse into the wall as she took him back to his room. She stated it took approximately 20 minutes from the time Resident #2 entered her room until she got help from the staff. She added she was extremely scared and could not sleep after that. She also stated she continued to have soreness to her neck when she	F 323	with resulting harm, pain or mental anguish. Additionally, education included call light response, rounding, and supervision of residents with emphasis on ensuring call lights are responded to as quickly as possible, performing unit rounds to supervise and identify any resident needs and strategies to manage residents with aggressive behaviors. On each shift, the Licensed Nurse will assign staggered break and lunch times to all scheduled Nurse Aides, as the Licensed Nurse acts as the Nurse Aides' immediate supervisor. The Nurse Aides will verbally notify the Licensed Nurse they will be leaving the unit for their assigned break. Any staff member who was not in-serviced will not work and will be removed from the schedule until this in-servicing is completed with them. These in-services will be added to the general orientation of all new staff from this point forward. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; To remain in compliance and under the direction of the Administrator, beginning 10-12-17, on second shift (3:00PM – 11:00PM), call light monitoring commenced. This call light monitoring will be performed every shift (on first shift, 7:00AM-3:00PM, second shift, 3:00PM-11:00PM and third shift, 11:00PM-7:00AM), including weekends for		

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F 323	<p>Continued From page 6</p> <p>tried to turn her head. Resident #1 added she did not want to be alone in the room as she was afraid someone was going to come in and attack her again and her family took her home on 9/18/17. She stated her concern was that it took so long for anyone to come and help her.</p> <p>An interview was conducted on 10/11/17 at 6:30 pm with Resident #3 (the roommate of Resident #1 during the incident) who was identified as alert and oriented per Section C of her most recent MDS. Resident #3 stated she did recall the night that Resident #1 was choked by another resident. She stated it was Resident #1's first night at the facility and they were both in bed. She had the privacy curtain pulled between them, but at about 10:00 pm she heard Resident #1 call out there was a man in the room and he was choking her. Resident #1 yelled out to me for help and asked me to turn on the call light. The roommate stated she turned on her call light but no one came, she believed their NA was on her break. She explained it was too dark in her room to see her clock but estimated it was about 10 or 15 minutes before anyone came. The roommate stated that somehow Resident #1 was able to get loose from the male resident and went out into the hallway to call for help. The male resident remained in their room. She added eventually the NA came and got the male resident out of the room. She stated the male resident kept saying to Resident #1 that this was his wife's bed and you need to get out of it. The roommate stated Resident #1 was very upset about the incident and was afraid to go to sleep. She stated she didn't understand why it took so long for the staff to come because the door to their room was open and she thought someone would have heard them yelling for help. The roommate added after the incident they started</p>	F 323	<p>2 weeks, then 3x per week, all shifts, including weekends for 6 weeks, then weekly for 4 weeks all shifts. This monitoring will be performed by the Administrator, Director of Nursing, Staff Development Coordinator or Administrator's designee.</p> <p>A facility questionnaire will be conducted by Nursing Management asking each resident:</p> <p>Is your call light answered in a timely manner? Do you feel safe here in the facility? Has anyone ever wandered into your room and made you feel threatened? If you feel threatened do you know what to do?</p> <p>The questionnaire will be utilized to include 10 residents per day for 2 weeks, including weekends, then 10 residents 3x per week, including weekends for 6 weeks, then 10 residents weekly for 4 weeks. This monitoring will be performed by the Administrator, Director of Nursing, Staff Development Coordinator or Administrator's designee. Any areas of concern will be addressed through the facilities' grievance process.</p> <p>By 11/13/17, all licensed and non-licensed staff will be educated by the Director of Nursing, Unit Manager and/or Regional Clinical Director on resident rights. Specifically, education will emphasize ensuring residents have a right to be free from abuse and resident rights should be</p>		

