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	345543	A. BUILDING _____ B. WING _____	C 04/16/2018

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BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

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F 000	INITIAL COMMENTS The survey team entered the facility on 04/09/18 to conduct a complaint survey and exited on 04/12/18. The survey team returned to the facility on 04/16/18 to obtain additional information and investigate another complaint intake and exited on 04/16/18. Therefore, the survey's exit date was changed to 04/16/18. Event #OVWF11. A complaint investigation was conducted on 04/09/18 through 04/16/18. Immediate Jeopardy was identified at: CFR 483.10 at F 550 for scope and severity J. CFR 483.12 at F 600 for scope and severity J. CFR 483.12 at F 608 for scope and severity J. CFR 483.25 at F 689 for scope and severity J. Tags F 550, F 600, F 608 and F 689 constituted Substandard Quality of Care. Immediate Jeopardy began on 03/08/18 and was removed on 04/16/18. A Partial extended survey was completed. As a result of IDR on June 11, 2018 the it was concluded that F 550 and F 600 were changed to past non-compliance and F 689 J will remain as cited during the April 16, 2018 survey. In addition, F 608 J will be deleted.	F 000		
F 550 SS=J	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550		7/9/18

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

Electronically Signed | 07/09/2018

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F 550	Continued From page 1 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interviews, phlebotomist and physician interviews and record review the facility failed to honor a resident's refusal to have her	F 550	Past noncompliance: no plan of correction required.	

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blood draw when a contract phlebotomist held a resident's arm down and forced the resident against her will to have blood drawn for 1 of 3 sampled residents for resident rights (Resident #3).

The findings included:

Resident #3 was admitted to the facility on 06/12/17 with diagnoses that included chronic diastolic heart failure, paroxysmal atrial fibrillation, presence of a pacemaker, history of a deep vein thrombosis and others. The most recent Minimum Data Set (MDS) dated 01/10/18 specified the resident had clear speech and was usually able to make herself understood and usually able to understand others. The MDS also specified the resident had moderately impaired cognition but did not resist care and took anticoagulant medication daily. In addition, the resident was receiving Hospice Care.

A care plan updated 01/11/18 for impaired cognition identified the following approaches for staff:
- Approach me in a calm unhurried manner
- Ask yes/no questions to determine my needs
- Validate my thoughts and feelings when I get confused or anxious

Review of the medical record revealed a physician progress note made by the Medical Director (MD) dated 02/27/18 specified Resident #3 was seen for a routine visit and assessed the resident's atrial fibrillation was controlled with Coumadin (anticoagulant medication). The note also specified the dose had been increased due to low INR (International Normalized Ratio) and the next INR check was scheduled for 03/01/18.

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The physician also documented to limit bloodwork with goal of comfort since the resident was on Hospice.

Laboratory test results found in the medical record revealed:
- On 03/01/18 the resident's INR was 1.5 (low) and the physician ordered to increase Coumadin and recheck on 03/05/18.
- On 03/05/18 the resident's INR was 3.0 (high) and physician ordered to decrease Coumadin and recheck INR on 03/08/18.
- On 03/08/18 the resident's INR was 4.9 (critical)

A progress note dated 03/08/18 made by Nurse #1 read in part, "two lab phlebotomists in resident's room attempting to collect ordered blood work. Resident was lying in bed with eyes closed mumbling. A staff member (housekeeper #1) entered the resident's room to console resident while blood draw completed. Resident then got notably louder and could be heard from the adjoining room. I (Nurse #1) entered resident's room and noted blood on the bed linen. Resident was bleeding from 2 separate sites and the gauze with tape was not intact to resident's arm. A large blood blister was noted forming to the inside of the left forearm." The note specified the Nurse called physician #2 and nurse #2 into the room to help assess the resident.

Resident #3 died on 03/13/18.

