STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	C 11/16/2017

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UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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F 000	INITIAL COMMENTS A complaint survey was conducted 11/13/17 through 11/16/17. Immediate Jeopardy was identified at: CFR 483.12 at tag F 223 at a scope and severity (J) CFR 483.12 at tag F 225 at a scope and severity (J) CFR 483.12 at tag F 226 at a scope and severity (J) The tags F223, F225, F226 constitued Substandard Quality of Care. Immediate Jeopardy began on 10/26/17 for resident #1 and was removed on 11/16/17. An extended survey was conducted. The state of deficiencies was amended on 12/19/17 at tag 241 to scope and severity from a D to G.	F 000		
F 157 SS=E	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 157		12/28/17

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

Electronically Signed | 12/11/2017

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F 157	Continued From page 1 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident and physician interviews, the facility failed to notify the physician when insulin injections were not administered as ordered for 3 of 3 residents	F 157	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an	

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F 157	Continued From page 2 reviewed (Residents #1, #6 and #7). Findings included: 1. Record review revealed Resident #1 was admitted to the facility on 5/12/2017 with diagnoses which included Diabetes, Hypertension and Coronary Artery Disease. Review of Resident #1's signed physician orders revealed an order initiated and dated 5/13/2017 for 12 units of insulin to be administered subcutaneously (injected between the skin and muscle) twice a day at 8:30 AM and 4:30 PM. The order was continued monthly and signed by the physician. The Admission Minimum Data Set (MDS) dated 5/19/29017 indicated Resident #1 was cognitively intact and required limited assistance of 1 person with all activities of daily living (ADLs). The MDS indicated the resident received insulin injections daily. Review of Resident #1's care plan dated 5/19/2017 revealed the resident was at risk for hypoglycemia/hyperglycemia (low blood sugar levels/high blood sugar levels). The interventions for the risk included medications and insulin to be administered as ordered. Record review of the Medication Administration Record (MAR) for Resident #1 from 10/19/2017 through 11/14/2017 revealed 11 documented late administration times for the resident's 8:30 AM insulin dose and 7 documented late administration times for the 4:30 PM insulin dose. The documented times for administration were beyond the 60 minute window of administration opportunity. An interview and medication administration observation was conducted with Resident #1 on 11/15/2017 at 8:55 AM. The resident was	F 157	admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F157E ROOT CAUSE This alleged noncompliance was resulted from the Center's Licensed staff not signing medication on the electronic health records immediately after medication is administered, and the facility lack of awareness of requirements related to notification to Physician of medication administered out of time frame as specified in the center s medication administration Policy and Procedures. IMMEDIATE ACTION On 12/08/2017 Resident #1, #6, #7 attending physician(s) were notified of incidents of late administered insulin in that happen in the last 30 day by the Assistant Director of Nursing. No new orders received from this notification. IDENTIFICATION OF OTHERS 100% audit of all current resident with insulin orders completed on 12/08/2017 by Director of Nursing, and/or Assistant Director of Nursing to identify any other resident with the documented times of administration beyond the 60 minutes window in the last 30 days, and verified whether Physician was notified or not. The audit revealed 29 other residents	

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F 157	Continued From page 3 observed sitting up in bed. Nurse #5 prepared and administered the resident's insulin. Nurse #5 exited the room after the medication was administered. During the interview with the resident she indicated her insulin was to be administered at 8:30 AM and 4:30 PM. She reported there were times the insulin administration was late. The resident also reported she knew the nurses had an hour past the scheduled time to administer it before they considered it late. The resident indicated there were times it was several hours late. The resident reported her 4:30 PM insulin dose was administered around 8:30 PM by Nurse #2 the evening prior to the interview. The resident stated she felt fine and was aware when she had issues with her blood sugars, but felt the insulin should be administered as ordered. An interview was conducted with Nurse #5 on 11/15/2017 at 9:17 AM. Nurse #5 indicated Resident #1 was on her regular assignment and she was very familiar with her care. Nurse #5 reported there were times she administered the residents morning insulin late but tried to be very conscious of the time. Nurse #5 indicated most mornings it was administered within the hour of opportunity but there were mornings she just couldn't get to her due to other situations. Nurse # 5 stated she did not notify the physician when the insulin was administered late. An interview was conducted with Nurse #2 on 11/15/2017 at 10:40 AM. Nurse #2 confirmed he was the nurse who worked with Resident #1 on 11/14/2017. Nurse # 2 indicated the resident's 4:30 PM insulin was administered at around 8:30 PM. The nurse stated he apologized to the resident for the late administration. Nurse #2 reported he probably administered the insulin late because he was busy with admissions or	F 157	identified with insulin orders with documented times of administration beyond 60 minutes, attending physician for each resident notified on 12/08/2017 by the Director of Nursing. No new orders received from this notification. SYSTEMIC CHANGES Effective 12/28/2017, and moving forward, all insulin orders will be administered within 60 minutes of administration opportunity window. Licensed nurses will document the administration immediately afterward in resident's record. In the event that insulin administration take place outside the 60 minutes window of administration opportunity, resident attending Physician will be notified immediately. The notification will be documented in resident's clinical records. Effective 12/28/2017, and moving forward, If a Licensed nurse delayed to document in Electronic Medication Administration Record (eMAR) immediately after the administration of insulin that occurs within 60 minutes of administration opportunity window, the Licensed nurses will document administration both on eMARs immediately after is able and on resident's nurses notes indicating the accurate time of administration that will clarify auto stamped time on eMARs. In this event the physician will not be notified as the insulin administration took place within the 60 minutes window of administration opportunity. Effective 12/28/2017, the center nursing administrative team, which includes Director of Nursing, Assistant Director of Nursing, and/or Staff Development	

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F 157	Continued From page 4 something else. Nurse # 2 indicated there were times he was unable to get the resident's insulin to her on time for various reasons. Nurse #2 indicated he did not document the reason when it was administered late and he did not notify the physician. Nurse #2 further indicated if the resident displayed signs or symptoms of blood sugar issues he would notify the physician. An interview was conducted with Resident #1's physician on 11/16/2017 at 2:20 PM. The physician reported he was very familiar with Resident #1 and her medication regimen. The physician also reported he reviewed her blood sugars and labs when he made his facility visits to ensure there were no concerns or issues with her diabetic management. The physician indicated he was unaware of any scheduled insulin doses given late. The physician stated there was an hour of opportunity for the administration and he expected the insulin to be administered on time. The physician indicated the insulin was scheduled for the well-being of the resident and he expected to be notified if the insulin was administered beyond the hour of opportunity. An interview was conducted with the Director of Nursing (DON) on 11/16/2017 at 3:32 PM. The DON indicated the expectation was the physician be notified if scheduled insulin was administered late. 2. Record review revealed Resident #6 was admitted to the facility on 1/21/2013 with diagnoses which included Diabetes, Hypertension and Hemiplegia (paralysis on one side of the body). Review of Resident #6's signed physician orders for October 2017 and November 2017 revealed an order for 15 units of insulin to be administered	F 157	Coordinator will initiate a process for reviewing clinical documentation for the last 24 hours, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DHS, ADHS, SDC and/or Unit coordinators. This process will be incorporated in a daily clinical rounds. Any negative findings will be documented on the daily clinical checklist form and maintained in the daily clinical meeting binder. Effective 12/28/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place every Saturday & Sunday. Any identified issues will be addressed promptly and appropriate actions will be implemented by the DHS, ADHS, SDC and/or Registered Nurse supervisor. This process will be incorporated in daily clinical rounds. Any negative findings will be documented on the daily checklist form and maintained in the daily clinical	

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F 157	Continued From page 5 subcutaneously (injected between the skin and muscle) twice a day at 9:00 AM and 5:00 PM. Review of Resident #6's Annual Minimum Data Set (MDS) dated 9/25/2017 revealed the resident was moderately cognitively impaired and required the extensive assistance of 2 persons for all activities of daily living (ADLs). The MDS indicated the resident received insulin injections daily. Review of Resident #6's care plan updated 11/14/2017 revealed the resident was at risk for alteration in blood sugars related to Diabetes. The interventions for the risk included medications and insulin to be administered as ordered. Record review of the Medication Administration Record (MAR) for Resident #6 from 10/19/2017 through 11/14/2017 revealed 7 documented late administration times for the resident's 9:00 AM insulin dose and 7 documented late administration times for the 5:00 PM insulin dose. The documented times for administration were beyond the 60 minute window of administration opportunity. An interview was conducted with Nurse #6 on 11/16/2017 at 10:15 AM. Nurse #6 indicated she worked with Resident #6 regularly. Nurse #6 reported the resident would wheel around the facility in his wheel chair and the insulin is given late due to the resident not being available at the time the insulin was scheduled to be given. The nurse indicated there were times it was administered outside of the hour window of opportunity to administer medications. The nurse stated she did not document the reason the insulin was given late and did not notify the physician. An interview was conducted with Resident #6's physician on 11/16/2017 at 2:20 PM. The	F 157	meeting binder. Director of Nursing (DHS), Assistant Director of Nursing (ADHS) and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses and Medication aides, to include full time, part time and as needed staff. The emphasis of this education was on the importance of notifying Physician in a timely manner for any medication specifically insulin administered beyond the 60 minute window of opportunity, and the documentation requirement if and when the insulin is administered within the 60 minutes window. This education will be completed by 12/28/2017. Any Licensed Nurse or Medication Aide not educated by 12/28/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new licensed nurses and Medication Aides effective 12/28/2017. MONITORING PROCESS: Effective 12/28/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with notification of changes to Physician by conducting clinical meeting daily (M-F), review the daily clinical meeting checklist to ensure completion and proper follow through, and will also review all insulin administered in the last 24 hours and/or from the previous clinical meeting to ensure that proper documentation are in place to include notification to resident's physician. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be	

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F 157	Continued From page 6 physician reported he was very familiar with Resident #6 and his medication regimen. The physician also reported he reviewed the resident's blood sugars and labs when he made his facility visits to ensure there were no concerns or issues with diabetic management. . The physician indicated he was unaware of any scheduled insulin doses given late. The physician stated there was an hour of opportunity for the administration and he expected the insulin to be administered on time. The physician indicated the insulin was scheduled for the well-being of the resident and he expected to be notified if the insulin was administered beyond the hour of opportunity. An interview was conducted with the Director of Nursing (DON) on 11/16/2017 at 3:32 PM. The DON indicated the expectation was the physician be notified if scheduled insulin was administered late. 3. Record review revealed Resident #7 was admitted to the facility on 11/2/2017 with diagnoses which included Diabetes and Gout. Review of Resident #7's signed physician orders for November 2017 revealed an order for 10 units of insulin to be administered subcutaneously (injected between the skin and muscle) twice a day at 9:00 AM and 9:00 PM. Review of Resident #7's Admission Minimum Data Set (MDS) dated 11/9/2017 revealed the resident was severely cognitively impaired and required the extensive assistance of 1 to 2 persons for all activities of daily living (ADLs). The MDS indicated the resident received insulin injections daily. Review of Resident #7's care plan updated 11/14/2017 revealed the resident was at risk for alteration in blood sugars related to Diabetes.	F 157	documented on a daily clinical report form and filed in a clinical meeting binder in the Director of Nursing office. Director of Nursing and/or Assistant Director of Nursing will review the completion of daily clinical report, and daily clinical checklist forms daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 12/28/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 12/28/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 12/28/2017	

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F 157	Continued From page 7	F 157		

The interventions for the risk included medications and insulin to be administered as ordered.
Record review of the Medication Administration Record (MAR) for Resident #7 from 11/9/2017 through 11/14/2017 revealed 7 documented late administration times for the resident's 9:00 AM insulin dose and 4 documented late administration times for the 9:00 PM insulin dose. The documented times for administration were beyond the 60 minute window of administration opportunity.
An interview was conducted with Nurse #6 on 11/16/2017 at 10:15 AM. Nurse #6 indicated she worked with Resident #7 regularly. The nurse indicated there were times the insulin was administered outside of the hour window of opportunity to administer medications. The nurse indicated sometimes she was busy and could not get to everything on time. The nurse stated she did not document the reason the insulin was given late and she did not notify the physician.
An interview was conducted with Resident #7's physician on 11/16/2017 at 2:20 PM. The physician reported he was very familiar with Resident #7 and his medication regimen. The physician also reported he reviewed the resident's blood sugars and labs when he made his facility visits to ensure there were no concerns or issues with diabetic management. The physician indicated he was unaware of any scheduled insulin doses given late. The physician stated there was an hour of opportunity for the administration and he expected the insulin to be administered on time. The physician indicated the insulin was scheduled for the well-being of the resident and expected to be notified if the insulin was administered beyond the hour of opportunity.
An interview was conducted with the Director of

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F 157	Continued From page 8 Nursing (DON) on 11/16/2017 at 3:32 PM. The DON indicated the expectation was the physician be notified if scheduled insulin was administered late.	F 157		
F 223 SS=J	FREE FROM ABUSE/INVOLUNTARY SECLUSION CFR(s): 483.12(a)(1) 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and record review the facility failed to protect residents from staff to resident physical abuse resulting in a bruise to the resident's arm for 1 of 1 sampled residents (Resident #1). The immediate jeopardy (IJ) began on 10/26/2017 when Nurse Aide (NA) #1 grabbed Resident #1 by the wrists and sat her down hard on the shower seat in the resident's bathroom, resulting in a bruise to her right wrist. The IJ was removed on 11/16/2017 when the facility's acceptable credible allegation was verified. The facility remained out of compliance at a scope and severity of D (no actual harm with the	F 223	F223 ROOT CAUSE This alleged noncompliance resulted from the Center s former Director of Nursing #1 misinterpretation of regulatory requirements related to protection of residents during allegation of abuse and or neglect investigation, misunderstanding of how to conduct the detail investigation of allegation of abuse or neglect. The former DON stated the way she understood is that she can only document what resident stated on both 24 hour and a 5-day report, she added that when she	12/28/17

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F 223	Continued From page 9 potential for more than minimal harm that is not IJ) to allow the facility to monitor and implement its plan of correction for abuse. Findings included: Resident #1 was admitted to the facility on 5/12/2017 with diagnoses to include diabetes, hypertension, and contracture of left hand. Review of a quarterly Minimum Data Set (MDS) assessment for Resident #1, dated 9/22/2017 revealed the resident had intact cognition. She required extensive assistance with toileting, dressing, personal hygiene and bathing. She was not steady, but able to transfer herself with limited assistance between bed and wheelchair. Her weight was 115 pounds. An interview was conducted on 11/13/2017 at 11:05 AM with Resident #1. Resident #1 stated her body was sick but her mind was not. She stated a couple of weeks ago, she was not sure of the date, she had a bowel movement (BM) and soiled herself at about 6:00 AM. The resident got in her wheelchair and took herself to the bathroom, and turned on the bathroom call light for someone to come and help clean her up. She indicated a NA, who had curly hair and was stout, and was not her night NA, came in about 6:15 AM and turned off the call light and told her if someone didn't come to help her after a while, to put her call light back on. The resident could see what time it was from the big numbered clock on her night stand that faced the bathroom. Resident #1 stated she waited for a long time, and was very still because she didn't want to get any mess on the floor. She stated she was cold and the bathroom smelled bad, and she was embarrassed. Resident #1 stated that NA #3, the	F 223	saw the bruise, she assumed that it resulted from uses of blood thinners. Because of the medication resident is taking she did not consider the bruise to be potentially caused by an alleged perpetrator (Nurse Aide #1). Resident #1 however alleged that Nurse Aide #1 grabbed her while in the bathroom and caused a bruise on her arm 10/26/2017. The DON stated, she felt she protected the resident as she removed the alleged perpetrator from the hall where resident #1 resided during the investigation period. This is contrary to center s abuse Prohibition process which requires for the alleged perpetrator to be suspended pending investigation. IMMEDIATE ACTION TAKEN On 11/14/2017 at approximately 9:00PM Director of Rehabilitation at the center followed by the facility Director of Social services interviewed resident #1. Resident #1 voiced that on 10/26/2017 approximately between 6:00 AM and 7:00 AM, she had an episode of loose stool, she wheeled herself to the bathroom and turn the bathroom call bell on. Nursing Aide #2 responded to the call bell and told the resident she will notify her assigned Nurse Aide (Nurse Aide #1), and if the assigned aide is not back to care for her, she asked resident #1 to turn the light back on (no time lapse specified). On the morning of 10/26/2017, during initial round, noted resident #1 to be soiled. Nurse Aide #3 communicated to Nurse Aide #1 about resident#1 being soiled and asked for Nurse Aide #1 to clean the	

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F 223	Continued From page 10 day shift NA, came in the bathroom and said how long have you been sitting here waiting, and the resident replied, "for an hour." NA #3 told her she was going to get NA #1. NA #1 came in and was real mad and kept saying that the other NA should have cleaned her up. The Resident stated she stood up and NA #1 grabbed her by the arm and said, "I want you to sit here," moved her over and sat her down very hard on the shower seat, then she scrubbed her hard. Resident #1 said she was crying and scared and she knew the NA was too mad. Resident #1 said she finally said to the NA, "you don't have to treat me like a dog." When the shower was over the Resident asked for the NA's name, and the NA wouldn't tell her, and never apolized to her. Resident #1 stated she gave me a bruise right here, and pointed to her inside right wrist, and indicated the bruise was about 2" by 3" with her fingers. The bruise was not visible on this date, and the resident confirmed that the bruise had gone away by now. NA #3 came to her room after NA #1 had left and the Resident asked NA #3 what the name of NA #1 was, but NA #3 said she didn't know. Record review revealed the facility filed a 24-Hour Initial Report to the State Agency on 10/31/2017 for resident abuse and neglect. The alleged description was: "Resident stated that Aide pushed her in the bathroom." This report was signed by the Director of Nursing. Record reviews revealed the facility filed a 5-Working Day Report to the State Agency on 11/3/2017 for resident abuse and neglect. The alleged description was: "Resident stated that aide pushed her in the bathroom and was rough and left a bruise on her wrist. Education teaching given and aide was removed from Hall. (The NA	F 223	resident#1 before leaving on 10/26/2017. Nurse Aide #1 provided care to Resident#1 and gave her a shower on 10/26/2017. Resident #1 added that Nurse Aide#1 pushed her and grabbed her on the arm, which caused a bruise. Resident #1 added that she reported this allegation to Nurse Aide #3 on 10/26/17, Nurse Aide #4 on 10/30/2017, and Director of Nursing #1 on 10/30/2017. Interview with Nurse Aide #4 by the Center Executive Director conducted on 10/31/2017 revealed she reported the Allegation made by Resident #1 to the Center Human Resources Director on 10/30/2017. Interview with Nurse Aide #3, and Nurse Aide # 4 did not report this allegation to their direct supervisor and the center s Executive Director per facility Abuse Prohibition policies and procedures revised June 2017. Director of Human Resources reported the Allegation to Director of Nursing #1 on 10/30/2017 and to the executive Director via written statement on 10/30/2017 that was read by the Center Executive Director on 10/31/2017. On 10/31/2017 and 11/3/2017, the 24 hour report and a 5 day report were sent to the Department of Health and Human Services respectively, related to resident #1 s allegation of abuse made on 10/26/2017. These reports were completed and submitted by the former Director of Nursing #1. Five days report completed on 11/3/2017 indicated an investigation that was not detailed enough. On 11/15/2017 another 5 day	