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F 323	<p>Continued From page 7</p> <p>keeping their door closed at night.</p> <p>An interview with the Director of Nursing (DON) on 10/11/17 at 4:30 pm revealed she was aware of the incident between Resident #1 and Resident #2. She stated she was notified on Sunday (09/17/17) about Resident #2 entering Resident #1's room and choking her on 09/15/17. She stated that she had spoken to the nurse and NA that were assigned to Resident #1 about the incident. The DON added she had spoken to Resident #1 on Monday and she thought the resident seemed okay. She stated she had not initiated any formal investigation of the incident.</p> <p>An interview on 10/11/17 at 7:50 pm with NA #1 revealed she was the NA for Resident #1 and Resident #2 the evening the incident occurred on 09/15/17. She stated she had taken her break, but couldn't remember exactly what time it was because they don't have a set break time. She believed it was about 9:00 pm or 9:30 pm. NA #1 explained that when they took their 30 minute break they were supposed to let the nurse and another NA know that they were off the unit so they could watch their residents and answer their call lights. She couldn't recall who covered for her that night when she went on break or if she had informed them that she was going on her break. NA #1 stated when she got back from her break she heard a male resident calling for someone to come and help Resident #1. NA #1 explained that Resident #1 was out in the hallway and Resident #2 was in Resident #1's room. She added that she tried to get Resident #2 back to his own room, but he was agitated and didn't want to leave the room. He pushed NA #1 up against the wall. She stated she eventually got him back to his room and stayed with him until the ambulance</p>	F 323	<p>protected by staff. The facility will protect resident rights by ensuring ongoing education of staff including ensuring licensed and non-licensed staff have annual and PRN (as needed) education related to resident rights. Education on resident rights will continue to be a part of general orientation for all new staff.</p> <p>By 11/13/17, all licensed and non-licensed staff will be educated by the Director of Nursing, Unit Manager and/or Regional Clinical Director on how to identify residents with dementia who may have the potential to exhibit violent behaviors including resident to resident altercations. Education will focus on ensuring staff are able to recognize potential triggers such as environmental and internal triggers and are adept to manage/address potential violent behaviors.</p> <p>Director of Nursing, Unit Managers, Staff Development and Weekend Supervisor will validate the staff's retention of the education presented by conducting education validation audits randomly throughout all three shifts including weekends. Licensed and Non-Licensed Staff will be presented with a series of questions regarding the education presented. Those noted with opportunities will be immediately re-educated. The Administrator and/or Staff Development Coordinator will review these audits weekly for 12 weeks.</p> <p>Upon admission and quarterly thereafter, all residents will be assessed by the</p>		

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F 323	<p>Continued From page 8</p> <p>came. NA #1 added that Resident #1's family came to the facility and they were trying to get Resident #1 to go back into her room. She stated Resident #1 told her that Resident #2 had choked her and she didn't want to be alone in her room. NA #1 explained that she had cared for Resident #2 since he had been there and he was confused, but she had never seen him be aggressive before. She added that she had not observed Resident #2 wandering that evening and he had been in his room when she left to go on break.</p> <p>A phone interview on 10/11/17 at 8:10 pm with Nurse #1 confirmed she was the nurse for both Resident #1 and Resident #2 the evening of the incident on 09/15/17. She stated she was in the medication room getting Resident #1's medications together when a NA #1 came and got her and told her that Resident #2 had entered Resident #1's room and choked her. She went to Resident #1's room and assessed Resident #1's neck for any injuries. Nurse #1 explained Resident #1 was in her bed at that time and as far as she knew Resident #1 had never gotten out of her bed during the incident. She stated that NA #1 had gotten Resident #2 back in his room. She contacted the physician (MD) and he told her to have Resident #2 sent to the hospital. She arranged for transport and contacted both of the resident's families. Nurse #1 stated she also notified the administrator on call who contacted the DON. Nurse #1 added she did not recall the MD giving any new orders or instructions for Resident #1 after the incident. She explained that she had cared for Resident #2 and he had sundowners. She added that he would sometimes wander during the evening looking for</p>	F 323	<p>Licensed Nurse utilizing section "B" (cognition/communication/mood/behavior) of the resident data set in Point Click Care. Based on this assessment, individualized care needs will be established for residents with dementia who have the potential to exhibit outburst and/or violent behaviors. Care needs will be communicated to licensed and non-licensed staff via the resident care plan and Kardex.