A document titled "Investigation Report" dated 03/14/18 specified Resident Abuse was investigated for Resident #3 and determined that the resident suffered physical harm/injury and mental anguish from the incident. The injury was

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a 12-centimeter by 13-centimeter hematoma on the left antecube. and bruising consistent of fingerprints to the left wrist. The report specified the resident suffered mental anguish in response by guarding her arm throughout the day and cried out, "no, no, no" when staff entered the room. There was one accused individual (Phlebotomist #1) and two witnesses (Housekeeper #1 and Nurse #1). The facility's investigation substantiated the allegation of abuse.

On 04/09/18 at 10:12 AM Housekeeper #1 was interviewed and described that on 03/08/18 in the morning she heard Resident #3 from inside her room crying out "no, no, NO" and sounded agitated. The housekeeper stated she had a good relationship with the resident and was aware phlebotomists had entered the room to draw blood. Housekeeper #1 stated she asked Nurse #1 if she could go in the room. Housekeeper #1 reported that when she entered the room Resident #3 was in bed and she saw phlebotomist (PH) #1 standing on the left side of the bed holding the resident's left arm. Phlebotomist #2 was standing on the right side of the bed holding the resident's right arm and appeared as if they were going to attempt to draw blood at the same time. The Housekeeper added that when she entered the room, PH #2 let go of the resident's arm and stepped away from the bed. She went on to explain that she could see the resident had already been stuck once by PH #1 as evidenced by a needle stick to the left wrist that was bleeding. The Housekeeper described the resident was visibly upset and she went to the resident to console her; and while the housekeeper was consoling the resident, PH #1 made a second attempt to draw blood. The second attempt made the resident become upset

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again which caused the Housekeeper to raise her head from having it rested on the resident's shoulder to see PH #1 holding the resident's left arm with force at the elbow. The Housekeeper described that PH #1 had the resident's left arm trapped between her legs pressed against the bed with a "firmer than she needed" hold of the arm at the elbow, then lifted the elbow to draw blood from the ante cube, sticking the resident a second time. The resident was fighting PH #1 saying "STOP, STOP, STOP!" The housekeeper said that she realized PH #1 was too rough and not listening to the resident but the blood draw was over. Housekeeper #1 left the room and notified Nurse #1 of what had occurred.

On 04/09/18 at 11:08 AM Nurse #1 was interviewed and reported on 03/08/18 she attempted to administer morning medications to Resident #3 but the resident had refused, shaking her head "no, no" and had the covers pulled over her head. The Nurse added that the resident had been up most of the night and wanted to rest that morning. The Nurse described that she proceeded to gather medications for another resident and just as she was about to enter another resident's room, Housekeeper #1 asked if she could console Resident #3 while she got her blood drawn. Nurse #1 stated she told Housekeeper #1 that would be fine and continued into the adjoined room. She stated she was able to hear slight moaning coming from Resident #3's room but added that as she exited the room she was in, she could hear that Resident #3 was agitated and got the sense something had "escalated." Nurse #1 reported she was met by Housekeeper #1 who asked the nurse to look at Resident #3's left arm. The nurse explained that when she entered the room the resident was in

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bed shaking her head, "no, no" and the phlebotomists had finished the blood draw and left the room but the resident was bleeding. Nurse #1 reported she called for Nurse #2 and physician #2 to assess the Resident's arm.

On 04/09/18 at 11:36 AM Nurse #2 was interviewed and reported that on 03/08/18 Nurse #1 stated to her, "I need you!" Nurse #2 described going into Resident #3's room and observing the resident cradling her left arm, her eyes were closed and she was shaking her head saying "no, no, no." In the same interview the nurse reported she calmed the resident down to assess the left arm. Nurse #2 measured a 12 centimeter by 13-centimeter hematoma that covered the resident's left forearm below the ante cube. Nurse #2 also stated that there was the appearance of fresh fingerprints marks on the resident's left wrist. Nurse #2 explained that she called PH #1 into the room to ask her how the resident sustained the injuries. The nurse stated that PH #1 became "belligerent" and defensive stating "you ain't going to blame this on me." Nurse #2 added the PH reported that she had to get the blood sample but the resident was being resistant and refusing to let the PH draw her blood so she had to hold the resident's arm down. Nurse #2 stated she informed the phlebotomist that Resident #3 had the right to refuse the blood draw and the phlebotomist denied knowing that a resident had the right to refuse a treatment.