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F 223	Continued From page 11 at fault) Was not NA #1, was a different aide. Was not a hand print bruise upon investigation." This report was signed by the Director of Nursing. Review of statement by NA #1 included with the 5-Working Day Report revealed she was in the middle of her last round when NA #2 told her Resident #1 needed her. NA #1 said she was getting another resident ready for an appointment and told NA #2 she could not go back down to Resident #1's room because her resident needed breakfast. NA #1 left the hall to get breakfast for that resident, and then finished doing her resident rounds and charting. When she finished with her resident on the hall she "actually forgot about going back down there" because she had found a few things on the hall that needed to be corrected before change of shift. NA #1 gave report to the oncoming NA #3, and told her NA #2 had answered Resident #1's call light and NA #1 had not gone back in Resident #1's room. When NA #1 was doing her charting NA #3 came up to her and fussed that Resident #1 was in a mess and had feces all over her in the bathroom with the door closed. NA #1 got towels and wash cloths and went back down the hall, and cleaned up the mess that could have been prevented if NA #2 would have just put Resident #1 on the toilet. NA #1 had to first calm down Resident #1 "because she was crying terrible." After calming the Resident, she asked what happened and the Resident said she had put on the call light and NA #2 had turned off the light and told her she was going to get her NA. NA #2 had told the resident if your NA doesn't come then turn on your light again. NA #1 gave the resident a shower and dressed her and left around 7:30 AM on that morning. The report was signed on 11/1/2017 by NA #1.	F 223	report was completed after detail investigation conducted by the Center Executive Director, Director of Social Services and/or Director of Nursing #1. The investigation conducted 11/13/2017 by the Center Executive Director, Director of Social services, Director of Rehabilitation Center and MDS nurse by interviewing 100% of all current alert and oriented resident s in the facility to determine if any other resident voiced and allegation of abuse or neglect that involve the alleged perpetrator (Nurse Aide #1). No other residents alleged abuse and/or neglect that involve the alleged perpetrator. Likewise, the Director of Human Resources conducted interviews with current employee who were on duty on 10/26/2017 between the 6AM and 7AM to determine if any staff on duty witnessed any abuse and/or neglect towards Resident #1 specifically from Alleged Perpetrator (Nurse Aide #1). No other staff witness any abuse and/or neglect. Resident s #1 allegation of abuse voiced on 10/26/2017 was unsubstantiated based on findings of investigation conducted. Nurse Aide #1 did not care for Resident #1 at the time of investigation. It is the Center practice to suspend the Alleged Perpetrator at the time of investigation. IDENTIFICATION OF OTHERS 100% audit of all residents clinical documentation within the last 30 days was completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to determine if there is any	

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F 223	Continued From page 12 On 11/13/2017 at 4:35 PM, an interview was conducted with NA #1, who requested only to be interviewed with the DON present. NA #1 stated the only thing she recalled was between 6:00 and 7:00 AM, NA #2 had told her that Resident #1 needed her assistance, and so she went in and assisted her. NA #1 had been giving a bath to another resident, and so it was a little while before she was able to go down and help Resident #1. NA #1 stated she went to Resident #1's room before she had given report to day shift, and the Resident was already in the bathroom. She pushed the Resident up to the shower bar, and the Resident grabbed hold of it and sat down. The NA then gave her a shower and dressed her. She stated the Resident was crying and NA #1 calmed her down, told her not to cry it would be okay, about her being left in the bathroom. When asked about her written statement of 11/1/2017, that she forgot to go back in and clean her up, NA #1 just shrugged her shoulders and said it wasn't that long for the resident to wait and that was all she could remember. When asked about her written statement of 11/1/2017 that she had given report to day shift before she went in to clean up Resident #1, NA #1 said it wasn't that long, and she couldn't remember. Further questions were answered in that manner. A review of the statement by NA #2 included with the 5-Day Working Report revealed that NA #2 answered the light for Resident #1 who was already in the bathroom. The NA turned off the light and told the Resident she needed to get some things to get her cleaned up. NA #2 walked directly to NA #1 and told her Resident #1 needed her. NA #1 looked down the hall and said, "oh	F 223	documentation in any resident s medical records that indicate allegation of abuse, neglect, and/or misappropriation of resident s properties, if any, determine whether a 24 hours and 5 days investigation reports were completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed no other documented allegation of abuse, and/or neglect documented in resident s medical records. This audit was completed on 11/15/17. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. On 11/15/2017, 100% interviews was completed by the Director of Social Services, Director of Rehabilitation Services, Dietary Manager, Business office manager and/or Medical Records clerk for all current alert and oriented residents in the facility to identify any other resident with allegation of Abuse, Neglect and or Misappropriation of properties. Four other residents, Resident#2, Resident #3, Resident #4 and Resident #5 voiced allegation of abuse, neglect and/or misappropriation of resident s properties. Alleged perpetrators suspended pending investigation by the facility Executive director, 24 hour report submitted on 11/14/2017, thorough investigation initiated, resident attending Physician and Responsible Party notified of the allegation. Resident #2, #3, #4 and #5 will be informed of the findings and actions taken when the investigation is completed	

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F 223	Continued From page 13 well, I'm not going back down there, I already been down there and I'm not going back." NA #2 said she was doing something else at the moment. NA #2 went back to her hall and NA #1 went into another resident room. NA #2 documented she was informed of a complaint against her by Nurse #1, who had received all her information from NA #1 and not the resident. On 11/13/2017 at 5:38 PM, a phone interview was conducted with NA #2. NA #2 stated she was working on the 500 hall, and went to the 600 hall to answer a bathroom call light. Resident #1 was already in the bathroom, sitting in her wheelchair facing towards the call light. The NA smelled BM, and knew it would take some time to clean her up, and the Resident said she needed help to be cleaned up. NA #2 stated she told the Resident she needed to go get a gown and stuff, and then NA #2 went directly to the room NA #1 was in. NA #2 told NA #1 that Resident #1 needed her. NA #1 stated she was not going back in that room. NA #2 went to get linens and proceeded back to the 500 hall. NA #2 stated that Resident #1 put her call light back on at shift change, and NA #2 would've gone back to her room, but saw 2 NA's standing at her door, and they answered the call light. Later, NA #2 was told by NA #3 that NA #1 and NA #3 had gotten in an altercation about it and NA #1 had volunteered to go back in and give Resident #1 a shower. NA #2 stated that bad feelings about the altercation lingered for a few days and on 10/31/2017, Nurse #1 told NA #2 a complaint had been made against her for a dignity issue. NA # 2 stated she waited after her shift for the DON to arrive, because she felt like she was being framed because she had not even touched the resident, and had not pushed the resident in the bathroom because she was	F 223	by the Center Executive Director and/or Director of Social Services. SYSTEMIC CHANGES Effective 12/28/2017, interviews for alert and oriented residents will be completed by the Director of Social Services, Director of Recreational Services and/or designated staff member at least once every quarter to identify any allegation of Abuse, Neglect and or Misappropriation of properties. This interview process will be incorporated to social services quarterly assessment schedule and documented on psychosocial assessment tool . Any voiced allegation of abuse, neglect and/or misappropriation of resident s properties will be reported to the Center Executive Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according to the regulatory requirements. Effective 12/28/2017, the center nursing administrative team, which includes DON, Nurse supervisors, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident s properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation, and reported to the facility Executive Director per center s abuse	

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F 223	Continued From page 14 already in there. The DON told NA #2 there was an allegation that she had pushed Resident #1 in the bathroom, and then cut the light off. NA #2 requested the DON move her to another hall to get away from NA #1 and Nurse #1, and the DON moved her to another part of the facility. NA #2 stated she did not know if she had neglected the resident and didn't know if this incident was a dignity issue or something else. On 11/14/2017 at 8:34 AM, an interview was conducted with NA #3. NA #3 stated Resident #1 was alert, oriented, and could propel herself to the bathroom in her wheelchair. She has been incontinent at times and when she had soiled herself, she could not clean herself up from that. NA #3 stated on the morning of 10/26/2017, she and NA #1 were conducting walking rounds on the residents, which meant they were going door to door of each resident's room for report. At Resident #1's door, NA #1 stated the Resident was in the bathroom and she had been busy so NA #2 had answered the light and told NA #1 that Resident #1 had needed her. After NA #1 had walked away, NA #3 was standing with NA #5 when Resident #1's call light went on. NA #3 went into Resident #1's bathroom, and Resident #1 told her the NA's had left her like that, and NA #3 looked at her and saw BM on her gown and under pad, and the bathroom smelled like BM, and she was crying and upset. NA #3 told the resident she would get it taken care of. NA #3 went up the hall and told NA #1 she couldn't leave until she cleaned up Resident #1. NA #1 raised her voice and there was some loud altercation between the two, and then NA #1 said she would go down and give the Resident a shower. NA #3 did not think what could happen to a resident by sending a mad NA to the room by herself to clean	F 223	policy. Effective 12/28/2017, The Executive Director, Director of Health Services and/or Director of Social Services complete 24-hour and 5-days investigation reports, these reports are then reviewed by the Executive Director before submitted to the state agency and other officials as required by regulation and/or Elder Justice Act. This process will be incorporated in a daily stand up meeting. Any negative findings will be documented on the daily stand up meeting form and maintained in the daily stand up meeting binder. Effective 12/28/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident s properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation and reported the event to the facility Executive Director. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the week end supervisor report form and maintained in the daily clinical meeting binder. Effective 12/28/2017, All alleged violations	

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F 223	Continued From page 15 up the Resident. NA #3 stated she got linens and went to take care of someone else. NA #3 stated after NA #1 left, she had talked to Resident #1, and was told that NA #1 was mad and mean and rough with her and had grabbed her hard, and she was scared of her. The Resident asked the name of NA #1, but NA #3 told her she didn't know. The Resident did not show NA #3 the bruise at that time, and thought the Resident showed her the bruise on 10/31/2017 after she had talked to the DON. On 11/13/2017 at 1:47 PM, an interview was conducted with NA #4. NA #4 stated Resident #1 was alert and oriented, and could tell you about her day, and always remembered who NA #4 was. NA #4 indicated Resident #1 needed help with bathing and dressing. Resident #1 could take herself to the toilet, but when she had an occasional incontinence accident, she needed help with being cleaned up. NA #4 stated Resident #1 showed her bruise on her right inner wrist to her, and told her she had been pushed when in the shower and manhandled, and was so scared and upset, and didn't want to be at the facility. A review of a document dated 10/30/2017, written by the Human Resource Manager (HR) was conducted. The HR Manager reported she was at the 500/600 Hall Nurse's Station when she was notified by NA #4 that Resident #1 was scared to stay at the facility, and the NA saw bruises on Resident #1's arm. An interview was conducted on 11/13/2017 at 4:04 PM, with the HR Manager. The HR Manager stated she was at the 500/600 Hall Nursing station when NA #4 called her over and told her that Resident #1 was scared to stay at	F 223	involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. This report will be done in person, or via phone by facility staff on duty to the employee's direct supervisor and the administrator of the facility. Effective 12/28/2017 The facility Administrator, Director of Health services, Director of social services and/or designated licensed nurse will report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The reports will be made to State Survey Agency and adult protective in accordance with State law through established procedures. Facility Executive Director, Director of Nursing (DON), and/or Director of Social Services will complete 100% re-education on the facility s abuse/neglect policy including notification, protection, and	

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F 223	Continued From page 16 the facility because NA #1 had been really mean to her and gave her a bruise. NA #4 saw the bruise on her arm, like someone would've grabbed her. ON 11/13/2017 at 12:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated, and repeated many times, that she first heard of the abuse allegation on 10/31/2017, when Resident #1 came to the nurse's desk and said she was looking for the SW. The DON told Resident #1 that she could help, and Resident #1 showed her arm with the bruise on it. Resident #1 told her the NA had grabbed and pushed her in the shower, and was crying when she talked to her, but the DON didn't ask why. The DON stated she determined there was no abuse because the bruise was just a round bruise on the Resident's wrist, and it wasn't a hand print bruise. The DON indicated that if a NA had grabbed Resident #1's wrist, it would have left a hand print bruise, because especially on Caucasians, you could always see the handprint if they were grabbed. The DON stated the bruise must have come from Resident's #1's medication, as she was on Plavix (a blood thinner), and aspirin. On 11/14/2017 at 11:00 AM, an interview was conducted with the SW. The SW stated the DON had brought Resident #1 to her on 10/31/2017, and showed the SW the Resident's bruise. The SW stated the bruise was a little less than quarter size on her inner right wrist. The DON stated she would handle it. The SW talked to the DON on 11/3/2017, and the DON reported a NA had put the Resident in the bathroom, and another NA said Resident #1 could take herself to the bathroom. The DON stated she couldn't say	F 223	investigation protocols. This education will be provided for all employee, to include full time, part time and as needed staff. This education will be completed by 12/28/2017. Any employee not educated by 12/28/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 12/28/2017, and will also be provided semi-annually. MONITORING PROCESS Effective 12/28/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with abuse policies and procedures, resident s protection, thorough investigation, injuries of unknown sources and resident s neglect by conducting clinical meeting daily (M-F). This meeting will allow all allegation of abuse the team to review the incidents or accidents occurred from the prior clinical meeting to ensure any injury is thoroughly investigated and reported per abuse policy. The nursing administrative team in will also review completion of skin assessments from prior day and ensure any documented injury of unknown source was followed through per policy. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow ups are done. This monitoring process will take place daily (M-F) for 2weeks, weekly x 2 more	

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F 223	Continued From page 17 what happened, or who did what, so she just removed the NA from the hall. The SW understood the DON to mean that the bruise happened on the way to the bathroom, and since no one had taken the Resident to the bathroom, abuse didn't happen. The SW reported that Resident #1 was alert and oriented. On 11/14/2017 at 5:57 PM the facility was notified of IJ. The facility provided the following credible allegation of compliance on 11/16/2017. DATE: 11/15/2017 PROCESSES THAT LEAD TO THE ALLEGED DEFFICIENCY CITED This alleged noncompliance resulted from the Center's former Director of Nursing #1 misinterpretation of regulatory requirements related to protection of residents during allegation of abuse and or neglect investigation, misunderstanding of how to conduct the detail investigation of allegation of abuse or neglect. "The former DON stated the way she understood is that she can only document what resident stated on both 24 hour and a 5-day report, she added that when she saw the bruise, she assumed that it resulted from uses of blood thinners". Because of the medication resident is taking she did not consider the bruise to be potentially caused by an alleged perpetrator (Nurse Aide #1). Resident #1 however alleged that Nurse Aide #1 grabbed her while in the bathroom and caused a bruise on her arm 10/26/2017. The DON stated, she felt she protected the resident as she removed the alleged perpetrator from the hall where resident #1 resided during the investigation period. This is contrary to center's abuse Prohibition process which requires for the alleged perpetrator to be	F 223	weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 12/28/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 12/28/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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suspended pending investigation.
Director of Nursing #1 is no longer employed at the Center effective 11/15/2017. New Director of Nursing employed to oversee clinical services effective 11/15/2017.
The Director of operation from the Management and consulting company that manages the center, re-educated the Center Executive Director and the Director of Nursing #1 on 11/14/2017 on the center's Abuse Prohibition and Investigation policies and procedures, and emphasized the importance of protecting resident(s), to include suspending the alleged perpetrator during the investigation period, investigating thoroughly all alleged abuse, and/or neglect as well as injuries noted or reported to determine etiology, and reporting such in a timely manner per state regulatory requirements. This education was also provided to the new Director of Nursing on 11/15/2017 by the Director of Operation.
On 11/14/2017 at approximately 9:00PM Director of Rehabilitation at the center followed by the facility Director of Social services interviewed resident #1. Resident #1 voiced that on 10/26/2017 approximately between 6:00 AM and 7:00 AM, she had an episode of loose stool, she wheeled herself to the bathroom and turn the bathroom call bell on. Nursing Aide #2 responded to the call bell and told the resident she will notify her assigned Nurse Aide (Nurse Aide #1), and if the assigned aide is not back to care for her, she asked resident #1 to turn the light back on (no time lapse specified). On the morning of 10/26/2017, during initial round, noted resident #1 to be soiled. Nurse Aide #3 communicated to Nurse Aide #1 about resident#1 being soiled and asked for Nurse Aide #1 to clean the resident#1 before leaving on 10/26/2017. Nurse Aide #1 provided care to Resident#1 and gave her a

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shower on 10/26/2017.
Resident #1 added that Nurse Aide#1 pushed her and grabbed her on the arm, which caused a bruise. Resident #1 added that she reported this allegation to Nurse Aide #3 on 10/26/17, Nurse Aide #4 on 10/30/2017, and Director of Nursing #1 on 10/30/2017. Interview with Nurse Aide #4 by the Center Executive Director conducted on 11/13/2017 revealed she reported the Allegation made by Resident #1 to the Center Human Resources Director on 10/30/2017. Interview with Nurse Aide #3, and Nurse Aide # 4 did not report this allegation to their direct supervisor and the center's Executive Director per facility Abuse Prohibition policies and procedures revised June 2017. Director of Human Resources reported the Allegation to Director of Nursing #1 on 10/30/2017 and to the executive Director via written statement on 10/30/2017 that was read by the Center Executive Director on 10/31/2017.
On 10/31/2017 and 11/3/2017, the 24 hour report and a 5 day report were sent to the Department of Health and Human Services respectively, related to resident #1's allegation of abuse made on 10/26/2017. These reports were completed and submitted by the former Director of Nursing #1. Five days report completed on 11/3/2017 indicated an investigation that was not detailed enough. On 11/15/2017 another 5 day report was completed after detail investigation conducted by the Center Executive Director, Director of Social Services and/or Director of Nursing #1.
The investigation conducted 11/13/2017 by the Center Executive Director, Director of Social services, Director of Rehabilitation Center and MDS nurse by interviewing 100% of all current alert and oriented resident's in the facility to determine if any other resident voiced and allegation of abuse or neglect that involve the

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alleged perpetrator (Nurse Aide #1). No other residents alleged abuse and/or neglect that involve the alleged perpetrator. Likewise, the Director of Human Resources conducted interviews with current employee who were on duty on 10/26/2017 between the 6AM and 7AM to determine if any staff on duty witnessed any abuse and/or neglect towards Resident #1 specifically from Alleged Perpetrator (Nurse Aide #1). No other staff witness any abuse and/or neglect. Resident's #1 allegation of abuse voiced on 10/26/2017 was unsubstantiated based on findings of investigation conducted. Nurse Aide #1 did not care for Resident #1 at the time of investigation. It is the Center practice to suspend the Alleged Perpetrator at the time of investigation of any alleged Abuse and/or Neglect.
THE PROCEDURES FOR IMPLEMENTING THE ACCEPTABLE CREDIBLE ALLEGATION FOR THE ALLEGED IMMEDIATE JEOPARDY.

100% audit of all residents' clinical documentation within the last 30 days was completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to determine if there is any documentation in any resident's medical records that indicate allegation of abuse, neglect, and/or misappropriation of resident's properties, if any, determine whether a 24 hours and 5 days investigation reports were completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed no other documented allegation of abuse, and/or neglect documented in resident's medical records. This audit was completed on 11/15/17. Findings of this audit is documented on "clinical records audit tool" located at the facility compliance binder.