</p> <p>All monitoring tools, call light monitoring, resident questionnaires and staff retention of education, will be reviewed by the Director of Nursing and any deficiencies will be addressed immediately, then reported to the Administrator. The findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action, monthly for 3 months or until substantial compliance is achieved.</p> <p>The title of the person responsible for implementing the acceptable plan of correction:</p> <p>Mark Farran, Administrator.</p>		

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F 323	<p>Continued From page 9</p> <p>his wife and they would let him call her on the phone. She stated Resident #2 would make statements like where was his wife going to stay and how was he going to pay for this, but he had not displayed any physically aggressive behaviors. She added that Resident #2 had been in his room the last time she had seen him during the evening of 09/15/17. Nurse #1 stated that when a NA goes on break one of the other NAs would cover their assignment and also the nurse should help answer call lights if needed. She stated the NAs were supposed to notify the nurse and another NA when they left the unit for their break, but she didn't recall if NA #1 notified anyone that evening that she was going on break. Nurse #1 added that they were fully staffed on their unit that evening.</p> <p>During an interview on 10/11/17 at 8:43 pm with NA #2 stated he was also working on the unit the evening of the incident on 9/15/17. He further stated he heard that Resident #2 had entered Resident #1's room and choked her, but he didn't know either of the residents and hadn't been assigned to them. He added there were typically 3 NAs scheduled for second shift on their unit and they had 10 to 11 residents on their assignment. NA #2 explained that they had a 30 minute break and they usually didn't start taking their breaks until 8:00 pm to 8:30 pm. He stated that the 30 minute breaks were not scheduled; they were just supposed to let their nurse and another NA know they were going on break so they could cover their assignments.</p> <p>An interview on 10/11/17 at 8:51 pm with NA #3 revealed she was assigned to the unit that Resident #1 and Resident #2 resided on the evening of the incident on 9/15/17. She stated the</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>nurse had told her about what happened, but she had not been assigned to either of the residents. NA #3 added that she was somewhat familiar with Resident #2, she would occasionally see him roll around the unit in his wheelchair but the majority of the time she saw him in his room. NA #3 explained that there were 3 NA's assigned to their unit and they each typically had 4 or 5 rooms a piece (8 to 10 residents). She added that they were fully staffed the evening of the incident. NA #3 stated she would try and take her break about 8:30 pm and she would notify the nurse and NAs that she was going on break so they could watch for the call lights on her assignment. She added that she did not recall who was covering for NA #1 when she was on break the night of the incident, but she had not responded to any call lights on that assignment. NA #3 stated they did not have assigned break times.</p> <p>A review of the employee schedule for 9/15/17, provided by the DON, revealed there were 5 staff members assigned for second shift (3:00 PM to 11:00 PM) to the nursing unit that Resident #1 resided on. The 5 staff members consisted of 2 nurses and 3 NAs. The time card records dated 9/15/17 for the 5 staff members were provided by the DON. The records revealed that NA #1 went on break at 9:03 pm and returned at 9:35 pm. NA #2 went on break at 9:18 pm and returned at 9:48 pm. These records revealed that left only 1 NA (NA #3) on the unit for 34 residents.</p> <p>An interview on 10/12/17 at 3:25 pm with the DON revealed that the NA's were supposed to stagger their breaks so they weren't off the unit at the same time. She stated that their breaks were currently not scheduled.</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>An interview on 10/13/17 at 10:30 am with the physician for Resident #1 and Resident #2 revealed he recalled being contacted about the incident between the two residents on 9/15/17. He stated he gave a verbal order to have Resident #2 sent to the emergency room and for him to be admitted to the behavioral health unit. The physician added he had seen Resident #1 on 9/18/17 and she had complained of soreness to her neck with movement of her head. He did not recall that she had any bruising or scratches to her neck. He clarified that the police had not been contacted regarding the incident as he had documented in his progress note for Resident #1 on 9/18/17.