On 04/09/18 at 2:33 PM the Director of Nursing (DON) was interviewed on the telephone and explained that on 03/08/18 she was in a meeting when she made aware of an incident regarding Resident #3 and phlebotomist #1. She stated she instructed staff to have phlebotomist #1 wait

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in the front of building to meet with her. The DON reported when she spoke with PH #1, the phlebotomist stated she didn't know it was wrong to hold down a resident's arm or that a resident could refuse to have their blood drawn. The DON added she was shocked by the answer and asked the phlebotomists to leave the building. The DON added she proceeded by filing an abuse allegation and notified the lab company that their services were being suspended pending an abuse investigation.

On 04/09/18 at 4:00 PM Phlebotomist (PH) #2 was interviewed on the telephone and explained that it was her first time trying to collect Resident #3's blood on 03/08/18. She described that she entered the room, startled Resident #3 who began shaking her head no. The phlebotomist stated she told Resident #3 she wasn't there to get her out of bed just to draw her blood. She stated she realized she was going to need help with the resident and called for phlebotomist #1 to come into the room. She went on to describe that "for the most part the resident was okay until PH #1 stuck the needle in and then she (Resident #3) started to get real cranky." PH #2 was asked to define "cranky" and she stated Resident #3 started pulling her arm away, moaning, yelling and fighting us and PH #1 had to pull the needle out of the resident's wrist because of the risk for injury. Then she went on to describe that Housekeeper #1 entered the room and attended to Resident #3 and calmed the resident down slightly by resting her head on the resident's head and singing in her ear. PH #2 explained that during this time, a second attempt was made to draw blood which upset the resident again and PH #1 had to grab the resident's arm to hold the arm still because the needle was in the arm.

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On 04/10/18 at 1:10 PM Phlebotomist (PH) #1 was able to be reached for a telephone interview and described having been a phlebotomist for a long time and had drawn Resident #3's blood before. The PH described Resident #3 as being a "little difficult" at times and understood why phlebotomist #2 asked for help because the resident had "her good days and not good days." She went on to describe that as she entered the room Resident #3 was whining and moaning "a lot" and "did not want to be bothered." The PH reported that she told the resident she needed to draw her blood. The phlebotomist proceeded to draw the blood and reported that "things were going fine" until the resident became anxious and started fighting the needle so she held the resident's arm because the resident was trying to "jerk the needle out." The PH acknowledged Housekeeper #1 came in the room and calmed the resident but denied that she stuck the resident twice in the arm. The PH offered no explanation why the resident was bleeding from two separate sticks on her left arm. The PH added that it was very important that she got Resident #3's blood sample because later she found out the INR was critical.

On 04/10/18 at 4:10 PM the Medical Director (MD) was interviewed on the telephone and stated she had been made aware of an unfortunate incident with Resident #3 which resulted in traumatic bruising. The MD described that she assessed the resident on 03/08/18 later in the day and noted the bruising was consistent with a traumatic event and noted the bruising to be "deep, deep, purple."

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On 04/10/18 at 10:10 AM the Administrator provided the following corrective action plan.

On 04/11/18 at 5:05 PM the facility provided an acceptable credible allegation of compliance that included:
Plan for correcting specific area of concern identified, include the process that led to the concern:

· On 03/08/18 a housekeeper witnessed phlebotomist (PH) #1 use unnecessary force to obtain a blood specimen from Resident #3 who was resisting the procedure. A second phlebotomist (PH) #2 was in the room during the incident. Housekeeper #1 immediately reported the incident to the nurse. The DON was notified of the incident.
· Resident #3 was assessed by nurse #2 and the physician for injuries.
· PH #1 had no further interaction with residents following the incident and was asked about the bruising sustained during the blood draw.
· PH #1 stated she was unaware a resident had a right to refuse. Nurse #1 educated the PH on Resident Rights. The PH left the facility.
· On 03/08/18 the facility filed a 24-hour abuse allegation and notified the lab company of the incident.
· On 03/09/18 the facility temporarily suspended the lab company from entering the facility pending an investigation.
· Facility staff, trained on resident rights and abuse, were allowed to perform blood draws on residents with orders for laboratory testing.
· On 03/09/18 a meeting was held with the lab company to notify them of the temporary suspension of services until the following terms

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were met:

· Full Names of both Phlebotomists involved in the incident. We have to provide this to the Health Care Personnel Registry. (Name, Full Social Security, DOB, Job Title, Date of Hire, Last known mailing address, Phone number)

· Statements from both Phlebotomists as to what occurred.