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F 223	Continued From page 21 On 11/15/2017, 100% interviews was completed by the Director of Social Services, Director of Rehabilitation Services, Dietary Manager, Business office manager and/or Medical Records clerk for all current alert and oriented residents in the facility to identify any other resident with allegation of Abuse, Neglect and or Misappropriation of properties. Four other residents, Resident#2, Resident #3, Resident #4 and Resident #5 voiced allegation of abuse, neglect and/or misappropriation of resident's properties. Alleged perpetrators suspended pending investigation by the facility Executive director, 24 hour report submitted on 11/14/2017, thorough investigation initiated, resident attending Physician and Responsible Party notified of the allegation. Resident #2, #3, #4 and #5 will be informed of the findings and actions taken when the investigation is completed by the Center Executive Director and/or Director of Social Services. Effective 11/15/2017, interviews for alert and oriented residents will be completed by the Director of Social Services, Director of Recreational Services and/or designated staff member at least once every quarter to identify any allegation of Abuse, Neglect and or Misappropriation of properties. This interview process will be incorporated to social services quarterly assessment schedule and documented on "psychosocial assessment tool". Any voiced allegation of abuse, neglect and/or misappropriation of resident's properties will be reported to the Center Executive Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according to the regulatory requirements.	F 223		

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Effective 11/15/2017, the center nursing administrative team, which includes DON, Nurse supervisors, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation, and reported to the facility Executive Director per center's abuse policy.

Effective 11/15/2017, 24-hour and 5-days investigation reports are completed and reviewed by the Executive Director before submitted to the state agency and other officials as required by regulation and/or Elder Justice Act. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the Executive Director, DON, ADON, and/or Nurse Supervisor. This process will be incorporated in a daily sand up meeting. Any negative findings will be documented on the "daily stand up meeting form" and maintained in the daily stand up meeting binder.

Effective 11/15/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources reported/documented is investigated

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thoroughly, alleged perpetrator is suspended pending investigation and reported to the facility Executive Director. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the "week end supervisor report form" and maintained in the daily clinical meeting binder. Effective 11/15/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation and reported to the facility Executive Director. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the "week end supervisor report form" and maintained in the daily clinical meeting binder.

Effective 11/15/2017, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through

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established procedures.
Effective 11/15/2017, Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
Facility Executive Director, Director of Nursing (DON), and/or Director of Social Services will complete 100% re-education on the facility's abuse/neglect policy including notification, protection, and investigation protocols. This education will be provided for all employee, to include full time, part time and as needed staff. This education will be completed by 11/15/2017. Any employee not educated by 11/15/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 11/15/2017, and will also be provided semi-annually.

THE MONITORING PROCEDURE TO ENSURE THAT THE CREDIBLE ALLEGATION IS EFFECTIVE AND REMOVE THE ALLEGED IMMEDIATE JEOPARDY

Effective 11/15/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with abuse policies and procedures, resident's protection, thorough investigation, injuries of unknown sources and resident's neglect by conducting clinical meeting daily (M-F). This meeting will allow all allegation of abuse the team to review the incidents or accidents occurred from the prior clinical meeting to ensure any injury is thoroughly investigated and reported

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per abuse policy. The nursing administrative team in will also review completion of skin assessments from prior day and ensure any documented injury of unknown source was followed through per policy. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow ups are done. This monitoring process will take place daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.

Effective 11/15/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.
TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION
Effective 11/15/17, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of credible allegation to remove this alleged immediate jeopardy.

Compliance Date: 11/15/2017

The Credible Allegation was verified on 11/16/2017 by the following:
1. The survey team reviewed the audit of current resident's medical records titled "clinical records audit tool", which reviewed documentation that would indicate any allegation

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F 223	Continued From page 26 of abuse, neglect, misappropriation of resident's properties and /or injuries of unknown sources. 2. The survey team reviewed the audit of all incidents within the last 30 days which was completed to identify any unknown source of injuries. 3. The survey team reviewed the in-service provided by staff and signed by staff. The survey team conducted staff interviews with 16 on-duty staff. The staff interviewed confirmed the recent in-service regarding abuse identification, reporting, and recognizing signs and symptoms of staff burnout. 4. The survey team interviewed 41 current alert and oriented residents. The residents confirmed education they had received on whom to report abuse to.	F 223		
F 224 SS=D	PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN CFR(s): 483.12(b)(1)-(3) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and	F 224		12/28/17

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F 224	Continued From page 27 (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and record review the facility failed to protect resident from neglect, by leaving the resident in the bathroom, soiled and unattended, for 1 of 1 sampled residents (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/12/2017 with diagnoses to include diabetes, hypertension, and contracture of left hand. Review of a quarterly Minimum Data Set (MDS) assessment for Resident #1, dated 9/22/2017 revealed the resident had intact cognition. She required extensive assistance with toileting, dressing, personal hygiene and bathing. She was not steady, but able to transfer herself with limited assistance between bed and wheelchair. Her weight was 115 pounds. An interview was conducted on 11/13/2017 at 11:05 AM with Resident #1. Resident #1 stated a couple of weeks ago, she was not sure of the date, she had a bowel movement (BM) and soiled herself at about 6:00 AM. The resident got in her wheelchair and took herself to the bathroom, and turned on the bathroom call light for someone to come and help clean her up. She indicated a NA, who was not her night NA, came in about 6:15 AM and turned off the call light and told her if someone didn't come to help her after a while, to put her call light back on. The resident could see what time it was from the big numbered clock on her night stand that faced the bathroom.	F 224	F224D ROOT CAUSE This alleged noncompliance resulted from the Nursing aide #1 failure to follow the facility abuse prohibition policy and procedures and lack of understanding on what constituted neglect or violation of resident s dignity. When interviewed by the former Director of Nursing, nurse aide #1 indicated she did not think her acts constituted neglect or violation of resident s dignity. Nurse aide number #1 is no longer employed at the center. Likewise Director of Nursing #1 is no longer employed at the Center effective 11/15/2017 following this event. New Director of Nursing employed to oversee clinical services effective 11/15/2017. On 11/14/2017 at approximately 9:00PM Director of Rehabilitation at the center followed by the facility Director of Social services interviewed resident #1. Resident #1 voiced that on 10/26/2017 approximately between 6:00 AM and 7:00 AM, she had an episode of loose stool, she wheeled herself to the bathroom and turn the bathroom call bell on. Nursing Aide #2 responded to the call bell and told the resident she will notify her assigned Nurse Aide (Nurse Aide #1), and if the assigned aide is not back to care for her, she asked resident #1 to turn the light	

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F 224	Continued From page 28 Resident #1 stated she waited for a long time, and was very still because she didn't want to get any mess on the floor. She stated she was cold and the bathroom smelled bad, and she was embarrassed. Resident #1 stated that NA #3, the day shift NA, came in the bathroom and asked how long she had been waiting, and the Resident replied, "for an hour." NA #3 told her she was going to get NA #1. NA #1 came in and was real mad and kept saying that the other NA should have cleaned her up. Resident #1 said she was crying and scared when NA #1 gave her a shower and cleaned her up. Resident #1 asked for the NA's name, and the NA wouldn't tell her. Review of statement by NA #1 included with the 5-Working Day Report revealed she was in the middle of her last round when NA #2 told her Resident #1 needed her. NA #1 said she was getting another resident ready for an appointment and told NA #2 she could not go back down to Resident #1's room because her resident needed breakfast. NA #1 left the hall to get breakfast for that resident, and then finished doing her resident rounds and charting. When she finished with her resident on the hall she "actually forgot about going back down there" because she had found a few things on the hall that needed to be corrected before change of shift. NA #1 gave report to the oncoming NA #3, and told her NA #2 had answered Resident #1's call light and NA #1 had not gone back in Resident #1's room. When NA #1 was doing her charting NA #3 came up to her and fussed that Resident #1 was in a mess and had feces all over her in the bathroom with the door closed. NA #1 got towels and wash cloths and went back down the hall, and cleaned up the mess that could have been prevented if NA #2 would have just put Resident #1 on the toilet. NA	F 224	back on (no time lapse specified). On the morning of 10/26/2017, during initial round, noted resident #1 to be soiled. Resident # 1 alleged that she was left in the bathroom for about an hour by nursing aide #1, she added she was embarrassed by this event. Nurse Aide #3 communicated to Nurse Aide #1 about resident#1 being soiled and asked for Nurse Aide #1 to clean the resident#1 before leaving on 10/26/2017. Nurse Aide #1 provided care to Resident#1 and gave her a shower on 10/26/2017. IMMEDIATE ACTION On the morning of 10/26/2017, during initial round, noted resident #1 to be soiled. Nurse Aide #3 communicated to Nurse Aide #1 about resident#1 being soiled and asked for Nurse Aide #1 to clean the resident#1 before leaving on 10/26/2017. Nurse Aide #1 provided care to Resident#1 and gave her a shower on 10/26/2017. Resident On 10/31/2017 and 11/3/2017, the 24 hour report and a 5 day report were sent to the Department of Health and Human Services respectively, related to resident #1 s allegation of neglect made on 10/26/2017. These reports were completed and submitted by the former Director of Nursing #1. Five days report completed on 11/3/2017 indicated an investigation that was not detailed enough and did not include the allegation of neglect. On 11/13/2017 another 24 hour and 5 day report was completed after detail investigation conducted by the	

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F 224	Continued From page 29 #1 had to first calm down Resident #1 "because she was crying terrible." After calming the Resident, she asked what happened and the Resident said she had put on the call light and NA #2 had turned off the light and told her she was going to get her NA. NA #2 had told the resident if your NA doesn't come then turn on your light again. NA #1 gave the resident a shower and dressed her and left around 7:30 AM on that morning. The report was signed on 11/1/2017 by NA #1. On 11/13/2017 at 4:35 PM, an interview was conducted with NA #1, who stated the only thing she recalled was between 6:00 and 7:00 AM on 10/26/107, NA #2 had told her that Resident #1 needed her assistance, and so she went in and assisted her. NA #1 had been giving a bath to another resident, and so it was a little while before she was able to go down and help Resident #1. NA #1 stated she went to Resident #1's room before she had given report to day shift, and the Resident was already in the bathroom. The NA then gave her a shower and dressed her. She stated the Resident was crying and NA #1 calmed her down, told her not to cry it would be okay, about her being left in the bathroom. When asked about her written statement of 11/1/2017, that she forgot to go back in and clean the resident up, and that she had given report to day shift before she went in to clean her up, NA #1 just shrugged her shoulders and said it wasn't that long for the resident to wait and that was all she could remember. Further questions were answered in that manner. A review of the statement by NA #2 included with the 5-Day Working Report revealed that NA #2 answered the light for Resident #1 who was	F 224	Center Executive Director, Director of Social Services and/or Director of Nursing #1. IDENTIFICATION OF OTHERS The investigation conducted 11/14/2017 by the Center Executive Director, Director of Social services, Director of Rehabilitation Center and MDS nurse by interviewing 100% of all current alert and oriented residents in the facility to determine if any other resident voiced and allegation of abuse and/or neglect that involve the alleged perpetrator (Nurse Aide #1). No other residents alleged abuse and/or neglect that involve the alleged perpetrator. Likewise, the Director of Human Resources conducted interviews with current employees who were on duty on 10/26/2017 between the 6AM and 7AM to determine if any staff on duty witnessed any abuse and/or neglect towards Resident #1 specifically from Alleged Perpetrator (Nurse Aide #1). No other staff witness any abuse and/or neglect. Resident s #1 allegation of abuse voiced on 10/26/2017 was unsubstantiated based on findings of investigation conducted. Nurse Aide #1 did not care for Resident #1 at the time of investigation. It is the Center practice to suspend the Alleged Perpetrator at the time of investigation of any alleged Abuse and/or Neglect. 100% audit was completed by the Center Executive Director for all allegation of abuse and/or neglect reported to North	

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F 224	Continued From page 30 already in the bathroom. The NA turned off the light and told the Resident she needed to get some things to get her cleaned up. NA #2 walked directly to NA #1 and told her Resident #1 needed her. NA #1 looked down the hall and said, "oh well, I'm not going back down there, I already been down there and I'm not going back." NA #2 said she was doing something else at the moment. NA #2 went back to her hall and NA #1 went into another resident room. On 11/13/2017 at 5:38 PM, a phone interview was conducted with NA #2. NA #2 stated she was working on the 500 hall, and went to the 600 hall to answer a bathroom call light. Resident #1 was already in the bathroom, sitting in her wheelchair facing towards the call light. The NA smelled BM, and knew it would take some time to clean her up, and the Resident said she needed help to be cleaned up. NA #2 stated she told the Resident she needed to go get a gown, and then NA #2 went directly to the room NA #1 was in. NA #2 told NA #1 that Resident #1 needed her. NA #1 stated she was not going back in that room. NA #2 went to get linens and proceeded back to the 500 hall. NA #2 stated that Resident #1 put her call light back on at shift change, and NA #2 would've gone back to her room, but saw 2 NA's standing at her door, and they answered the call light. NA #2 stated she did not know if she had neglected the resident and didn't know if this incident was a dignity issue or something else. On 11/14/2017 at 8:34 AM, an interview was conducted with NA #3. NA #3 stated Resident #1 was alert, oriented, and could propel herself to the bathroom in her wheelchair. She has been incontinent at times and when she had soiled herself, she could not clean herself up from that.	F 224	Carolina Department of Health and Human Services in the last 12 months to determine if the alleged perpetrator(s) was/were suspended during the investigation period. This audit also identified whether the 24 hours and a 5 days reports are completed and submitted to the state agency as required by regulation and Elder Justice Act in a timely manner. The audit revealed all completed reportable in the last 12 months noted with detail investigation and the Alleged Perpetrator(s) were suspended. This audit was completed on 11/15/2017. 100% audit of all current residents clinical documentation within the last 30 days was completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to determine if there is any documentation in any resident s medical records that indicate allegation of abuse, neglect, and/or misappropriation of resident s properties, if any, determine whether a 24 hours and 5 days investigation reports were completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed no other documented allegation of abuse, and/or neglect documented in resident s medical records. This audit was completed on 11/15/17. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. On 11/14/2017, 100% interviews was completed by the Director of Social	

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F 224	Continued From page 31 NA #3 stated on the morning of 10/26/2017, she received report from NA #1 who stated the Resident was in the bathroom. NA #1 reported she had been busy so NA #2 had answered the light and told NA #1 that Resident #1 had needed her. Shortly after report, NA #3 was standing with NA #5 when Resident #1's call light went on. NA #3 went into Resident #1's bathroom, and Resident #1 told her the NA's had left, and NA #3 looked at her and saw BM on her gown and under pad, and the bathroom smelled like BM, and she was crying and upset. NA #3 told the Resident she would get it taken care of. NA #3 went up the hall and told NA #1 she couldn't leave until she cleaned up Resident #1. NA #1 raised her voice and there was some loud altercation between the two, and then NA #1 said she would go down and give the Resident a shower. On 11/13/2017 at 12:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she talked to NA #2, and that NA #2 stated Resident #1 was in the bathroom when she turned off the light and went to get NA #1. The DON stated she expected NA #2 to take care of the resident when she answered the call light. The DON stated she decided to give NA #2 a second chance, and moved her to a different hall.	F 224	Services, Director of Rehabilitation Services, Dietary Manager, Business office manager and/or Medical Records clerk for all current alert and oriented residents in the facility to identify any other resident with allegation of Abuse, Neglect and or Misappropriation of properties. Four other residents, Resident#2, Resident #3, Resident #4 and Resident #5 voiced allegation of abuse, neglect and/or misappropriation of resident s properties. Alleged perpetrators suspended pending investigation by the facility Executive director, 24 hour report submitted on 11/14/2017, thorough investigation initiated, resident attending Physician and Responsible Party notified of the allegation. Resident #2, #3, #4 and #5 will be informed of the findings and actions taken when the investigation is completed by the Center Executive Director and/or Director of Social Services. SYSTEMIC CHANGES Effective 11/15/2017, interviews for alert and oriented residents will be completed by the Director of Social Services, Director of Recreational Services and/or designated staff member at least once every quarter to identify any allegation of Abuse, Neglect and or Misappropriation of properties. This interview process will be incorporated to social services quarterly assessment schedule and documented on psychosocial assessment tool . Any voiced allegation of abuse, neglect and/or misappropriation of resident s properties will be reported to the Center Executive	

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F 224	Continued From page 32	F 224	Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according to the regulatory requirements. Effective 12/28/2017, the center nursing administrative team, which includes DON, Nurse supervisors, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident s properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation, and reported to the facility Executive Director per center s abuse policy. Effective 12/28/2017,Executive Director, Director of Health Services and/or Director of Social Services will complete 24-hour and 5-days investigation reports and reviewed by the Executive Director before submitted to the state agency and other officials as required by regulation and/or Elder Justice Act. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the Executive Director, DON, ADON, and/or Nurse Supervisor. This process will be incorporated in a daily sand up meeting. Any negative findings will be documented	

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F 224	Continued From page 33	F 224	on the daily stand up meeting form and maintained in the daily stand up meeting binder. Effective 12/28/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident s properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation and reported to the facility Executive Director. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the week end supervisor report form and maintained in the daily clinical meeting binder. Effective 12/28/2017, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. This report will be done in person, or via phone by facility staff on duty to the employee's	

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F 224	Continued From page 34	F 224	direct supervisor and the administrator of the facility. Effective 12/28/2017 The facility Administrator, Director of Health services, Director of social services and/or designated licensed nurse will report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The reports will be made to State Survey Agency and adult protective in accordance with State law through established procedures. Effective 12/28/2017, Abuse reporting process will be discussed to current alert and oriented residents every months during resident council meeting and at least quarterly during each resident care plan meeting. This process will be managed by the Center Director of Social Services effective 12/28/2017. Facility Executive Director, Director of Nursing (DON), and/or Director of Social Services will complete 100% re-education on the facility s abuse/neglect policy including notification, protection, and investigation protocols. This education will be provided for all employee, to include full time, part time and as needed staff.	

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F 224	Continued From page 35	F 224	This education will be completed by 12/28/2017. Any employee not educated by 12/28/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 12/28/2017, and will also be provided semi-annually. MONITORING PROCESS Effective 12/28/2017, Executive Director and or Director of Social Services will review all alleged violation to ensure a thorough investigation is completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on abuse prohibition tool and filed in daily meeting binder after proper follow ups are done. This monitoring process will take place daily to include Saturdays and Sundays for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 12/28/2017, Director of Execution director and/or Director of Social Services will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial	

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F 224	Continued From page 36	F 224	compliance. TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION Effective 12/28/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction to ensure the facility attain and maintain the substantial compliance.	
F 225 SS=J	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of	F 225		12/28/17

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actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

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F 225	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and record review the facility failed to report staff to resident physical abuse within 24 hours to the State Agency, failed to thoroughly investigate the abuse allegation for 1 of 1 sampled residents (Resident #1). The immediate jeopardy (IJ) began on 10/26/2017 when NA #3 did not report to the Nurse, the Director of Nursing, or the Administrator, when Resident #1 told her Nurse Aide (NA) #1 grabbed her by the wrists and sat her down hard on the shower seat in the resident's bathroom, resulting in a bruise to her right wrist. The IJ was removed on 11/16/2017 when the facility's acceptable credible allegation was verified. The facility remained out of compliance at a scope and severity of D (no actual harm with the potential for more than minimal harm that is not IJ) to allow the facility to monitor and implement its plan of correction for abuse. Findings included: #1. Resident #1 was admitted to the facility on 5/12/2017 with diagnoses to include diabetes, hypertension, and contracture of left hand. Review of a quarterly Minimum Data Set (MDS) assessment for Resident #1, dated 9/22/2017 revealed the resident had intact cognition. She required extensive assistance with toileting, dressing, personal hygiene and bathing. She was not steady, but able to transfer herself with limited assistance between bed and wheelchair. Her weight was 115 pounds.	F 225	F225 ROOT CAUSE This alleged noncompliance resulted from the Center s Director of Nursing #1 misinterpretation of regulatory requirements related to how to conduct the detail investigation of any allegation of abuse or neglect. The former DON stated the way she understood is that she can only document what resident states on both 24 hour and a 5-day report. Director of Nursing #1 is no longer employed at the Center effective 11/15/2017. New Director of Nursing employed to oversee clinical services effective 11/15/2017. The Director of operation from the Management and consulting company that manages the center, re-educated the Center Executive Director and the Director of Nursing #1 on 11/14/2017 on the center s Abuse Prohibition and Investigation policies and procedures, and emphasized the importance of protecting resident(s), to include suspending the alleged perpetrator during the investigation period, investigating thoroughly all alleged abuse, and/or neglect as well as injuries noted or reported to determine etiology, and reporting such in a timely manner per state regulatory requirements. This education was also provided to the new Director of Nursing on 11/15/2017 by the Director of Operation.	