</p> <p>On 10/12/17 at 3:25 pm, the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation on 10/13/17 at 1:42 pm. The allegation of compliance indicated:</p> <p>On 9/15/17 at approximately 9:45PM, Resident #2 entered Resident #1 's room, unobserved by staff. Per resident #1, Resident #2 attempted to "choke" resident #1. Once staff became aware of incident, staff responded to resident #1's room and resident #2 assisted away from the area. Between 9:18PM and 9:35PM, two nursing staff members were on meal break. During this timeframe three nursing staff members remained to provide care for the 34 residents on the unit. There were no incidents or grievances outside of this event.</p> <p>Resident #2 was discharged to the emergency room after the incident on 9/15/17 and did not return to the facility. Resident #1 was discharged from the facility on 9/18/17.</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>An initial investigation began on 9-16-17, into the incident between Resident #1 and Resident #2, was conducted by the Director of Nursing to include interview of staff who were assigned to resident # 1 and resident #2 and all other staff working second shift (3:00PM - 11:00PM) on unit "A", on 9-15-17. The investigation revealed that resident #1 stated she "felt safe" in the facility as long as resident #2 was not in the facility. Interviews by the Director of Nursing and Social Services with Resident #1 and her family member revealed there were no concerns regarding the timeliness of call light response. There was no reasonable foreseeability that the incident would occur based on the assessment of resident #2 prior to the incident.</p> <p>An additional investigation was initiated on 10/12/17 due to new information that was relayed to the nursing home administrator and director of nursing by the state surveyor. State surveyor stated that resident #1 stated her call light was on for twenty minutes, resident# 1's roommate stated the call light was on for fifteen minutes and nobody responded. This was the first time the facility was made aware of a delay in call light response time during the incident. Upon interviewing resident #1's roommate on 10/12/17, she stated the call light response time on the night of the incident was "five or ten minutes, but more like five". Roommate stated she has never had a concern with call light response during her stay.</p> <p>An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted on 10/13/17 and included the Administrator, Director of Nursing, Medical Director, Staff Development</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>Coordinator, Social Worker and Primary Care Physician, to analyze incident occurring on 9-15-17 and developed a Quality Assurance Improvement Plan. The policy for abuse prohibition was reviewed with the QAPI committee on 10/13/17. F-323 and allegation of compliance with supporting documentation was reviewed by the QAPI committee on 10/13/17.</p> <p>All residents currently residing in the facility were assessed utilizing the Minimum Data Set (MDS) - Section C (cognition) and Section E (behaviors) by the facility MDS nurse(s), Social Service Director or Director of Nursing, by 10-13-17 to ensure there is no reasonable foreseeability of resident to resident altercation, based on those resident's assessed cognitive status and assessed patterns of behavior. After review, no residents were found to have reasonable foreseeability with regard to resident to resident altercations.</p> <p>A questionnaire to include 100% of all alert and oriented interview able residents was conducted on 10/12/17 by Nursing Management asking each resident:</p> <ul style="list-style-type: none"> · Is your call light answered in a timely manner? · Do you feel safe here in the facility? · Has anyone ever wandered into your room and made you feel threatened? · If you feel threatened do you know what to do? <p>After review of all questionnaires, no patterns were identified that indicated lack of substantial compliance with regards to call light response, resident supervision and/or facility safety.</p>	F 323			