· A copy of the training the lab company will provide for all their staff members who will be at any of our facilities with first priority being the facility.

This training should include Abuse prevention, what an employee should do when a resident refuses to get services done, what to do with a combative resident, how and when to report incidents to the facility receiving the service.

· Please note-the two accused Phlebotomists cannot return to the facility and any other company facility going forward to provide any services. You will have to send any other phlebotomists to the facility, who have received the above training after our review of the education/ training you provide us.

· The facility will need documentation from the lab company indicating when this education was done and also completed. This will be included in our investigation report which we will send to the Health Care Personnel Registry.

Representatives from the lab company Lab met with the Director of Nursing and Administrator on 03/09/2018 to discuss the event. The housekeeper and nurse was interviewed by the representatives. It was determined that the root cause was lack of knowledge. This is due to the fact that the phlebotomist reported to the nurse that she did not know that the patient had the

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right to refuse treatment and she did not recognize that the resident pushing her hand away was a refusal. Procedure for implementing an acceptable Quality Improvement Plan. Systematic Changes and Education provided: The lab company was contacted and notified on 3/8/2018 by the Quality Assurance Nurse Consultant and informed that: Phlebotomist #1 and Phlebotomist #2 will not be allowed to return to the facility to provide any services moving forward. Phlebotomist # 1 and Phlebotomist # 2 have not been allowed to provide any direct patient care services since 3/8/18. On 3/8/18 the facility determined that all services provided by the lab company would be suspended pending investigation. The lab company provided education to phlebotomists regarding resident rights and abuse. The lab company provided the facility with a copy of the education provided: Phlebotomy Continuing Education

A patient has the right to refuse care. When a patient refuses to consent to have a phlebotomy procedure initiated or completed this is considered a patient refusal.

Procedure
1. Patient refuses to have venipuncture started by any means including a verbal indication or a physical behavior.
2. Phlebotomist will not proceed with the procedure and will locate a nurse at that time.
3. The patient consents to the venipuncture and if at any time during the venipuncture the patient refuses to continue by verbally requesting the needle be removed or becoming combative the phlebotomist will immediately stop the procedure, bandage the site, safely dispose of the venipuncture device and locate a nurse.

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4. Once the nurse is notified the phlebotomist may return to the room with the nurse. If the patient consents to the nurse ' s request for the phlebotomist to perform the venipuncture, then the phlebotomist may only continue with the nurse present in the room.
5. If the patient still refuses the phlebotomist will document the refusal in the lab company Phlebotomy log at the facility. The refusal along with the nurse ' s name who assisted will be documented. The facility will follow their Standard Operating Procedure to inform the patient ' s physician.

The lab company provided signed attestations on 03/12/2018 of receiving resident rights and resident abuse education. The lab company phlebotomists were allowed to resume services to the facility on 03/13/2018.

On 4/11/18, the nurse managers completed skin checks on all non interviewable residents to determine if there was any unreported bruising that could indicate that a patient was forcibly restrained in denial of their right to refuse. It was determined that one out of thirty-seven patients has a bruise that was not previously address. The bruise in on the forearm of a patient who is able to move on his own. An investigation as to the etiology of the bruise and a 24-hour report injury of unknown origin was initiated by the Director of Nursing on 4/11/18.