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F 225	Continued From page 39 An interview was conducted on 11/13/2017 at 11:05 AM with Resident #1. Resident #1 stated her body was sick but her mind was not. She stated a couple of weeks ago, she was not sure of the date, she had a bowel movement (BM) and soiled herself at about 6:00 AM. The resident got in her wheel chair and took herself to the bathroom, and turned on the bathroom call light for someone to come and help clean her up. She indicated a NA, who was not her night NA, came in about 6:15 AM and turned off the call light and told her if someone didn't come to help her after a while, to put her call light back on. The resident could see what time it was from the big numbered clock on her night stand that faced the bathroom. Resident #1 stated she waited for a long time, and was very still because she didn't want to get any mess on the floor. She stated she was cold and the bathroom smelled bad, and she was embarrassed. Resident #1 stated that NA #3, the day shift NA, came in the bathroom and asked how long she had been waiting, and the Resident replied, "for an hour." NA #3 told her she was going to get NA #1. NA #1 came in and was real mad and kept saying that the other NA should have cleaned her up. The Resident stated she stood up and NA #1 grabbed her by the arm and said, "I want you to sit here," moved her over and sat her down very hard on the shower seat, then she scrubbed her hard. Resident #1 said she was crying and scared. Resident #1 said she finally said to the NA, "you don't have to treat me like a dog." When the shower was over the Resident asked for the NA's name, and the NA wouldn't tell her. Resident #1 stated she gave me a bruise right here, and pointed to her inside right wrist, and indicated the bruise was about 2" by 3" with her fingers. The bruise was not visible on	F 225	On 11/14/2017 at approximately 9:00PM Director of Rehabilitation at the center followed by the facility Director of Social services interviewed resident #1. Resident #1 voiced that on 10/26/2017 approximately between 6:00 AM and 7:00 AM, she had an episode of loose stool, she wheeled herself to the bathroom and turn the bathroom call bell on. Nursing Aide #2 responded to the call bell and told the resident she will notify her assigned Nurse Aide (Nurse Aide #1), and if the assigned aide is not back to care for her, she asked resident #1 to turn the light back on (no time lapse specified). On the morning of 10/26/2017, during initial round, noted resident #1 to be soiled. Nurse Aide #3 communicated to Nurse Aide #1 about resident#1 being soiled and asked for Nurse Aide #1 to clean the resident#1 before leaving on 10/26/2017. Nurse Aide #1 provided care to Resident#1 and gave her a shower on 10/26/2017. Resident #1 added that Nurse Aide#1 pushed her and grabbed her on the arm, which caused a bruise. Resident #1 added that she reported this allegation to Nurse Aide #3 on 10/26/17, Nurse Aide #4 on 10/30/2017, and Director of Nursing #1 on 10/30/2017. Interview with Nurse Aide #4 by the Center Executive Director conducted on 11/13/2017 revealed she reported the Allegation made by Resident #1 to the Center Human Resources Director on 10/30/2017. Interview with Nurse Aide #3, and Nurse Aide # 4 did not report this allegation to their direct	

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F 225	Continued From page 40 this date, and the resident confirmed that the bruise had gone away by now. NA #3 came to her room after NA #1 had left and the Resident asked NA #3 what the name of NA #1 was, but NA #3 said she didn't know. Resident #1 told NA #3 what had happened in the shower, and NA #3 said she should report it to the Social Worker (SW). The resident stated she wheeled herself to the nurse's station for 3 days after and asked to see the SW, but the SW never came, so the next day she asked NA #4 about it after NA #4 saw her bruise. The resident stated she went to the nurse's station on Halloween, and was frustrated because the SW had not contacted her. A lady at the desk said what did she need to tell the SW, and Resident #1 stated she just stuck out her arm with the bruise, and the lady said she was the Director of Nursing (DON), and she could help. The DON transported the Resident that day to the SW office and said we need to get started on interviews. The DON came back a couple of days later and told Resident #1 the decision was up to the DON and she decided not to fire the NA, but moved her to a different hall and gave her another chance. The Resident stated she believed in 2nd chances, but afterward, she was worried that NA #1 would let her temper explode on someone else. Record review revealed the facility filed a 24-Hour Initial Report to the Department of Health and Human Services on 10/31/2017 for resident abuse and neglect. The alleged description was: "Resident stated that Aide pushed her in the bathroom." The 24-Hour Report listed the "Accused Individual Information" as NA #1. The Report was signed by the Director of Nursing. Record reviews revealed the facility filed a	F 225	supervisor and the center s Executive Director per facility Abuse Prohibition policies and procedures revised June 2017. Director of Human Resources reported the Allegation to Director of Nursing #1 on 10/30/2017 and to the executive Director via written statement on 10/30/2017 that was read by the Center Executive Director on 10/31/2017 Nurse Aide #3, Nurse Aide # 4 did not report this allegation to their direct supervisor and the center s Executive Director per facility Abuse Prohibition policies and procedures revised June 2017. Director of Human Resources reported the Allegation to Director of Nursing #1 on 10/30/2017 and to the executive Director via written statement on 10/30/2017 that was read by the Center Executive Director on 10/31/2017 IMMEDIATE ACTION On 10/31/2017 and 11/3/2017, the 24 hour report and a 5 day report were sent to the Department of Health and Human Services respectively, related to resident #1 s allegation of abuse made on 10/26/2017. These reports were completed and submitted by the former Director of Nursing #1. Five days report completed on 11/3/2017 indicated an investigation that was not detailed enough. On 11/13/2017 another 5 day report was completed after detail investigation conducted by the Center Executive Director, Director of Social Services and/or Director of Nursing #1. The investigation conducted 11/14/2017 by the Center Executive Director, Director	

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F 225	Continued From page 41 5-Working Day Report to the Department of Health and Human Services on 11/1/2017 for resident abuse and neglect. The alleged description was: "Resident stated that aide pushed her in the bathroom and was rough and left a bruise on her wrist. Education teaching given and aide was removed from Hall. (The accused NA) Was not NA #1, was a different aide. Was not a hand print bruise upon investigation." The 5-Working Day Report listed the "Accused Individual Information" as NA #1. The Report was signed by the Director of Nursing. Review of statement by NA #1 included with the 5-Working Day Report revealed she was in the middle of her last round when NA #2 told her Resident #1 needed her. NA #1 said she was getting another resident ready for an appointment and told NA #2 she could not go back down to Resident #1's room because her resident needed breakfast. NA #1 left the hall to get breakfast for that resident, and then finished doing her rounds and charting. When she finished with her residents on the hall she "actually forgot about going back down there" because she had found a few things on the hall that needed to be corrected before change of shift. NA #1 gave report to oncoming NA #3, and told her NA #2 had answered Resident #1's call light and NA #1 had not gone back in Resident #1's room. When NA #1 was doing her charting NA #3 came up to her and fussed that Resident #1 was in a mess and had feces all over her in the bathroom with the door closed. NA #1 got towels and wash cloths and went back down the hall, and cleaned up the mess that could have been prevented if NA #2 would have just put Resident #1 on the toilet. NA #1 had to first calm down Resident #1 "because	F 225	of Social services, Director of Rehabilitation Center and MDS nurse by interviewing 100% of all current alert and oriented residents in the facility to determine if any other resident voiced and allegation of abuse or neglect that involve the alleged perpetrator (Nurse Aide #1). No other residents alleged abuse and/or neglect that involve the alleged perpetrator. Likewise, the Director of Human Resources conducted interviews with current employees who were on duty on 10/26/2017 between the 6AM and 7AM to determine if any staff on duty witnessed any abuse and/or neglect towards Resident #1 specifically from Alleged Perpetrator (Nurse Aide #1). No other staff witness any abuse and/or neglect. Resident s #1 allegation of abuse voiced on 10/26/2017 was unsubstantiated based on findings of investigation conducted. Nurse Aide #1 did not care for Resident #1 at the time of investigation. It is the Center practice to suspend the Alleged Perpetrator at the time of investigation of any alleged Abuse and/or Neglect. IDENTIFICATION OF OTHERS 100% audit was completed by the Center Executive Director for all allegation of abuse and/or neglect reported to North Carolina Department of Health and Human Services in the last 12 months to determine if the alleged perpetrator(s) was/were suspended during the investigation period. This audit also identified whether the 24 hours and a 5 days reports are completed and submitted to the state agency as required by	

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F 225	Continued From page 42 she was crying terrible." After calming the Resident, she asked what happened and the Resident said she had put on the call light and NA #2 had turned off the light and told her she was going to get her NA. NA #2 had told the resident if your NA doesn't come then turn on your light again. NA #1 gave the resident a shower and dressed her and left around 7:30 AM on that morning. The report was signed on 11/1/2017 by NA #1. On 11/13/2017 at 4:35 PM, an interview was conducted with NA #1, who requested only to be interviewed with the DON present. NA #1 stated the only thing she recalled was between 6:00 and 7:00 AM, NA #2 had told her that Resident #1 needed her assistance, and so she went in and assisted her. NA #1 had been giving a bath to another resident, and so it was a little while before she was able to go down and help Resident #1. NA #1 stated she went to Resident #1's room before she had given report to day shift, and the Resident was already in the bathroom. She pushed the Resident up to the shower bar, and the Resident grabbed hold of it and sat down. The NA then gave her a shower and dressed her. She stated the Resident was crying and NA #1 calmed her down, told her not to cry it would be okay, about her being left in the bathroom. When asked about her written statement of 11/1/2017, that she forgot to go back in and clean the resident up, and that she had given report to day shift before she went in to clean her up, NA #1 just shrugged her shoulders and said it wasn't that long for the resident to wait and that was all she could remember. Further questions were answered with the same response.	F 225	regulation and Elder Justice Act in a timely manner. The audit revealed all completed reportable in the last 12 months noted with detail investigation and the Alleged Perpetrator(s) were suspended. This audit was completed on 11/15/2017. 100% audit of all current residents clinical documentation within the last 30 days was completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to determine if there is any documentation in any resident s medical records that indicate allegation of abuse, neglect, and/or misappropriation of resident s properties, if any, determine whether a 24 hours and 5 days investigation reports were completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed no other documented allegation of abuse, and/or neglect documented in resident s medical records. This audit was completed on 11/15/17. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. On 11/15/2017, 100% interviews was completed by the Director of Social Services, Director of Rehabilitation Services, Dietary Manager, Business office manager and/or Medical Records clerk for all current alert and oriented residents in the facility to identify any other resident with allegation of Abuse, Neglect and or Misappropriation of properties. Four other residents, Resident#2,	

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F 225	Continued From page 43 A review of the statement by NA #2 included with the 5-Day Working Report revealed that NA #2 answered the light for Resident #1 who was already in the bathroom. The NA turned off the light and told the Resident she needed to get some things to get her cleaned up. NA #2 walked directly to NA #1 and told her Resident #1 needed her. NA #1 looked down the hall and said, "oh well, I'm not going back down there, I already been down there and I'm not going back." NA #2 said she was doing something else at the moment. NA #2 went back to her hall and NA #1 went into another resident room. NA #2 documented she was informed of a complaint against her by Nurse #1, who had received all her information from NA #1 and not the resident. On 11/13/2017 at 5:38 PM, a phone interview was conducted with NA #2. NA #2 stated she was working on the 500 hall, and went to the 600 hall to answer a bathroom call light. Resident #1 was already in the bathroom, sitting in her wheelchair facing towards the call light. The NA smelled BM, and knew it would take some time to clean her up, and the Resident said she needed help to be cleaned up. NA #2 stated she told the Resident she needed to go get a gown and stuff, and then NA #2 went directly to the room NA #1 was in. NA #2 told NA #1 that Resident #1 needed her. NA #1 stated she was not going back in that room. NA #2 went to get linens and proceeded back to the 500 hall. NA #2 stated when she went back to work on 10/31/2017, Nurse #1 told NA #2 a complaint had been made against her for a dignity issue. The DON told NA #2 there was an allegation that she had pushed Resident #1 in the bathroom, and then cut the light off. NA #2 requested the DON move her to another hall to get away from NA #1 and Nurse #1, and the DON	F 225	Resident #3, Resident #4 and Resident #5 voiced allegation of abuse, neglect and/or misappropriation of resident s properties. Alleged perpetrators suspended pending investigation by the facility Executive director, 24 hour report submitted on 11/14/2017, thorough investigation initiated, resident attending Physician and Responsible Party notified of the allegation. Resident #2, #3, #4 and #5 will be informed of the findings and actions taken when the investigation is completed by the Center Executive Director and/or Director of Social Services. SYSTEMIC CHANGES Effective 12/28/2017, interviews for alert and oriented residents will be completed by the Director of Social Services, Director of Recreational Services and/or designated staff member at least once every quarter to identify any allegation of Abuse, Neglect and or Misappropriation of properties. This interview process will be incorporated to social services quarterly assessment schedule and documented on psychosocial assessment tool . Any voiced allegation of abuse, neglect and/or misappropriation of resident s properties will be reported to the Center Executive Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according to the regulatory requirements. Effective 12/28/2017, the center nursing administrative team, which includes DON, Nurse supervisors, and/or SDC, initiated a process for reviewing clinical	

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F 225	Continued From page 44 moved her to another part of the facility. NA #2 stated she did not know if she had neglected the resident and didn't know if this incident was a dignity issue or something else. On 11/14/2017 at 8:34 AM, an interview was conducted with NA #3. NA #3 stated Resident #1 was alert, oriented, and could propel herself to the bathroom in her wheelchair. She has been incontinent at times and when she had soiled herself, she could not clean herself up from that. NA #3 stated on the morning of 10/26/2017, she received report from NA #1 that Resident #1 was in the bathroom and NA #1 had been busy so NA #2 had answered the light and told NA #1 that Resident #1 had needed her. Shortly after, NA #3 was standing with NA #5 when Resident #1's call light went on. NA #3 went into Resident #1's bathroom, and Resident #1 told her the NA's had left her like that, and NA #3 looked at her and saw BM on her gown and under pad, and the bathroom smelled like BM, and she was crying and upset. NA #3 told the Resident she would take care of it, and NA #3 went up the hall and told NA #1 she couldn't leave until she cleaned up Resident #1. NA #1 raised her voice and there was some loud altercation between the two, and then NA #1 said she would go down and give the Resident a shower. NA #3 stated she had talked to Resident #1 a little later that morning, and was told that NA #1 was mad and mean and rough with her and had grabbed her hard, and she was scared of her. The Resident asked the name of NA #1, but NA #3 told her she didn't know. NA #3 did not report the abuse to anyone, and told the Resident it would be better if she reported it herself to the SW. The Resident did not show NA #3 the bruise at that time, and thought the Resident showed her the bruise on 10/31/2017	F 225	documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident s properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation, and reported to the facility Executive Director per center s abuse policy. Effective 12/28/2017, 24-hour and 5-days investigation reports are completed and reviewed by the Executive Director before submitted to the state agency and other officials as required by regulation and/or Elder Justice Act. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the Executive Director, DON, ADON, and/or Nurse Supervisor. This process will be incorporated in a daily sand up meeting. Any negative findings will be documented on the daily stand up meeting form and maintained in the daily stand up meeting binder. Effective 12/28/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24	

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F 225	Continued From page 45 after the resident had spoken to the DON. NA #3 stated she had been through abuse training, but could not say why she had not reported the abuse. On 11/13/2017 at 3:33 PM, an interview was conducted with Resident #1's family member. The family stated the Resident had told them of the NA being mean to her in the shower, that happened on 10/26/2017. The family member tried to call the DON's phone for 3 days in a row, but the voice mail had not been set up and she was unable to leave a message. The family member then called the facility's office in another town and talked to a corporate person about a meeting. The family member stated that by the time she met with the corporate person on 11/2/2017, the facility had called her about the abuse allegation. On 11/13/2017 at 1:47 PM, an interview was conducted with NA #4. NA #4 stated Resident #1 was alert and oriented, and could tell you about her day, and always remembered who NA #4 was. NA #4 indicated Resident #1 needed help with bathing, and dressing. Resident #1 could take herself to the toilet, but when she had occasional incontinent accident, she needed help with being cleaned up. NA #4 stated Resident #1 showed the bruise on her right inner wrist to her, and told her she had been pushed when in the shower and manhandled, and was so scared and upset, and didn't want to be at the facility. The Resident asked for a patient Bill of Rights to see what she could do about it. The NA stated this happened before Halloween, but was not sure of the date. The NA stated she left the Resident's room to see about getting her a Bill of Rights, and decided she had better tell someone of the	F 225	hours to ensure that any allegation of abuse, neglect, misappropriation of resident s properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation and reported to the facility Executive Director. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the week end supervisor report form and maintained in the daily clinical meeting binder. Effective 12/28/2017, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. This report will be done in person, or via phone by facility staff on duty to the employee's direct supervisor and the administrator of the facility. Effective 12/28/2017 The facility Administrator, Director of Health services, Director of social services and/or designated licensed nurse will report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property	

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F 225	Continued From page 46 abuse. The NA saw the HR manager at the nurse's desk, and told her there was abuse in the facility. The HR Manager stated the Administrator and DON needed to be notified. The HR Manager told the DON and then wrote a report. A review of a document dated 10/30/2017, written by the Human Resource Manager (HR) was conducted. The HR Manager reported she was at the 500/600 Hall Nurse's Station when she was notified by NA #4 that abuse was going on in the facility. NA #4 told her Resident #1 was scared to stay at the facility, and the NA saw bruises on Resident #1's arm. HR told NA #4 she was going to speak to the Director of Nursing (DON) about it. The HR Manager told the DON and the DON wrote down something and stated she was going to address it. An interview was conducted on 11/13/2017 at 4:04 PM, with the HR Manager. The HR Manager stated she was at the 500/600 Hall Nursing station when NA #4 had called her over and told her that Resident #1 was scared to stay at the facility because NA #1 had been really mean to her and gave her a bruise. NA #4 reported to her that she saw the bruise on the Resident's arm, like someone would've grabbed her. The HR Manager told NA #4 we have to report this, and so the HR Manager talked to the DON on the 10/30/2017 before she went home. The DON told the HR Manager she would take care of it. The time was late, and so the HR Manager went home and wrote up the report, and took it to the Administrator when she came in on 10/31/2017. On 11/13/2017 at 12:12 PM, an interview was conducted with the Director of Nursing (DON).	F 225	immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The reports will be made to State Survey Agency and adult protective in accordance with State law through established procedures. Effective 12/28/2017, Director of Health Services, Director of Social Services and/or Assistant Director of Health Services will report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Effective 12/28/2017, Abuse reporting process will be discussed to current alert and oriented residents every months during resident council meeting and at least quarterly during each resident care plan meeting. This process will be managed by the Center Director of Social Services effective 12/28/2017. Facility Executive Director, Director of Nursing (DON), and/or Director of Social Services will complete 100% re-education on the facility s abuse/neglect policy including notification, protection, and investigation protocols. This education will be provided for all employee, to include	