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F 323	Continued From page 14 In-servicing of 100% of all licensed and non-licensed staff to include; The Facility's Policy on Abuse, Call light response, Assigned staff break times, Rounding and supervision of assigned residents, and preventing aggressive resident injuries was completed by 10-13-17, by the Staff Development Coordinator, Social Services Director, and Human Resources Coordinator. The education consisted of the definition of abuse meaning; the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish. Additionally, education included call light response, rounding, and supervision of residents with emphasis on ensuring call lights are responded to as quickly as possible, performing unit rounds to supervise and identify any resident needs and strategies to manage residents with aggressive behaviors. On each shift, the Licensed Nurse will assign staggered break and lunch times to all scheduled Nurse Aides, as the Licensed Nurse acts as the Nurse Aides ' immediate supervisor. The Nurse Aides will verbally notify the Licensed Nurse they will be leaving the unit for their assigned break. Any staff member who was not in-serviced will not work and will be removed from the schedule until this in-servicing is completed with them. These in-services will be added to the general orientation of all new staff from this point forward. To remain in compliance and under the direction of the Administrator, beginning 10-12-17, on second shift (3:00PM - 11:00PM), call light monitoring commenced. This call light monitoring will be performed every shift (on first shift, 7:00AM-3:00PM, second shift, 3:00PM-11:00PM and third shift, 11:00PM-7:00AM), including	F 323			

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F 323	<p>Continued From page 15</p> <p>weekends for 2 weeks, then 3x per week, all shifts, including weekends for 6 weeks, then weekly for 4 weeks all shifts. This monitoring will be performed by the Administrator, Director of Nursing, Staff Development Coordinator or Administrator's designee.</p> <p>A facility questionnaire will be conducted by Nursing Management asking each resident:</p> <ul style="list-style-type: none"> · Is your call light answered in a timely manner? · Do you feel safe here in the facility? · Has anyone ever wandered into your room and made you feel threatened? · If you feel threatened do you know what to do? <p>The questionnaire will be utilized to include 10 residents per day for 2 weeks, including weekends, then 10 residents 3x per week, including weekends for 6 weeks, then 10 residents weekly for 4 weeks. This monitoring will be performed by the Administrator, Director of Nursing, Staff Development Coordinator or Administrator's designee. Any areas of concern will be addressed through the facilities' grievance process.</p> <p>Director of Nursing, Unit Managers, Staff Development and Weekend Supervisor will validate the staff 's retention of the education presented by conducting education validation audits randomly throughout all three shifts including weekends. Licensed and Non-Licensed Staff will be presented with a series of questions regarding the education presented. Those noted with opportunities will be immediately re-educated. The Administrator and/or Staff</p>	F 323			

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F 323	<p>Continued From page 16</p> <p>Development Coordinator will review these audits weekly for 12 weeks.</p> <p>The title of the person responsible for implementing the acceptable plan of correction: Mark Farran, Administrator.</p> <p>The credible allegation was verified on 10/13/17 at 4:39 pm. Random observations were made through-out the facility on 10/13/17 from 1:45 pm through 3:45 pm and no concerns were identified related to resident supervision. The Ad Hoc QA meeting was reviewed and identified the meeting had been conducted on 10/13/17 at 9:30 am and was attended by the Administrator, DON, Medical Director (via phone), Vice President of Operations, Regional Clinical Director, Staff Development Coordinator, Social Worker and Primary Care Physician. The agenda for the meeting revealed the meeting was conducted to address the allegation of compliance for F-323 as it related to supervision to prevent accidents and timely response to call bells. The MDS audits for all residents residing in the facility were reviewed and confirmed that Section C (Cognition) and Section E (Behaviors) had been completed and the results of the audit did not identify any concern for resident to resident altercations. The results of the questionnaire that had been completed with alert and oriented residents residing in the facility were reviewed. 62 residents were able to complete the questionnaire. 7 of the 62 responses identified that call bells were not answered timely. No residents identified that they did not feel safe at the facility. Random staff interviews were conducted in person and via the phone on 10/13/17 from 3:05 pm through 3:45 pm. All staff members interviewed were able to confirm that</p>	F 323			

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F 323	Continued From page 17 they had been in-serviced on abuse, call light response, assigned staff break times, rounding / supervision and prevention of aggressive resident injuries. Immediate jeopardy was removed on 10/13/17.	F 323			