On 4/11/18, the nurse managers also interviewed all interviewable patients to see if staff/vendors had not honored their right to refuse care/treatments. Forty-six residents were interviewed and no resident reported that either of

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these circumstances had occurred.
On 4/11/2018 Director of Nursing and nurse management initiated education to staff at the facility (This includes all RN, LPN, NA, nursing staff, therapy, activities, social services, dietary and housekeeping): A facility must treat each resident with respect and dignity 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. A resident has the right to select or refuse specific treatment or nursing care. "Treatment" refers to medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms. Residents cannot be restrained in any form in order to provide care or treatment. Ex: include-holding a resident ' s arm or hand down to provide care or treatment. Applying any form of physical restraint in order to complete care or treatment. Resident refusals should be reported to the ADON or DON and documented in the medical record. Notify the physician/clinician of refusals. If you see a violation of resident refusal of care/treatment: Immediately STOP the person involved violating the resident ' s right. (staff, vendor, visitors, volunteers). Assure the resident(s) safety. Immediately report the incident to the nurse/ADON/DON/Administrator. Continue to monitor resident(s) as appropriate interventions are initiated to maintain their safety. The nurse is to notify the clinician. This training is ongoing but beginning 4/11/2018 on evening shift no employee will be allowed to work until education has been completed. The Director of Nursing will ensure that this education is completed by all employees.

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Training was incorporated into the general orientation program and will be discussed during all general orientation programs that is completed for identified staff.

Monitoring Procedure to ensure that the identified areas for improvement are effective and change is sustained.

As of 4/11/18 The Director of nursing and /or Administrator will begin monitoring compliance by: interviewing 5 alert and oriented residents weekly in reference to: if staff/vendors had not honored their right to refuse care/treatments. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee.

As of 4/11/18 the support nurse will monitor compliance by: observing the phlebotomist obtain lab specimens for 5 non- alert and oriented residents weekly to ensure that right to refusal is honored. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee.

Phlebotomist routinely come to the facility to obtain specimens on Monday and Thursday. The Support Nurse will validate that the phlebotomist who arrive to obtain specimens have received the training by comparing their names to those listed on the attestation forms. If a lab company employee who is not on the list arrives at the facility, they will not be allowed to obtain specimens and the lab company leadership will be notified that the education should be completed and that labs need to be obtained by another staff member. Before any new

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F 550	Continued From page 15 phlebotomists are sent to the facility---Lab Manager has been requested to send their name as well as a signed attestation to DON. As of 4/12/18 reports will be presented to the weekly Quality Assurance committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The corrective action plan was validated on 04/12/18.	F 550		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff, physician and phlebotomist interviews and record review the facility failed to	F 600	Past noncompliance: no plan of correction required.	7/9/18

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protect a resident's right to be free from abuse when a contract phlebotomist held a resident's arm down and forced the resident against her will to have blood drawn. The abuse resulted in injuries and mental anguish for 1 of 3 sampled residents for abuse (Resident #3).

The findings included:

Resident #3 was admitted to the facility on 06/12/17 with diagnoses that included chronic heart failure, atrial fibrillation, presence of a pacemaker, history of a deep vein thrombosis (DVT) and others. The most recent Minimum Data Set (MDS) dated 01/10/18 specified the resident had clear speech and was usually able to make herself understood and usually able to understand others. The MDS also specified the resident had moderately impaired cognition but did not resist care and took anticoagulant medication daily. In addition, the resident was receiving Hospice Care.

A care plan updated 01/11/18 for risk for toxicity and abnormal bleeding related to anticoagulant therapy. Interventions to prevent adverse reactions from the medication included:
- Daily skin inspections report abnormalities to the nurse
- Labs as ordered and report abnormal lab results to the physician
- Observe for bruising

Review of the medical record revealed a physician progress note made by the Medical Director (MD) dated 02/27/18 specified Resident #3 was seen for a routine visit and assessed the resident's atrial fibrillation was controlled with Coumadin (anticoagulant medication). The note

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also specified the dose had been increased due to low INR (International Normalized Ratio) and the next INR check was scheduled for 03/01/18. The physician also documented to limit bloodwork with goal of comfort since the resident was on Hospice.