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F 225	Continued From page 47 The DON stated, and repeated many times, that she first heard of the abuse allegation on 10/31/2017, when Resident #1 came to the nurse's desk and said she was looking for the SW. The DON told Resident #1 that she could help, and Resident #1 showed her arm with the bruise on it. Resident #1 told her the NA had grabbed and pushed her in the shower. The DON stated she immediately wheeled Resident #1 to the SW, showed the SW the bruise, and told the SW she was going to start on the interviews. The DON stated she filed a 24-Hour Report, and then talked to NA #1 and NA #2, and determined there was no abuse because the bruise was just a round bruise on the Resident's wrist, and it wasn't a hand print bruise. The DON indicated that if a NA had grabbed Resident #1's wrist, it would have left a hand print bruise, because especially on Caucasians, you could always see the handprint if they were grabbed. The DON stated the bruise must have come from Resident's #1's medication, as she was on Plavix (a blood thinner), and aspirin. The DON stated after she talked to NA #1, she realized that was not the NA who had pushed the resident to the bathroom, because the Resident was already in the bathroom when NA #1 went in to shower her. The DON stated that NA #2 had pushed Resident #1 into the bathroom, but she had no proof that Resident #1 was abused, so she decided to give NA #2 a second chance and moved NA #2 to a different hall, and that had been her decision. The DON stated she had called Resident #1's family, but they had told her they already had a meeting with the corporate people. A corporate person had told her everything was fine with the family, so she thought everything was settled. The DON had not asked Resident #1 if she had been fearful or scared, or any of the details of the	F 225	full time, part time and as needed staff. This education will be completed by 12/28/2017. Any employee not educated by 12/28/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 12/28/2017, and will also be provided semi-annually. MONITORING PROCESS Effective 12/28/2017, Executive Director and or Director of Social Services will review all alleged violation to ensure a thorough investigation is completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on abuse prohibition tool and filed in daily meeting binder after proper follow ups are done. This monitoring process will take place daily to include Saturdays and Sundays for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 12/28/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility	

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F 225	Continued From page 48 incident, and her only documentation of what happened to the resident was the sentence she wrote on the 24-Hour and 5-Day Reports. The DON stated the Administrator had told her of the abuse allegation on 10/31/2017, but she had told him she already knew. When the DON was asked if she knew about the abuse allegation from the Human Resource Manager on 10/30/2017, the DON stated again that the first she heard of the allegation was when the Resident told her on 10/31/2017. An interview was conducted on 11/13/2017 at 4:18 PM, with Nurse #1. The Nurse stated she did not know anything about the abuse on the morning of 10/26/2017, and could not remember when she and NA #1 and NA #2 were all on the 500/600 hall, so the staffing schedules were reviewed. The Nurse stated she was informed the next night, which would've been the night of 10/26/2017, by NA #1, that NA #2 had pushed Resident #1 to the bathroom and left her there, while she went to tell NA #1. The Nurse stated she worked the evening of 10/31/2017 and talked to NA #2 on the morning of 11/1/2017 and asked her why she had taken Resident #1 to the bathroom and not completed the task. NA #2 told her she had to finish taking care of her own resident. Nurse #1 told NA #2 that a report had been filed against her for a dignity issue, according to a report she had heard from NA #1, and she did not think it was abuse, but was dignity. She had told NA #2, you just don't push a resident to the bathroom and just leave them. Nurse #1 stated she was informed by the DON on 11/2/2017 that NA #2 had been assigned to another hall, and had already been informed. On 11/13/2017 at 5:29 PM, an interview was	F 225	remains in substantial compliance. TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION Effective 12/28/17, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction to assure the facility remains in substantial compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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conducted with the Administrator. The Administrator stated he had been informed of the abuse allegation when he received a written report from the HR Manager on 10/31/2017. He informed the DON about the report. He stated in his opinion the 24-Hour Report and the 5-Day Report reflected a thorough investigation and interview with the resident. He stated it was concerning that NA #4 had reported the Resident was fearful, but would make no other comments.

On 11/14/2017 at 11:00 AM, an interview was conducted with the SW. The SW stated the DON had brought Resident #1 to her on 10/31/2017, and showed the SW the Resident's bruise. The SW stated the bruise was a little less than quarter size on her inner right wrist. The DON stated she would handle it. The SW was not familiar with the steps taken to investigate abuse, and only knew that the DON had to report it to the State.

On 11/14/2017 at 5:57 PM the facility was notified of IJ. The facility provided the following credible allegation of compliance on 11/16/2017.

DATE: 11/15/2017
PROCESSES THAT LEAD TO THE ALLEGED DEFFICIENCY CITED
This alleged noncompliance resulted from the Center's Director of Nursing #1 misinterpretation of regulatory requirements related to how to conduct the detail investigation of any allegation of abuse or neglect. "The former DON stated the way she understood is that she can only document what resident states on both 24 hour and a 5-day report
Director of Nursing #1 is no longer employed at the Center effective 10/15/2017. New Director of Nursing employed to oversee clinical services

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effective 10/15/2017.
The Director of operation from the Management and consulting company that manages the center, re-educated the Center Executive Director and the Director of Nursing #1 on 11/14/2017 on the center's Abuse Prohibition and Investigation policies and procedures, and emphasized the importance of protecting resident(s), to include suspending the alleged perpetrator during the investigation period, investigating thoroughly all alleged abuse, and/or neglect as well as injuries noted or reported to determine etiology, and reporting such in a timely manner per state regulatory requirements. This education was also provided to the new Director of Nursing on 11/15/2017 by the Director of Operation.
On 11/14/2017 at approximately 9:00PM Director of Rehabilitation at the center followed by the facility Director of Social services interviewed resident #1. Resident #1 voiced that on 10/26/2017 approximately between 6:00 AM and 7:00 AM, she had an episode of loose stool, she wheeled herself to the bathroom and turn the bathroom call bell on. Nursing Aide #2 responded to the call bell and told the resident she will notify her assigned Nurse Aide (Nurse Aide #1), and if the assigned aide is not back to care for her, she asked resident #1 to turn the light back on (no time lapse specified). On the morning of 10/26/2017, during initial round, noted resident #1 to be soiled. Nurse Aide #3 communicated to Nurse Aide #1 about resident#1 being soiled and asked for Nurse Aide #1 to clean the resident#1 before leaving on 10/26/2017. Nurse Aide #1 provided care to Resident#1 and gave her a shower on 10/26/2017.
Resident #1 added that Nurse Aide#1 pushed her and grabbed her on the arm, which caused a bruise. Resident #1 added that she reported this

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allegation to Nurse Aide #3 on 10/26/17, Nurse Aide #4 on 10/30/2017, and Director of Nursing #1 on 10/30/2017. Interview with Nurse Aide #4 by the Center Executive Director conducted on 11/13/2017 revealed she reported the Allegation made by Resident #1 to the Center Human Resources Director on 10/30/2017. Interview with Nurse Aide #3, and Nurse Aide # 4 did not report this allegation to their direct supervisor and the center's Executive Director per facility Abuse Prohibition policies and procedures revised June 2017. Director of Human Resources reported the Allegation to Director of Nursing #1 on 10/30/2017 and to the executive Director via written statement on 10/30/2017 that was read by the Center Executive Director on 10/31/2017 Nurse Aide #3, Nurse Aide # 4 did not report this allegation to their direct supervisor and the center's Executive Director per facility Abuse Prohibition policies and procedures revised June 2017. Director of Human Resources reported the Allegation to Director of Nursing #1 on 10/30/2017 and to the executive Director via written statement on 10/30/2017 that was read by the Center Executive Director on 10/31/2017
On 10/31/2017 and 11/3/2017, the 24 hour report and a 5 day report were sent to the Department of Health and Human Services respectively, related to resident #1's allegation of abuse made on 10/26/2017. These reports were completed and submitted by the former Director of Nursing #1. Five days report completed on 11/3/2017 indicated an investigation that was not detailed enough. On 11/13/2017 another 5 day report was completed after detail investigation conducted by the Center Executive Director, Director of Social Services and/or Director of Nursing #1.
The investigation conducted 11/13/2017 by the Center Executive Director, Director of Social

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services, Director of Rehabilitation Center and MDS nurse by interviewing 100% of all current alert and oriented residents in the facility to determine if any other resident voiced and allegation of abuse or neglect that involve the alleged perpetrator (Nurse Aide #1). No other residents alleged abuse and/or neglect that involve the alleged perpetrator. Likewise, the Director of Human Resources conducted interviews with current employees who were on duty on 10/26/2017 between the 6AM and 7AM to determine if any staff on duty witnessed any abuse and/or neglect towards Resident #1 specifically from Alleged Perpetrator (Nurse Aide #1). No other staff witness any abuse and/or neglect. Resident's #1 allegation of abuse voiced on 10/26/2017 was unsubstantiated based on findings of investigation conducted. Nurse Aide #1 did not care for Resident #1 at the time of investigation. It is the Center practice to suspend the Alleged Perpetrator at the time of investigation of any alleged Abuse and/or Neglect.

THE PROCEDURES FOR IMPLEMENTING THE ACCEPTABLE CREDIBLE ALLEGATION FOR THE ALLEGED IMMEDIATE JEOPARDY.

100% audit was completed by the Center Executive Director for all allegation of abuse and/or neglect reported to North Carolina Department of Health and Human Services in the last 12 months to determine if the alleged perpetrator(s) was/were suspended during the investigation period. This audit also identified whether the 24 hours and a 5 days reports are completed and submitted to the state agency as required by regulation and Elder Justice Act in a timely manner. The audit revealed all completed reportable in the last 12 months noted with detail investigation and the Alleged Perpetrator(s) were

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suspended. This audit was completed on 11/15/2017.

100% audit of all current residents' clinical documentation within the last 30 days was completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to determine if there is any documentation in any resident's medical records that indicate allegation of abuse, neglect, and/or misappropriation of resident's properties, if any, determine whether a 24 hours and 5 days investigation reports were completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed no other documented allegation of abuse, and/or neglect documented in resident's medical records. This audit was completed on 11/15/17. Findings of this audit is documented on "clinical records audit tool" located at the facility compliance binder.

On 11/15/2017, 100% interviews was completed by the Director of Social Services, Director of Rehabilitation Services, Dietary Manager, Business office manager and/or Medical Records clerk for all current alert and oriented residents in the facility to identify any other resident with allegation of Abuse, Neglect and or Misappropriation of properties. Four other residents, Resident#2, Resident #3, Resident #4 and Resident #5 voiced allegation of abuse, neglect and/or misappropriation of resident's properties. Alleged perpetrators suspended pending investigation by the facility Executive director, 24 hour report submitted on 11/14/2017, thorough investigation initiated, resident attending Physician and Responsible Party notified of the allegation. Resident #2, #3, #4 and #5 will be informed of the findings and actions taken when

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the investigation is completed by the Center Executive Director and/or Director of Social Services.

Effective 11/15/2017, interviews for alert and oriented residents will be completed by the Director of Social Services, Director of Recreational Services and/or designated staff member at least once every quarter to identify any allegation of Abuse, Neglect and or Misappropriation of properties. This interview process will be incorporated to social services quarterly assessment schedule and documented on "psychosocial assessment tool". Any voiced allegation of abuse, neglect and/or misappropriation of resident's properties will be reported to the Center Executive Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according to the regulatory requirements.

Effective 11/15/2017, the center nursing administrative team, which includes DON, Nurse supervisors, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation, and reported to the facility Executive Director per center's abuse policy.

Effective 11/15/2017, 24-hour and 5-days investigation reports are completed and reviewed by the Executive Director before submitted to the state agency and other officials as required by

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regulation and/or Elder Justice Act. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the Executive Director, DON, ADON, and/or Nurse Supervisor. This process will be incorporated in a daily sand up meeting. Any negative findings will be documented on the "daily stand up meeting form" and maintained in the daily stand up meeting binder.

Effective 11/15/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation and reported to the facility Executive Director. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the "week end supervisor report form" and maintained in the daily clinical meeting binder.

Effective 11/15/2017, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to

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other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.
Effective 11/15/2017, Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Effective 11/15/2017, Abuse reporting process will be discussed to current alert and oriented residents every months during resident council meeting and at least quarterly during each resident care plan meeting. This process will be managed by the Center Director of Social Services effective 11/15/2017.

Facility Executive Director, Director of Nursing (DON), and/or Director of Social Services will complete 100% re-education on the facility's abuse/neglect policy including notification, protection, and investigation protocols. This education will be provided for all employee, to include full time, part time and as needed staff. This education will be completed by 11/15/2017. Any employee not educated by 11/15/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 11/15/2017, and will also be provided semi-annually.

100% audit of all current residents' clinical documentation within the last 30 days was completed by the Director of Nursing, Assistant

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Director of Nursing and/or Nurse Supervisor to determine if there is any documentation in any resident's medical records that indicate allegation of abuse, neglect, and/or misappropriation of resident's properties, if any, determine whether a 24 hours and 5 days investigation reports were completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed no other documented allegation of abuse, and/or neglect documented in resident's medical records. This audit was completed on 11/15/17. Findings of this audit is documented on "clinical records audit tool" located at the facility compliance binder.

On 11/15/2017, 100% interviews was completed by the Director of Social Services, Director of Rehabilitation Services, Dietary Manager, Business office manager and/or Medical Records clerk for all current alert and oriented residents in the facility to identify any other resident with allegation of Abuse, Neglect and or Misappropriation of properties. Four other residents, Resident#2, Resident #3, Resident #4 and Resident #5 voiced allegation of abuse, neglect and/or misappropriation of resident's properties. Alleged perpetrators suspended pending investigation by the facility Executive director, 24 hour report submitted on 11/14/2017, thorough investigation initiated, resident attending Physician and Responsible Party notified of the allegation. Resident #2, #3, #4 and #5 will be informed of the findings and actions taken when the investigation is completed by the Center Executive Director and/or Director of Social Services.

Effective 11/15/2017, interviews for alert and oriented residents will be completed by the

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Director of Social Services, Director of Recreational Services and/or designated staff member at least once every quarter to identify any allegation of Abuse, Neglect and or Misappropriation of properties. This interview process will be incorporated to social services quarterly assessment schedule and documented on "psychosocial assessment tool". Any voiced allegation of abuse, neglect and/or misappropriation of resident's properties will be reported to the Center Executive Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according to the regulatory requirements.

Effective 11/15/2017, the center nursing administrative team, which includes DON, Nurse supervisors, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation, and reported to the facility Executive Director per center's abuse policy.

Effective 11/15/2017, 24-hour and 5-days investigation reports are completed and reviewed by the Executive Director before submitted to the state agency and other officials as required by regulation and/or Elder Justice Act. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the Executive Director, DON, ADON, and/or Nurse Supervisor. This process

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will be incorporated in a daily sand up meeting. Any negative findings will be documented on the "daily stand up meeting form" and maintained in the daily stand up meeting binder.

Effective 11/15/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation and reported to the facility Executive Director. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the "week end supervisor report form" and maintained in the daily clinical meeting binder.

Facility Executive Director, Director of Nursing (DON), and/or Director of Social Services will complete 100% re-education on the facility's abuse/neglect policy including notification, protection, and investigation protocols. This education will be provided for all employee, to include full time, part time and as needed staff. This education will be completed by 11/15/2017. Any employee not educated by 11/15/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 11/15/2017, and will also be provided semi-annually. 100% audit of all current residents' clinical documentation within the last 30 days was completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to

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determine if there is any documentation in any resident's medical records that indicate allegation of abuse, neglect, and/or misappropriation of resident's properties, if any, determine whether a 24 hours and 5 days investigation reports were completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed no other documented allegation of abuse, and/or neglect documented in resident's medical records. This audit was completed on 11/15/17. Findings of this audit is documented on "clinical records audit tool" located at the facility compliance binder.

Effective 11/15/2017, interviews for alert and oriented residents will be completed by the Director of Social Services, Director of Recreational Services and/or designated staff member at least once every quarter to identify any allegation of Abuse, Neglect and or Misappropriation of properties. This interview process will be incorporated to social services quarterly assessment schedule and documented on "psychosocial assessment tool". Any voiced allegation of abuse, neglect and/or misappropriation of resident's properties will be reported to the Center Executive Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according to the regulatory requirements.

Effective 11/15/2017, the center nursing administrative team, which includes DON, Nurse supervisors, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation

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UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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F 225	Continued From page 61	F 225		

of resident's properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation, and reported to the facility Executive Director per center's abuse policy.

Effective 11/15/2017, 24-hour and 5-days investigation reports are completed and reviewed by the Executive Director before submitted to the state agency and other officials as required by regulation and/or Elder Justice Act. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the Executive Director, DON, ADON, and/or Nurse Supervisor. This process will be incorporated in a daily sand up meeting. Any negative findings will be documented on the "daily stand up meeting form" and maintained in the daily stand up meeting binder.

Effective 11/15/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation and reported to the facility Executive Director. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the "week end supervisor report form" and maintained in the daily clinical meeting binder.

Facility Executive Director, Director of Nursing

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F 225	Continued From page 62	F 225		

(DON), and/or Director of Social Services will complete 100% re-education on the facility's abuse/neglect policy including notification, protection, and investigation protocols. This education will be provided for all employee, to include full time, part time and as needed staff. This education will be completed by 11/15/2017. Any employee not educated by 11/15/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 11/15/2017, and will also be provided semi-annually.

THE MONITORING PROCEDURE TO ENSURE THAT THE CREDIBLE ALLEGATION IS EFFECTIVE AND REMOVE THE ALLEGED IMMEDIATE JEOPARDY

Effective 11/15/2017, Executive Director and or Director of Social Services will review all alleged violation to ensure a thorough investigation is completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on "abuse prohibition tool" and filed in daily meeting binder after proper follow ups are done. This monitoring process will take place daily to include Saturdays and Sundays for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.

Effective 11/15/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3

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months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.
TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION
Effective 11/15/17, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of credible allegation to remove this alleged immediate jeopardy.

Compliance Date: 11/15/2017

The Credible Allegation was verified on 11/16/2017 by the following:

1. The survey team reviewed the audit of current resident's medical records titled "clinical records audit tool", which reviewed documentation that would indicate any allegation of abuse, neglect, misappropriation of resident's properties and /or injuries of unknown sources.
2. The survey team reviewed the audit of all incidents within the last 30 days which was completed to identify any unknown source of injuries.
3. The survey team reviewed the in-service provided by staff and signed by staff. The survey team conducted staff interviews with 16 on-duty staff. The staff interviewed confirmed the recent in-service regarding abuse identification, reporting, and recognizing signs and symptoms of staff burnout.
4. The survey team interviewed 41 current alert and oriented residents. The residents confirmed education they had received on whom to report abuse to.

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F 226	Continued From page 64	F 226		
F 226 SS=J	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and record review the facility failed to	F 226	F226 ROOT CAUSE	12/28/17

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F 226	Continued From page 65 follow their policy in the areas of prevention, protection, investigaion and reporting for staff to resident physical abuse for 1 of 1 sampled residents (Resident #1). The immediate jeopardy (IJ) began on 10/26/2017 when Nurse Aide (NA) #1 grabbed Resident #1 by the wrists and sat her down hard on the shower seat in the resident's bathroom, resulting in a bruise to her right wrist, and not reporting to Administration. The IJ was removed on 11/16/2017 when the facility's acceptable credible allegation was verified. The facility remains out of compliance at a scope and severity of D (no actual harm with the potential for more than minimal harm that is not IJ) to allow the facility to monitor and implement its plan of correction for abuse. Findings included: Review of the facility's Abuse Prevention Policy, revised on 6/2017, stated: "It is the responsibility of employees to promptly report to center management any incident or suspected incident of neglect or resident abuse . . . Staff are state mandated reporters . . . and must comply with state regulations regarding reporting any reasonable suspicion of a crime against a resident or other individual receiving care by the center." The Policy listed under Investigation: #5. "Investigations will be thorough and objective." The Policy listed under Protection: ". . . Any person or persons accused or suspected of involvement in resident abuse . . . is immediately suspended for the course of the investigation pending the outcome of the investigation."	F 226	This alleged noncompliance resulted from the Center s former Director of Nursing #1, Nurse Aide #3 and Nurse Aide #4 failure to follow the Abuse Prohibition Policies and procedures revised June 2017. Director of Nursing #1 failed to follow the facility policies procedure as she failed report an allegation from resident #1 to the Executive Director timely. Former Director of Nursing #1 also failed to protect the resident who alleged abuse as she did not suspend Nurse Aide #1 during investigation period and also failed to notify the resident and/or resident #1 responsible party of the findings of the investigation and actions taken post investigation for Resident #1 allegation of abuse voiced on 10/26/2017. Director of Nursing #1 is no longer employed at the Center effective 11/15/2017. New Director of Nursing employed to oversee clinical services effective 11/15/2017. IMMEDIATE ACTION The Director of operation from the Management and consulting company that manages the center, re-educated the Center Executive Director and the Director of Nursing #1 on 11/14/2017 on the center s Abuse Prohibition and Investigation policies and procedures, and emphasized the importance of protecting resident(s), to include suspending the alleged perpetrator during the investigation period, investigating thoroughly all alleged abuse, and/or neglect as well as injuries noted or reported to determine etiology, and	

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F 226	Continued From page 66 Resident #1 was admitted to the facility on 5/12/2017 with diagnoses to include diabetes, hypertension, and contracture of left hand. Review of a quarterly Minimum Data Set (MDS) assessment for Resident #1, dated 9/22/2017 revealed the resident had intact cognition. An interview was conducted on 11/13/2017 at 11:05 AM with Resident #1. She stated a couple of weeks ago, she was not sure of the date, she had a bowel movement (BM) and soiled herself at about 6:00 AM. The resident got in her wheel chair and took herself to the bathroom, and turned on the bathroom call light for someone to come and help clean her up. Nursing Assistant (NA) #1 came in and was real mad and kept saying that the other NA should have cleaned her up. The Resident stated she stood up and NA #1 grabbed her by the arm and said, "I want you to sit here", moved her over and sat her down very hard on the shower seat, then she scrubbed her hard. Resident #1 said she was crying and scared and she knew the NA was too mad. Resident #1 said she finally said to the NA, "you don't have to treat me like a dog." When the shower was over the resident asked for the NA's name, and the NA wouldn't tell her. Resident #1 stated she gave me a bruise right here, and pointed to her inside right wrist, and indicated the bruise was about 2" by 3" with her fingers. Resident #1 told NA #3 what had happened in the shower, and NA #3 said she (the resident) should report it to the Social Worker (SW). The resident stated she wheeled herself to the nurse's station for 3 days after and asked to see the SW, but the SW never came, so she asked NA #4 about it after NA #4 saw her bruise. The resident stated she went to the nurse's station on Halloween, and was frustrated because the SW had not	F 226	reporting such in a timely manner per state regulatory requirements. This education was also provided to the new Director of Nursing on 11/15/2017 by the Director of Operation. The Center Executive Director, and the Director of Social Services re-educated Nurse Aide #3, and Nurse Aide #4 on 11/15/2017 on the center s Abuse Prohibition and Investigation policies and procedures, and emphasized the importance of protecting resident(s), and reporting any allegation of abuse or Neglect to their Direct supervisor and the Executive Director in a timely manner not to exceed 2 hours after forming suspicion, witness the abuse and/or after a resident, another staff and/or family member alleged abuse. On 11/14/2017 at approximately 9:00PM Director of Rehabilitation at the center followed by the facility Director of Social services interviewed resident #1. Resident #1 voiced that on 10/26/2017 approximately between 6:00 AM and 7:00 AM, she had an episode of loose stool, she wheeled herself to the bathroom and turn the bathroom call bell on. Nursing Aide #2 responded to the call bell and told the resident she will notify her assigned Nurse Aide (Nurse Aide #1), and if the assigned aide is not back to care for her, she asked resident #1 to turn the light back on (no time lapse specified). On the morning of 10/26/2017, during initial round, noted resident #1 to be soiled. Nurse Aide #3 communicated to Nurse Aide #1 about resident#1 being soiled and asked for Nurse Aide #1 to clean the	

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F 226	Continued From page 67 contacted her. A lady at the desk asked what she needed to tell the SW, and Resident #1 stated she just stuck out her arm with the bruise, and the lady said she was the Director of Nursing (DON), and she could help. The DON immediately then transported the Resident to the SW office and said we need to get started on interviews. The DON came back a couple of days after Halloween, and told Resident #1 the decision was up to the DON and she decided not to fire the NA, but had moved her to a different hall and given her another chance. The Resident stated she believed in 2nd chances, but afterward, she was worried that NA #1 would let her temper explode on someone else. Record review revealed the facility filed a 24-Hour Initial Report to the State Agency on 10/31/2017 for resident abuse and neglect. The allegation was: "Resident stated that Aide pushed her in the bathroom." The "accused individual information" listed the details for NA #1. The report was signed by the Director of Nursing. Record reviews revealed the facility filed a 5-Working Day Report to the State Agency on 11/3/2017 for resident abuse and neglect. The allegation was: "Resident stated that aide pushed her in the bathroom and was rough and left a bruise on her wrist. Education teaching given and aide was removed from Hall. (The NA at fault) Was not NA #1 was a different aide. Was not a hand print bruise upon investigation." The "accused individual information" listed details for NA #1. The report was signed by the Director of Nursing. On 11/13/2017 at 4:35 PM, an interview was conducted with NA #1, who requested only to be interviewed with the DON present. NA #1 stated	F 226	resident#1 before leaving on 10/26/2017. Nurse Aide #1 provided care to Resident#1 and gave her a shower on 10/26/2017. Resident #1 added that Nurse Aide#1 pushed her and grabbed her on the arm, which caused a bruise. Resident #1 added that she reported this allegation to Nurse Aide #3 on 10/26/17, Nurse Aide #4 on 10/30/2017, and Director of Nursing #1 on 10/30/2017. Interview with Nurse Aide #4 by the Center Executive Director conducted on 11/13/2017 revealed she reported the Allegation made by Resident #1 to the Center Human Resources Director on 10/30/2017. Interview with Nurse Aide #3, and Nurse Aide # 4 did not report this allegation to their direct supervisor and the center s Executive Director per facility Abuse Prohibition policies and procedures revised June 2017. Director of Human Resources reported the Allegation to Director of Nursing #1 on 10/30/2017 and to the executive Director via written statement on 10/30/2017 that was read by the Center Executive Director on 10/31/2017 On 10/31/2017 and 11/3/2017, the 24 hour report and a 5 day report were sent to the Department of Health and Human Services respectively, related to resident #1 s allegation of abuse made on 10/26/2017. These reports were completed and submitted by the former Director of Nursing #1. Five days report completed on 11/3/2017 indicated an investigation that was not detailed enough. On 11/13/2017 another 5 day report was completed after detail	

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F 226	Continued From page 68 the only thing she recalled was between 6:00 and 7:00 AM, on 10/26/2017, NA #2 had told her that Resident #1 needed her assistance, and so she went in and assisted her. NA #1 had been giving a bath to another resident, and so it was a little while before she was able to go down and help Resident #1. NA #1 stated she went to Resident #1's room before she had given report to day shift, and the Resident was already in the bathroom. She pushed the Resident up to the shower bar, and the Resident grabbed hold of it and sat down in the shower. The NA then gave her a shower and dressed her. She stated the Resident was crying and NA #1 calmed her down, told her not to cry it would be okay, about her being left in the bathroom. When asked about her written statement of 11/1/2017, that she forgot to go back in and clean her up, NA #1 just shrugged her shoulders and said it wasn't that long for the resident to wait and that was all she could remember. When asked about her written statement of 11/1/2017 that she had given report to day shift before she went in to clean up Resident #1, NA #1 said it wasn't that long, and she couldn't remember. Further questions were answered with the same response. On 11/13/2017 at 5:38 PM, a phone interview was conducted with NA #2. NA #2 stated she was working on the 500 hall, and went to the 600 hall to answer a bathroom call light, on the morning of 10/26/2017. Resident #1 was already in the bathroom, sitting in her wheelchair facing towards the call light. The NA smelled BM, and knew it would take some time to clean her up, and the Resident said she needed help to be cleaned up. NA #2 stated she told the Resident she needed to go get a gown and stuff, and then NA #2 went directly to the room NA #1 was in. NA #2 told NA	F 226	investigation conducted by the Center Executive Director, Director of Social Services and/or Director of Nursing #1. The investigation conducted 11/13/2017 by the Center Executive Director, Director of Social services, Director of Rehabilitation Center and MDS nurse by interviewing 100% of all current alert and oriented residents in the facility to determine if any other resident voiced and allegation of abuse or neglect that involve the alleged perpetrator (Nurse Aide #1). No other residents alleged abuse and/or neglect that involve the alleged perpetrator. On 11/15/2017, Director of Human Resources conducted interviews with current employee who were on duty on 10/26/2017 between the 6AM and 7AM to determine if any staff on duty witnessed any abuse and/or neglect towards Resident #1 specifically from Alleged Perpetrator (Nurse Aide #1). No other staff witness any abuse and/or neglect per interview. On 11/13/2017 another 5 day report was completed after detail investigation completed by the Center Executive Director, Director of Social Services and/or Director of Nursing #1 services. Resident s #1 allegation of abuse voiced on 10/26/2017 was unsubstantiated. Nurse Aide #1 did not care for Resident #1 at the time of investigation. Facility Director of Social Services notified resident #1 of the findings of the investigation and actions taken for the Alleged Perpetrator to include customer service re-education.	

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F 226	Continued From page 69 #1 that Resident #1 needed her. NA #1 stated she was not going back in that room. NA #2 went to get linens and proceeded back to the 500 hall. NA #2 stated that Resident #1 put her call light back on at shift change, and NA #2 would've gone back to her room, but saw 2 NA's standing at her door, and they answered the call light. NA # 2 stated she waited after her shift for the DON to arrive, and the DON told NA #2 there was an allegation that she had pushed Resident #1 in the bathroom, and then cut the light off. NA #2 requested the DON move her to another hall to get away from NA #1 and Nurse #1, and the DON moved her to another part of the facility. NA #2 stated she did not know if she had neglected the resident and didn't know if this incident was a dignity issue or something else. On 11/14/2017 at 8:34 AM, an interview was conducted with NA #3. NA #3 stated she had talked to Resident #1, later that morning on 10/26/2017, and was told that NA #1 was mad and mean and rough with her and had grabbed her hard, and she was scared of her. The Resident asked the name of NA #1, but NA #3 told her she didn't know. NA #3 did not report the abuse to the DON that day, and told the Resident it would be better if she reported it herself to the SW. The Resident did not show NA #3 the bruise at that time, and thought the Resident showed her the bruise on 10/31/2017 after the resident had spoken to the DON. NA #3 stated she had been through abuse training, but could not say why she had not reported the abuse herself, and had advised Resident #1 to report it herself. NA #3 stated she talked to Nurse #2 on the morning of 10/26/2017, but did not tell him that Resident #1 had been mistreated during the shower. NA #3 stated she talked to the DON on 10/26/2017	F 226	IDENTIFICATION OF OTHERS 100% audit was completed by the Center executive Director for all allegation of abuse and/or neglect submitted in the last 12 months to determine is the alleged perpetrator was suspended during investigation and the 24 hours as well as 5 days reports are completed and submitted to the state agency as required by regulation and Elder Justice Act in a timely manner. The audit revealed all completed reportable in the last 12 months noted with detail investigation and the Alleged Perpetrator(s) were suspended. This audit was completed on 11/15/2017. 100% audit of all current residents clinical documentation within the last 30 days was completed by the Director of Nursing #1, Assistant Director of Nursing and/or Nurse Supervisor to determine if there is any documentation in any resident s medical records that indicate allegation of abuse, neglect, and/or misappropriation of resident s properties, if any, determine whether a 24 hours and 5 days investigation reports were completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed no other documented allegation of abuse, and/or neglect documented in resident s medical records. This audit was completed on 11/15/17. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder.	

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F 226	Continued From page 70 and stated to her that Resident #1 had a problem with NA #1. NA #3 did not tell the DON that Resident #1 had been mistreated and harmed in the shower by NA #1. On 11/13/2017 at 1:47 PM, an interview was conducted with NA #4. NA #4 stated Resident #1 was alert and oriented, and could tell you about her day, and always remembered who NA #4 was. NA #4 indicated Resident #1 needed help with bathing, and dressing. Resident #1 could take herself to the toilet, but when she had occasional incontinent accident, she needed help with being cleaned up. NA #4 stated Resident #1 showed the bruise on her right inner wrist to her, and told her she had been pushed when in the shower and manhandled, and was so scared and upset, and didn't want to be at the facility. The Resident asked for a patient Bill of Rights to see what she could do about it. The NA stated this happened before Halloween, but was not sure of the date. The NA stated she left the Resident's room to see about getting her a Bill of Rights, and decided she had better tell someone of the abuse. The NA saw the HR manager at the nurse's desk, and told her there was abuse in the facility. The HR Manager stated the Administrator and DON needed to be notified. The HR Manager told the DON and then wrote a report. A review of a document dated 10/30/2017, written by the Human Resource Manager (HR) was conducted. The HR Manager reported she was at the 500/600 Hall Nurse's Station when she was notified by NA #4 that abuse was going on in the facility. NA #4 told her Resident #1 was scared to stay at the facility, and the NA saw bruises on Resident #1's arm. HR told NA #4 she was going to speak to the Director of Nursing (DON) about	F 226	On 11/15/2017, 100% interviews was completed by the Director of Social Services, Director of Rehabilitation Services, Dietary Manager, Business office manager and/or Medical Records clerk for all current alert and oriented residents in the facility to identify any other resident with allegation of Abuse, Neglect and or Misappropriation of properties. Four other residents, Resident#2, Resident #3, Resident #4 and Resident #5 voiced allegation of abuse, neglect and/or misappropriation of resident s properties. Alleged perpetrators suspended pending investigation by the facility Executive director, 24 hour report submitted on 11/14/2017, thorough investigation initiated, resident attending Physician and Responsible Party notified of the allegation. Resident #2, #3, #4 and #5 will be informed of the findings and actions taken when the investigation is completed by the Center Executive Director and/or Director of Social Services. SYSTEMIC PROCESS Effective 12/28/2017, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the	

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F 226	Continued From page 71 it. The HR Manager told the DON and the DON wrote down something and stated she was going to address it. An interview was conducted on 11/13/2017 at 4:04 PM, with the HR Manager. The HR Manager stated she was at the 500/600 Hall Nursing station on 10/26/2017, when NA #4 had called her over and told her that Resident #1 was scared to stay at the facility because NA #1 had been really mean to her and gave her a bruise. NA #4 reported to her that she saw the bruise on the Resident's arm, like someone would've grabbed her. The HR Manager told NA #4, "we have to report this", and so the HR Manager talked to the DON on the 10/30/2017 before she went home. The DON told the HR Manager she would take care of it. The time was late, and so the HR Manager went home and wrote up the report, and took it to the Administrator when she came in on 10/31/2017. On 11/13/2017 at 12:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility did not have a policy on abuse, they followed State guidelines, which meant that abuse had to be reported within 2 hours. The DON stated, and repeated many times, that she first heard of the abuse allegation on 10/31/2017. Resident #1 came to the nurse's desk and said she was looking for the SW. Resident #1 told the DON that a NA had grabbed and pushed her in the shower, and had showed a bruise on her arm. The DON stated she then wheeled Resident #1 to the SW, showed the SW the bruise, and told the SW she was going to start on the interviews. The DON stated she filed a 24-Hour Report that day, and then talked to NA #1 and NA #2, and determined there was no	F 226	administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Effective 12/28/2017, Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Effective 12/28/2017, the Center Director of Social Services, Director of Recreational Services and/or designated staff member will conduct interviews for each current employee at least once a year. The interview will be intended to determine the employee understanding of the Center Abuse policies and Procedures and ensure that each employee receives the Abuse education at least once every six months. This interview process will be incorporated to the annual employee evaluating. Any staff member not interviewed by the anniversary date will not be allowed to work until educated. Any voiced allegation of abuse, neglect and/or misappropriation of resident s properties will be reported to the Center Executive Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according to the regulatory requirements.	

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F 226	Continued From page 72 abuse because the bruise was just a round bruise on the Resident's wrist, and it wasn't a hand print bruise. The DON indicated that if a NA had grabbed Resident #1's wrist, it would have left a hand print bruise. The DON stated the bruise must have come from Resident's #1's medication, as she was on Plavix (a blood thinner), and aspirin. The DON stated after she talked to NA #1, she realized that was the wrong NA, because the Resident was already in the bathroom when NA #1 went in to shower her. The DON stated that NA #2 had pushed Resident #1 into the bathroom, but she had no proof that Resident #1 was abused, so she decided to give NA #2 a second chance and moved NA #2 to a different hall, and that had been her decision. The DON had not asked Resident #1 if she had been fearful or scared, or any of the details of the incident, and her only documentation of what happened to the resident was the sentence she wrote on the 24-Hour and 5-Day Reports. The DON stated the Administrator had told her of the abuse allegation on 10/31/2017, but she had told him she already knew. When asked if she had been notified of the abuse allegation on 10/30/2017 by the Human Resources Manager, the DON stated again that she found out about the allegation when the resident talked to her on 10/31/2017. On 11/14/2017 at 11:00 AM, an interview was conducted with the SW. The SW stated the DON had brought Resident #1 to her on 10/31/2017, and showed the SW the Resident's bruise. The SW stated the bruise was a little less than quarter size on her inner right wrist. The DON stated she would handle it. The SW talked to the DON on 11/3/2017, and the DON reported that NA #2 had put the Resident in the bathroom, and another NA	F 226	Effective 12/28/2017, Abuse reporting process will be discussed to current alert and oriented residents every months during resident council meeting and at least quarterly during each resident care plan meeting. This process will be managed by the Center Director of Social Services effective 12/28/2017. 100% of current alert and oriented residents in the facility re-educated on 12/28/2017 by the center Director of Social Services, Director of Rehabilitation Services, Dietary Manager, Business office manager and/or Medical Records clerk to ensure that each know about resident council meeting and who to report to in the event an abuse, neglect, and/or misappropriation of resident s properties is noted or witnessed. Residents re-educated to report any allegation, actual or suspicion of abuse to the nurse, any administrative staff on duty and/or the facility Executive Director effective 12/28/2017. The reporting can be made verbally or in writing. Effective 12/28/2017, the facility initiated a process of open door policy, will hold a staff meeting once a month to encourage staff to express concerns and request training in challenging situations. Effective 12/28/2017, the center administrative staff will observe employees while on duty for any signs of burnout (example decrease in job performance, increase number of unexplained absences, less socializing etc.).	

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F 226	Continued From page 73 (NA#1), said Resident #1 could take herself to the bathroom. The DON stated she couldn't say what happened, or who did what, so she just removed the NA #2 from the hall. The SW understood the DON to mean that the bruise happened on the way to the bathroom, and since no one had taken the Resident to the bathroom, abuse didn't happen. The SW reported that Resident #1 was alert and oriented. The SW was not familiar with the steps taken to investigate abuse, and only knew that the DON had to report it to the State. On 11/14/2017 at 5:57 PM the facility was notified of IJ. The facility provided the following credible allegation of compliance on 11/16/2017. DATE: 11/15/2017 PROCESSES THAT LEAD TO THE ALLEGED DEFFICIENCY CITED This alleged noncompliance resulted from the Center's former Director of Nursing #1, Nurse Aide #3 and Nurse Aide #4 failure to follow the Abuse Prohibition Policies and procedures revised June 2017. Director of Nursing #1 failed to follow the facility policies procedure as she failed report an allegation from resident #1 to the Executive Director timely. Former Director of Nursing #1 also failed to protect the resident who alleged abuse as she did not suspend Nurse Aide #1 during investigation period and also failed to notify the resident and/or resident #1 responsible party of the findings of the investigation and actions taken post investigation for Resident #1 allegation of abuse voiced on 10/26/2017. Director of Nursing #1 is no longer employed at the Center effective 11/15/2017. New Director of Nursing employed to oversee clinical services effective 11/15/2017.	F 226	Effective 12/28/2017, the nursing administrative team, which includes DON, Nurse supervisors, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident s properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation and reported to the facility Executive Director. Effective 12/28/2017, 24 hours and 5 days investigation reports is completed and reviewed by the Executive Director before submitted to the state agency and other officials as required by regulation and/or Elder Justice Act per regulatory requirement. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Nurse Supervisor. This process will be incorporated in a daily clinical rounds. Any negative findings will be documented on the daily clinical checklist form and maintained in the daily clinical meeting binder. Effective 12/28/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review	

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F 226	Continued From page 74 The Director of operation from the Management and consulting company that manages the center, re-educated the Center Executive Director and the Director of Nursing #1 on 11/14/2017 on the center's Abuse Prohibition and Investigation policies and procedures, and emphasized the importance of protecting resident(s), to include suspending the alleged perpetrator during the investigation period, investigating thoroughly all alleged abuse, and/or neglect as well as injuries noted or reported to determine etiology, and reporting such in a timely manner per state regulatory requirements. This education was also provided to the new Director of Nursing on 11/15/2017 by the Director of Operation. The Center Executive Director, and the Director of Social Services re-educated Nurse Aide #3, and Nurse Aide #4 on 11/15/2017 on the center's Abuse Prohibition and Investigation policies and procedures, and emphasized the importance of protecting resident(s), and reporting any allegation of abuse or Neglect to their Direct supervisor and the Executive Director in a timely manner not to exceed 2 hours after forming suspicion, witness the abuse and/or after a resident, another staff and/or family member alleged abuse. On 11/14/2017 at approximately 9:00PM Director of Rehabilitation at the center followed by the facility Director of Social services interviewed resident #1. Resident #1 voiced that on 10/26/2017 approximately between 6:00 AM and 7:00 AM, she had an episode of loose stool, she wheeled herself to the bathroom and turn the bathroom call bell on. Nursing Aide #2 responded to the call bell and told the resident she will notify her assigned Nurse Aide (Nurse Aide #1), and if	F 226	clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident s properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation and reported to the facility Executive Director. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the week end supervisor report form and maintained in the daily clinical meeting binder. Facility Executive Director, Director of Nursing (DON), and/or Director of Social Services will complete 100% re-education on the facility s abuse/neglect policy including notification, protection, and investigation protocols. This education will be provided for all employee, to include full time, part time and as needed staff. This education will be completed by 12/28/2017. Any employee not educated by 12/28/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 12/28/2017, and will also be provided semi-annually. MONITORING PROCESS Effective 12/28/2017, Executive Director and or Director of Social Services will review all alleged violation to ensure a	

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F 226	Continued From page 75 the assigned aide is not back to care for her, she asked resident #1 to turn the light back on (no time lapse specified). On the morning of 10/26/2017, during initial round, noted resident #1 to be soiled. Nurse Aide #3 communicated to Nurse Aide #1 about resident#1 being soiled and asked for Nurse Aide #1 to clean the resident#1 before leaving on 10/26/2017. Nurse Aide #1 provided care to Resident#1 and gave her a shower on 10/26/2017. Resident #1 added that Nurse Aide#1 pushed her and grabbed her on the arm, which caused a bruise. Resident #1 added that she reported this allegation to Nurse Aide #3 on 10/26/17, Nurse Aide #4 on 10/30/2017, and Director of Nursing #1 on 10/30/2017. Interview with Nurse Aide #4 by the Center Executive Director conducted on 11/13/2017 revealed she reported the Allegation made by Resident #1 to the Center Human Resources Director on 10/30/2017. Interview with Nurse Aide #3, and Nurse Aide # 4 did not report this allegation to their direct supervisor and the center's Executive Director per facility Abuse Prohibition policies and procedures revised June 2017. Director of Human Resources reported the Allegation to Director of Nursing #1 on 10/30/2017 and to the executive Director via written statement on 10/30/2017 that was read by the Center Executive Director on 10/31/2017 On 10/31/2017 and 11/3/2017, the 24 hour report and a 5 day report were sent to the Department of Health and Human Services respectively, related to resident #1's allegation of abuse made on 10/26/2017. These reports were completed and submitted by the former Director of Nursing #1. Five days report completed on 11/3/2017 indicated an investigation that was not detailed enough. On 11/13/2017 another 5 day report was completed after detail investigation conducted by	F 226	thorough investigation is completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on abuse prohibition tool and filed in daily meeting binder after proper follow ups are done. This monitoring process will take place daily to include Saturdays and Sundays for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 12/28/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION Effective 12/28/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction to assure the facility remains in the substantial compliance.	

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the Center Executive Director, Director of Social Services and/or Director of Nursing #1.
The investigation conducted 11/13/2017 by the Center Executive Director, Director of Social services, Director of Rehabilitation Center and MDS nurse by interviewing 100% of all current alert and oriented residents in the facility to determine if any other resident voiced and allegation of abuse or neglect that involve the alleged perpetrator (Nurse Aide #1). No other residents alleged abuse and/or neglect that involve the alleged perpetrator.
On 11/15/2017, Director of Human Resources conducted interviews with current employee who were on duty on 10/26/2017 between the 6AM and 7AM to determine if any staff on duty witnessed any abuse and/or neglect towards Resident #1 specifically from Alleged Perpetrator (Nurse Aide #1). No other staff witness any abuse and/or neglect per interview.
On 11/13/2017 another 5 day report was completed after detail investigation completed by the Center Executive Director, Director of Social Services and/or Director of Nursing #1 services.
Resident's #1 allegation of abuse voiced on 10/26/2017 was unsubstantiated. Nurse Aide #1 did not care for Resident #1 at the time of investigation.
Facility Director of Social Services notified resident #1 of the findings of the investigation and actions taken for the Alleged Perpetrator to include customer service re-education.
THE PROCEDURES FOR IMPLEMENTING THE ACCEPTABLE CREDIBLE ALLEGATION FOR THE ALLEGED IMMEDIATE JEOPARDY.
100% audit was completed by the Center executive Director for all allegation of abuse and/or neglect submitted in the last 12 months to determine is the alleged perpetrator was

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suspended during investigation and the 24 hours as well as 5 days reports are completed and submitted to the state agency as required by regulation and Elder Justice Act in a timely manner. The audit revealed all completed reportable in the last 12 months noted with detail investigation and the Alleged Perpetrator(s) were suspended. This audit was completed on 11/15/2017.

100% audit of all current residents' clinical documentation within the last 30 days was completed by the Director of Nursing #1, Assistant Director of Nursing and/or Nurse Supervisor to determine if there is any documentation in any resident's medical records that indicate allegation of abuse, neglect, and/or misappropriation of resident's properties, if any, determine whether a 24 hours and 5 days investigation reports were completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed no other documented allegation of abuse, and/or neglect documented in resident's medical records. This audit was completed on 11/15/17. Findings of this audit is documented on "clinical records audit tool" located at the facility compliance binder.

On 11/15/2017, 100% interviews was completed by the Director of Social Services, Director of Rehabilitation Services, Dietary Manager, Business office manager and/or Medical Records clerk for all current alert and oriented residents in the facility to identify any other resident with allegation of Abuse, Neglect and or Misappropriation of properties. Four other residents, Resident#2, Resident #3, Resident #4 and Resident #5 voiced allegation of abuse,

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neglect and/or misappropriation of resident's properties. Alleged perpetrators suspended pending investigation by the facility Executive director, 24 hour report submitted on 11/14/2017, thorough investigation initiated, resident attending Physician and Responsible Party notified of the allegation. Resident #2, #3, #4 and #5 will be informed of the findings and actions taken when the investigation is completed by the Center Executive Director and/or Director of Social Services.

Effective 11/15/2017, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.
Effective 11/15/2017, Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
Effective 11/15/2017, the Center Director of Social Services, Director of Recreational Services and/or designated staff member will conduct interviews for each current employee at least

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once a year. The interview will be intended to determine the employee understanding of the Center Abuse policies and Procedures and ensure that each employee receives the Abuse education at least once every six months. This interview process will be incorporated to the annual employee evaluating. Any staff member not interviewed by the anniversary date will not be allowed to work until educated. Any voiced allegation of abuse, neglect and/or misappropriation of resident's properties will be reported to the Center Executive Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according to the regulatory requirements.

Effective 11/15/2017, Abuse reporting process will be discussed to current alert and oriented residents every months during resident council meeting and at least quarterly during each resident care plan meeting. This process will be managed by the Center Director of Social Services effective 11/15/2017.

100% of current alert and oriented residents in the facility re-educated on 11/15/2017 by the center Director of Social Services, Director of Rehabilitation Services, Dietary Manager, Business office manager and/or Medical Records clerk to ensure that each know about resident council meeting and who to report to in the event an abuse, neglect, and/or misappropriation of resident's properties is noted or witnessed. Residents' re-educated to report any allegation, actual or suspicion of abuse to the nurse, any administrative staff on duty and/or the facility Executive Director effective 11/15/2017. The reporting can be made verbally or in writing.

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Effective 11/15/2017, the facility initiated a process of open door policy, will hold a staff meeting once a month to encourage staff to express concerns and request training in challenging situations. Effective 11/15/2017, the center administrative staff will observe employees while on duty for any signs of burnout (example decrease in job performance, increase number of unexplained absences, less socializing etc.).

Effective 11/15/2017, the nursing administrative team, which includes DON, Nurse supervisors, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation and reported to the facility Executive Director.

Effective 11/15/2017, 24 hours and 5 days investigation reports is completed and reviewed by the Executive Director before submitted to the state agency and other officials as required by regulation and/or Elder Justice Act per regulatory requirement. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Nurse Supervisor. This process will be incorporated in a daily clinical rounds. Any negative findings will be documented on the "daily clinical checklist form" and maintained in the daily clinical meeting binder.

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Effective 11/15/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any allegation of abuse, neglect, misappropriation of resident's properties and/or injuries of unknown sources reported/documented is investigated thoroughly, alleged perpetrator is suspended pending investigation and reported to the facility Executive Director. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the "week end supervisor report form" and maintained in the daily clinical meeting binder.

Facility Executive Director, Director of Nursing (DON), and/or Director of Social Services will complete 100% re-education on the facility's abuse/neglect policy including notification, protection, and investigation protocols. This education will be provided for all employee, to include full time, part time and as needed staff. This education will be completed by 11/15/2017. Any employee not educated by 11/15/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 11/15/2017, and will also be provided semi-annually.

THE MONITORING PROCEDURE TO ENSURE THAT THE CREDIBLE ALLEGATION IS EFFECTIVE AND REMOVE THE ALLEGED IMMEDIATE JEOPARDY

Effective 11/15/2017, Executive Director and or

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F 226	Continued From page 82	F 226		

Director of Social Services will review all alleged violation to ensure a thorough investigation is completed and reported to the state agency and other officials as required by regulation and/or Elder Justice Act. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on "abuse prohibition tool" and filed in daily meeting binder after proper follow ups are done. This monitoring process will take place daily to include Saturdays and Sundays for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.

Effective 11/15/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.

TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION
Effective 11/15/17, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of credible allegation to remove this alleged immediate jeopardy.

Compliance Date: 11/15/2017

The Credible Allegation was verified on 11/16/2017 by the following:

1. The survey team reviewed the audit of current resident's medical records titled "clinical

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F 226	Continued From page 83 records audit tool", which reviewed documentation that would indicate any allegation of abuse, neglect, misappropriation of resident's properties and /or injuries of unknown sources. 2. The survey team reviewed the audit of all incidents within the last 30 days which was completed to identify any unknown source of injuries. 3. The survey team reviewed the in-service provided by staff and signed by staff. The survey team conducted staff interviews with 16 on-duty staff. The staff interviewed confirmed the recent in-service regarding abuse identification, reporting, and recognizing signs and symptoms of staff burnout. 4. The survey team interviewed 41 current alert and oriented residents. The residents confirmed education they had received on whom to report abuse to.	F 226		
F 241 SS=G	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to maintain a resident's dignity by leaving the resident soiled and unattended which resulted in the resident feeling embarrassed and crying for 1 of 3 residents observed for dignity, (Resident #1). Findings included:	F 241	F241D ROOT CAUSE This alleged noncompliance resulted from the Nursing aide #1 failure to follow the facility abuse prohibition policy and procedures and lack of understanding on what constituted neglect or violation of resident s dignity. When interviewed by	12/28/17

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F 241	Continued From page 84 Resident #1 was admitted to the facility on 5/12/2017 with diagnoses to include diabetes, hypertension, and contracture of left hand. Review of a quarterly Minimum Data Set (MDS) assessment for Resident #1, dated 9/22/2017, revealed the resident had intact cognition. She required extensive assistance with toileting, dressing, personal hygiene and bathing. She was not steady, but able to transfer herself with limited assistance between bed and wheelchair. Her weight was 115 pounds. An interview was conducted on 11/13/2017 at 11:05 AM with Resident #1. Resident #1 stated a couple of weeks ago, she was not sure of the date, she had a bowel movement (BM) and soiled herself at about 6:00 AM. The resident got into her wheel chair herself, and took herself to the bathroom, and turned on the bathroom call light for someone to come and help clean her up. She indicated a NA, who was not her night NA, came in about 6:15 AM and turned off the call light and told her if someone didn't come to help her after a while, to put her call light back on. The resident could see what time it was from the big numbered clock on her night stand that faced the bathroom. Resident #1 stated she waited for a long time, and was very still because she didn't want to get any mess on the floor. She stated she was cold and the bathroom smelled bad, and she was embarrassed. Resident #1 stated that NA #3, the day shift NA, came in the bathroom and asked how long she had been sitting here waiting, and the resident replied for an hour. NA #3 told her she was going to get NA #1. NA #1 came in and kept saying that the other NA should have cleaned her up. Resident #1 stated she was crying and scared.	F 241	the former Director of Nursing, nurse aide #1 indicated she did not think her acts constituted neglect or violation of resident s dignity. Nurse aide number #1 is no longer employed at the center. Likewise Director of Nursing #1 is no longer employed at the Center effective 11/15/2017 following this event. New Director of Nursing employed to oversee clinical services effective 11/15/2017. On 11/14/2017 at approximately 9:00PM Director of Rehabilitation at the center followed by the facility Director of Social services interviewed resident #1. Resident #1 voiced that on 10/26/2017 approximately between 6:00 AM and 7:00 AM, she had an episode of loose stool, she wheeled herself to the bathroom and turn the bathroom call bell on. Nursing Aide #2 responded to the call bell and told the resident she will notify her assigned Nurse Aide (Nurse Aide #1), and if the assigned aide is not back to care for her, she asked resident #1 to turn the light back on (no time lapse specified). On the morning of 10/26/2017, during initial round, noted resident #1 to be soiled. Resident # 1 alleged that she was left in the bathroom for about an hour by nursing aide #1, she added she was embarrassed by this event. Nurse Aide #3 communicated to Nurse Aide #1 about resident#1 being soiled and asked for Nurse Aide #1 to clean the resident#1 before leaving on 10/26/2017. Nurse Aide #1 provided care to Resident#1 and gave her a shower on 10/26/2017.	

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F 241	Continued From page 85 Review of statement dated 11/1/2017, by Nursing Assistant (NA #1) included with a 5-Working Day Report revealed she was in the middle of her last round when NA #2 told her Resident #1 needed her. NA #1 said she was getting another resident ready for an appointment and told NA #2 she could not go back down to Resident #1's room because her resident needed breakfast. NA #1 left the hall to get breakfast for that resident, and then finished doing her rounds and charting. When she finished with her resident on the hall she "actually forgot about going back down there" because she had found a few things on the hall that needed to be corrected before change of shift. NA #1 wrote that she gave report to oncoming NA #3, and told her NA #2 had answered Resident #1's call light and NA #1 had not gone back in Resident #1's room. The report was signed on 11/1/2017 by NA #1. On 11/13/2017 at 4:35 PM, an interview was conducted with NA #1. NA #1 stated the only thing she recalled was between 6:00 and 7:00 AM, was that NA #2 had told her that Resident #1 needed her assistance, and so she went in and assisted her. NA #1 had been giving a bath to another resident, and so it was a little while before she was able to go down and help Resident #1. NA #1 stated she had gone to Resident #1's room before she had given report to day shift, and the Resident was already in the bathroom. NA #1 then gave her a shower and dressed her. She stated Resident #1 was crying and she calmed her down, and told her not to cry, it would be okay. When asked about her written statement of 11/1/2017, that she forgot to go back in and clean her up, NA #1 just shrugged her shoulders and said it wasn't that long for the	F 241	IMMEDIATE ACTION On the morning of 10/26/2017, during initial round, noted resident #1 to be soiled. Nurse Aide #3 communicated to Nurse Aide #1 about resident#1 being soiled and asked for Nurse Aide #1 to clean the resident#1 before leaving on 10/26/2017. Nurse Aide #1 provided care to Resident#1 and gave her a shower on 10/26/2017. Resident On 10/31/2017 and 11/3/2017, the 24 hour report and a 5 day report were sent to the Department of Health and Human Services respectively, related to resident #1 s allegation of neglect made on 10/26/2017. These reports were completed and submitted by the former Director of Nursing #1. Five days report completed on 11/3/2017 indicated an investigation that was not detailed enough and did not include the allegation of neglect. On 11/13/2017 another 24 hour and 5 day report was completed after detail investigation conducted by the Center Executive Director, Director of Social Services and/or Director of Nursing #1. IDENTIFICATION OF OTHERS The investigation conducted 11/14/2017 by the Center Executive Director, Director of Social services, Director of Rehabilitation Center and MDS nurse by interviewing 100% of all current alert and oriented residents in the facility to determine if any other resident voiced and allegation of abuse and/or neglect that	

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resident to wait and that was all she could remember.

A review of the statement, undated, by NA #2 included with a 5-Day Working Report revealed that NA #2 answered the light for Resident #1 who was already in the bathroom. The NA turned off the light and told the Resident she needed to get some things to get her cleaned up. NA #2 walked directly to NA #1 and told her Resident #1 needed her. NA #1 looked down the hall and said, "Oh well I'm not going back down there, I already been down there and I'm not going back." NA #2 said she was doing something else at the moment.

On 11/13/2017 at 5:38 PM, a phone interview was conducted with NA #2. NA #2 stated she went to answer a bathroom call light. Resident #1 was already in the bathroom, sitting in her wheelchair facing towards the call light. The NA smelled BM, and knew it would take some time to clean her up, and the resident said she needed help to be cleaned up. NA #2 stated she told the resident she needed to go get a gown, and then NA #2 went directly to the room where NA #1 was providing care to another resident. NA #2 told NA #1 that Resident #1 needed her.

On 11/14/2017 at 8:34 AM, an interview was conducted with NA #3. NA #3 stated Resident #1 was alert, oriented, and could propel herself to the bathroom in her wheelchair. She had been incontinent at times and when she had soiled herself, she could not clean herself up. NA #3 stated on the morning of 10/26/2017, she answered Resident #1's call light at 7:00 when she came on duty for the day shift (7:00 AM to 3:00 PM). She stated the resident was in the

involve the alleged perpetrator (Nurse Aide #1). No other residents alleged abuse and/or neglect that involve the alleged perpetrator. Likewise, the Director of Human Resources conducted interviews with current employees who were on duty on 10/26/2017 between the 6AM and 7AM to determine if any staff on duty witnessed any abuse and/or neglect towards Resident #1 specifically from Alleged Perpetrator (Nurse Aide #1). No other staff witness any abuse and/or neglect. Resident s #1 allegation of abuse voiced on 10/26/2017 was unsubstantiated based on findings of investigation conducted. Nurse Aide #1 did not care for Resident #1 at the time of investigation. It is the Center practice to suspend the Alleged Perpetrator at the time of investigation of any alleged Abuse and/or Neglect.
On 12/08/2017 and 12/11/2017 , 100% of all current alert and oriented residents in the facility were interviewed by the Center Executive Director, Director of Social services, Activity Director and/or Director of Nursing to determine if any other resident voiced concerns about dignity specifically being left soiled for extended period of time. No other residents complained of being left un-attended for long time (more than 1 hour).

100% audit of all current residents clinical documentation within the last 30 days was completed by the Director of Nursing, Assistant Director of Nursing and/or Nurse Supervisor to determine if there is any documentation in any resident s medical

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F 241	Continued From page 87 bathroom crying and upset, and reported the NA's had left her. NA #3 looked at her and saw BM on her gown and under pad, and the bathroom smelled like BM. An interview was conducted on 11/13/2017 at 4:18 PM, with Nurse #1. She stated she was informed on the night of 10/26/2017, by NA #1, that NA #2 had pushed Resident #1 to the bathroom and left her there, and then went to tell NA #1. Nurse #1 stated she worked the evening of 10/31/2017 and talked to NA #2 on the morning of 11/1/2017 and asked her why she had taken Resident #1 to the bathroom and not completed the task. NA #2 told her she had to finish taking care of her own resident. Nurse #1 stated she was informed by the DON on 11/2/2017 that NA #2 had been assigned to another hall. On 11/13/2017 at 12:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she talked to NA #2, and that NA #2 stated Resident #1 was in the bathroom when she turned off the light and went to get NA #1. The DON stated she expected NA #2 to take care of the resident when she answered the call light. The DON stated she decided to give NA #2 a second chance, and moved her to a different hall.	F 241	records that indicate dignity concerns, if any, determine whether appropriate actions were taken. The audit revealed zero residents had documentation to indicate dignity concerns or violation in resident s medical records. This audit was completed on 12/08/17 and 12/11/2017. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. SYSTEMIC CHANGES Effective 12/28/2017, interviews for alert and oriented residents will be completed by the Director of Social Services, Director of Recreational Services and/or designated staff member at least once every quarter to identify any allegation of Abuse, Neglect and or Misappropriation of properties. This interview process will be incorporated to social services quarterly assessment schedule and documented on psychosocial assessment tool . Any voiced allegation of abuse, neglect and/or misappropriation of resident s properties will be reported to the Center Executive Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according to the regulatory requirements. Effective 12/28/2017, the center nursing administrative team, which includes DON, Nurse supervisors, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, completed skin assessments, incident	

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F 241	Continued From page 88	F 241	reports for the last 24 hours, and Physician orders written in the last 24 hours to ensure that any documentation related to dignity violation and ensure that any dignity related concerns is investigated following the facility grievance policy and procedures. Effective 12/28/2017, the facility will utilize the revised assignment sheet and ensure that each assignment s acuity level is maintained. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will adjust the assignment sheets whenever necessary to ensure that the acuity level is maintained effective 12/28/2017. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will complete 100% education for all current facility employees, to include full time, part time and as needed employees about maintaining resident dignity and respect. The emphasis of this education was on the importance of attending to resident s needs in a timely manner and ensure resident s needs are anticipated. Any employee not educated by 12/28/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 12/28/2017. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will complete 100% education for all current nursing	

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F 241	Continued From page 89	F 241	staff to include licensed nurses and certified nurse aides, to include full time, part time and as needed nursing employees about incontinent care. The emphasis of this education was on the importance of providing incontinent care for each resident in a timely fashion and ensure resident s needs are anticipated. Any nursing staff not educated by 12/28/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new nursing employees effective 12/28/2017. MONITORING PROCESS Effective 12/28/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services, will complete the random audit of five residents to see if any resident is noted to be soiled. Any identified dignity related violation will be addressed promptly. Findings from this monitoring process will be documented on a Call light response audit form maintained in the facility compliance binder. This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Director of Nursing, Assistant Director of Nursing, and/or Director of Social Services will observe residents for any potential for dignity violation to include signs of being soiled or left unattended for extended period of time by activating the call bell in resident s room/bathroom and	

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F 241	Continued From page 90	F 241	observe and document response time. Effective 12/28/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and/or Director of Social Services, will complete the random audit of call light response for five rooms to determine the call light response time. Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will activate the call bell in resident s room/bathroom and observe and document response time. Findings from this monitoring process will be documented on a Call light response audit form maintained in the facility compliance binder. This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE	

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F 241	Continued From page 91	F 241	ALLEGATION Effective 12/28/17, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction to ensure the facility remains in substantial compliance.	
F 333 SS=E	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident and physician interviews, the facility failed to follow physician's orders which resulted in late administration of scheduled insulin injections for 3 of 3 residents reviewed (Residents # 1, #2 and #3). Findings included: 1-Record review revealed Resident #1 was admitted to the facility on 5/12/2017 with diagnoses which included Diabetes, Hypertension and Coronary Artery Disease. Review of Resident #1's signed physician orders revealed an order initiated and dated 5/13/2017 for 12 units of insulin to be administered subcutaneously (injected between the skin and muscle) twice a day at 8:30 AM and 4:30 PM.	F 333	F333E ROOT CAUSE This alleged noncompliance was resulted from the Center's Licensed staff not signing medication on the electronic health records immediately after medication is administered and/or not administering Insulin within 60 minutes of administration window of opportunity, and the facility lack of awareness of requirements related to notification to Physician of medication administered out of time frame as specified in the center s medication administration Policy and Procedures. IMMEDIATE ACTION On 12/08/2017 Resident #1, #6, #7	12/28/17

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F 333	Continued From page 92 The order was continued monthly and signed by the physician. The Admission Minimum Data Set (MDS) dated 5/19/29017 indicated Resident #1 was cognitively intact and required limited assistance of 1 person with all activities of daily living (ADLs). The MDS indicated the resident received insulin injections daily. Review of Resident #1's care plan dated 5/19/2017 revealed the resident was at risk for hypoglycemia/hyperglycemia (low blood sugar levels/high blood sugar levels). The interventions for the risk included medications and insulin to be administered as ordered. Record review of the Medication Administration Record (MAR) for Resident #1 from 10/19/2017 through 11/14/2017 revealed 11 documented late administration times for the resident's 8:30 AM insulin dose and 7 documented late administration times for the 4:30 PM insulin dose. The documented times for administration were beyond the 60 minute window of administration opportunity. An interview and medication administration observation was conducted with Resident #1 on 11/15/2017 at 8:55 AM. The resident was observed sitting up in bed, well kempt, and alert and oriented. Nurse #5 prepared and administered the resident's insulin without any observed concerns. Nurse #5 exited the room after the medication was administered. During the interview with the resident she indicated her insulin was to be administered at 8:30 AM and 4:30 PM. She reported there were times the insulin administration was late. The resident also	F 333	attending physician(s) were notified of incidents of late administered insulin in that happen in the last 30 day by the Assistant Director of Nursing. No new orders received from this notification. IDENTIFICATION OF OTHERS 100% audit of all current resident with insulin orders completed on 12/08/2017 by Director of Nursing, and/or Assistant Director of Nursing to identify any other resident with the documented times of administration beyond the 60 minutes window in the last 30 days, and verified whether Physician was notified or not. The audit revealed 29 other residents identified with insulin orders with documented times of administration beyond 60 minutes, attending physician for each resident notified on 12/08/2017 by the Director of Nursing. No new orders received from this notification. SYSTEMIC CHANGES Effective 12/28/2017, and moving forward, all insulin orders will be administered within 60 minutes of administration opportunity window. Licensed nurses will document administration time immediately after administration is done in Electronic Health Record. In the event that insulin administration will take place outside the 60 minutes window of administration opportunity, resident attending Physician will be notified immediately. Effective 12/28/2017, and moving forward, If a Licensed nurse delayed to document in Electronic Medication Administration Record (eMAR) immediately after administration insulin administered within	

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F 333	Continued From page 93 reported she knew the nurses had an hour past the scheduled time to administer it before they considered it late. The resident indicated there were times it was several hours late. The resident reported her 4:30 PM insulin dose was administered around 8:30 PM by Nurse #2 the evening prior to the interview. The resident stated she felt fine and was aware when she had issues with her blood sugars, but felt the insulin should be administered as ordered. An interview was conducted with Nurse #5 on 11/15/2017 at 9:17 AM. Nurse #5 indicated Resident #1 was on her regular assignment and she was very familiar with her care. Nurse #5 reported there were times she administered the residents morning insulin late but tried to be very conscious of the time. Nurse #5 indicated most mornings it was administered within the hour of opportunity but there were mornings she just couldn't get to her due to other situations. Nurse # 5 stated she did not notify the physician when the insulin was administered late. An interview was conducted with Nurse #2 on 11/15/2017 at 10:40 AM. Nurse #2 confirmed he was the nurse who worked with Resident #1 on 11/14/2017. Nurse # 2 indicated the resident's 4:30 PM insulin was administered at around 8:30 PM. The nurse stated he apologized to the resident for the late administration. Nurse #2 reported he probably administered the insulin late because he was busy with admissions or something else. Nurse # 2 indicated there were times he was unable to get the resident's insulin to her on time for various reasons. Nurse #2 indicated he did not document the reason when it was administered late and he did not notify the physician. Nurse #2 further indicated if the	F 333	60 minutes of administration opportunity window, the Licensed nurses will document administration both on eMARs immediately after is able and will aloo add an addendum in resident s nurses notes indicating the time of administration that will clarify auto stamped time on eMARs. In this event the physician will not be notified as the insulin administration took place within the 60 minutes window of administration opportunity. Effective 12/28/2017, the center nursing administrative team, which includes Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator will initiate a process for reviewing clinical documentation for the last 24 hours, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DHS, ADHS, SDC and/or Unit coordinators. This process will be incorporated in a daily clinical rounds. Any negative findings will be documented on the daily clinical checklist form and maintained in the daily clinical meeting binder. Effective 12/28/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24	

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F 333	Continued From page 94 resident displayed signs or symptoms of blood sugar issues he would notify the physician. An interview was conducted with Resident #1's physician on 11/16/2017 at 2:20 PM. The physician reported he was very familiar with Resident #1 and her medication regimen. The physician also reported he reviewed her blood sugars and labs when he made his facility visits to ensure there were no concerns or issues with her diabetic management. The physician indicated he was unaware of any scheduled insulin doses given late. The physician stated there was an hour of opportunity for the administration and he expected the insulin to be administered on time. The physician indicated the insulin was scheduled for the well-being of the residents and should be given as he ordered. An interview was conducted with the Director of Nursing (DON) on 11/16/2017 at 3:32 PM. The DON indicated the expectation was for insulin to be administered as scheduled and per the facility policy. 2-Record review revealed Resident #6 was admitted to the facility on 1/21/2013 with diagnoses which included Diabetes, Hypertension and Hemiplegia (paralysis on one side of the body). Review of Resident #6's signed physician orders for October 207 and November 2017 revealed an order for 15 units of insulin to be administered subcutaneously (injected between the skin and muscle) twice a day at 9:00 AM and 5:00 PM. Review of Resident #6's Annual Minimum Data Set dated 9/25/2017 revealed the resident was	F 333	hours, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place every Saturday & Sunday. Any identified issues will be addressed promptly and appropriate actions will be implemented by the DHS, ADHS, SDC and/or Registered Nurse supervisor. This process will be incorporated in daily clinical rounds. Any negative findings will be documented on the daily checklist form and maintained in the daily clinical meeting binder. Director of Nursing (DHS), Assistant Director of Nursing (ADHS) and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses and Medication aides, to include full time, part time and as needed staff. The emphasis of this education will be on the importance of administering medication as ordered by physician and in a timely manner for any medication specifically insulin. The education will also cover rites of medication administration and crushing of medication when appropriate. This education will be completed by 12/28/2017. Any Licensed Nurse or Medication Aide not educated by 12/28/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new licensed nurses and Medication Aides effective 12/28/2017.	

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F 333	Continued From page 95 moderately cognitively impaired and required the extensive assistance of 2 persons for all activities of daily living (ADLs). The MDS indicated the resident received insulin injections daily. Review of the Resident #6's care plan updated 11/14/2017 revealed the resident was at risk for alteration in blood sugars related to Diabetes. The interventions for the risk included medications and insulin to be administered as ordered. Record review of the Medication Administration Record (MAR) for Resident #6 from 10/19/2017 through 11/14/2017 revealed 7 documented late administration times for the resident's 9:00 AM insulin dose and 7 documented late administration times for the 5:00 PM insulin dose. The documented times for administration were beyond the 60 minute window of administration opportunity. An interview was conducted with Nurse #6 on 11/16/2017 at 10:15 AM. Nurse #6 indicated she worked with Resident #6 regularly. Nurse #6 reported the resident would wheel around the facility in his wheel chair and the insulin is given late due to the resident not being available at the time the insulin is ordered. The nurse indicated there were times it was administered outside of the hour window of opportunity to administer medications. The nurse stated she did not document the reason the insulin was given late. The nurse further indicated there were times the insulin was administered on time and she just did not document the administration until later in the shift, due to being tied up with other things. An interview was conducted with Resident #6 on	F 333	MONITORING PROCESS Effective 12/28/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with timely, and accurate medication administration by reviewing administration records from previous day to ensure timely administration and documentation as ordered by physician. This audit will be completed daily Monday through Friday and ensure that appropriate actions are taken in an instance that ordered insulin is administered in deviation of the physician orders. Findings from this monitoring process will be documented on a Medication administration report tool and filed in the facility compliance binder. This monitoring process will take place daily Monday through Friday for 2 weeks, then 3x/week for two more weeks, then weekly for 2 weeks then monthly afterwards. Effective 12/28/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 12/28/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure	

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F 333	Continued From page 96 11/16/2017 at 11:45 AM. The resident was in a wheelchair and appeared well kempt. The resident was alert and oriented. The resident indicated he didn't keep up with the time the nurse administered insulin. An interview was conducted with Resident #6's physician on 11/16/2017 at 2:20 PM. The physician reported he was very familiar with Resident #6 and his medication regimen. The physician also reported he reviewed the resident's blood sugars and labs when he made his facility visits to ensure there were no concerns or issues with diabetic management. The physician indicated he was unaware of any scheduled insulin doses given late. The physician stated there was an hour of opportunity for the administration and he expected the insulin to be administered on time. The physician indicated the insulin was scheduled for the well-being of the residents and should be given as he ordered. An interview was conducted with the Director of Nursing (DON) on 11/16/2017 at 3:32 PM. The DON indicated the expectation was for insulin to be administered as scheduled and per the facility policy. 3-Record review revealed Resident #7 was admitted to the facility on 11/2/2017 with diagnoses which included Diabetes and Gout. Review of Resident #7's signed physician orders for November 2017 revealed an order for 10 units of insulin to be administered subcutaneously (injected between the skin and muscle) twice a day at 9:00 AM and 9:00 PM. Review of Resident #7's Admission Minimum Data Set dated 11/9/2017 revealed the resident	F 333	implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 12/28/2017	

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F 333	Continued From page 97	F 333		

was severely cognitively impaired and required the extensive assistance of 1 to 2 persons for all activities of daily living (ADLs). The MDS indicated the resident received insulin injections daily.

Review of Resident #7's care plan updated 11/14/2017 revealed the resident was at risk for alteration in blood sugars related to Diabetes. The interventions for the risk included medications and insulin to be administered as ordered.

Record review of the Medication Administration Record (MAR) for Resident #7 from 11/9/2017 through 11/14/2017 revealed 7 documented late administration times for the resident's 9:00 AM insulin dose and 4 documented late administration times for the 9:00 PM insulin dose. The documented times for administration were beyond the 60 minute window of administration opportunity.

An interview was conducted with Nurse #6 on 11/16/2017 at 10:15 AM. Nurse #6 indicated she worked with Resident #7 regularly. The nurse indicated there were times the insulin was administered outside of the hour window of opportunity to administer medications. The nurse indicated sometimes she was busy and could not get to everything on time. The nurse stated she did not document the reason the insulin was given late. The nurse further indicated there were times the insulin was administered on time and she just did not document the administration until later in the shift, due to being tied up with other things.

An interview was conducted with Resident #7's

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F 333	Continued From page 98 physician on 11/16/2017 at 2:20 PM. The physician reported he was very familiar with Resident #7 and his medication regimen. The physician also reported he reviewed the resident's blood sugars and labs when he made his facility visits to ensure there were no concerns or issues with diabetic management. The physician indicated he was unaware of any scheduled insulin doses given late. The physician stated there was an hour of opportunity for the administration and he expected the insulin to be administered on time. The physician indicated the insulin was scheduled for the well-being of the residents and should be given as he ordered. An interview was conducted with the Director of Nursing (DON) on 11/16/2017 at 3:32 PM. The DON indicated the expectation was for insulin to be administered as scheduled and per the facility policy.	F 333		