Laboratory test results found in the medical record revealed:
- On 03/01/18 the resident's INR was 1.5 (low) and the physician ordered to increase Coumadin and recheck INR on 03/05/18.
- On 03/05/18 the resident's INR was 3.0 (high) and physician ordered to decrease Coumadin and recheck INR on 03/08/18.
- On 03/08/18 the resident's INR was 4.9 (critical)

A progress note dated 03/08/18 made by Nurse #1 read in part, "two lab phlebotomists in resident's room attempting to collect ordered blood work. Resident was lying in bed with eyes closed mumbling. A staff member (housekeeper #1) entered the resident's room to console resident while blood draw completed. Resident then got notably louder and could be heard from the adjoining room. I (Nurse #1) entered resident's room and noted blood on the bed linen. Resident was bleeding from 2 separate sites and the gauze with tape was not intact to resident's arm. A large blood blister was noted forming to the inside of the left forearm." The note specified the Nurse called physician #2 and nurse #2 into the room to help assess the resident.

A document titled "Initial Allegation Report" dated 03/08/18 indicated an allegation of Resident Abuse had been reported on 03/08/18 at 9:15 AM. The allegation was that a lab phlebotomist

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was rough with Resident #3 when trying to obtain labs and the violated the resident's rights by not allowing the resident to refuse the lab draw. This report was faxed to the Complaint Intake and Health Care Personnel Investigations on 03/08/18 at 11:54 AM.

Resident #3 died on 03/13/18.

A document titled "Investigation Report" dated 03/14/18 specified Resident Abuse was investigated for Resident #3 and determined that the resident suffered physical harm/injury and mental anguish from the incident. The injury was a 12-centimeter by 13-centimeter hematoma on the left ante-cube and bruising consistent of fingerprints to the left wrist. The report specified the resident suffered mental anguish in response by guarding her arm throughout the day and cried out, "no, no, no" when staff entered the room. There was one accused individual (Phlebotomist #1) and two witnesses (Housekeeper #1 and Nurse #1). The facility's investigation substantiated the allegation of abuse.

On 04/09/18 at 10:12 AM Housekeeper #1 was interviewed and described that on 03/08/18 in the morning she heard Resident #3 from inside her room crying out "no, no, NO" and sounded agitated. The housekeeper stated she had a good relationship with the resident and was aware phlebotomists had entered the room to draw blood. Housekeeper #1 stated she asked Nurse #1 if she could go in the room. Housekeeper #1 reported that when she entered the room Resident #3 was in bed and she saw phlebotomist (PH) #1 standing on the left side of the bed holding the resident's left arm phlebotomist PH #2 was standing on the right

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side of the bed holding the resident's right arm and appeared as if they were going to attempt to draw blood at the same time. The Housekeeper added that when she entered the room, PH #2 let go of the resident's arm and stepped away from the bed. She went on to explain that she could see the resident had already been stuck once by PH #1 as evidenced by a needle stick to the left wrist that was bleeding. The Housekeeper described the resident was visibly upset and she went to the resident to console her; and while the housekeeper was consoling the resident, PH #1 made a second attempt to draw blood. The second attempt upset the Resident again which caused the Housekeeper to raise her head from having it rested on the resident's shoulder to see PH #1 holding the resident's left arm with force at the elbow. The Housekeeper described that PH #1 had the resident's left arm trapped between her legs pressed against the bed with a "firmer than she needed" hold of the arm at the elbow, then lifted the elbow to draw blood from the ante cube, sticking the resident a second time. The resident was fighting PH #1 saying "STOP, STOP, STOP!" The housekeeper said that she realized PH #1 was too rough and not listening to the resident but the blood draw was over. Housekeeper #1 left the room and notified Nurse #1 of what had occurred.

On 04/09/18 at 11:08 AM Nurse #1 was interviewed and reported on 03/08/18 she attempted to administer morning medications to Resident #3 but the resident had refused, shaking her head "no, no" and had the covers pulled over her head. The Nurse added that the resident had been up most of the night and wanted to rest that morning. The Nurse described that she proceeded to gather medications for another

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resident and just as she was about to enter another resident's room, Housekeeper #1 asked if she could console Resident #3 while she got her blood drawn. Nurse #1 stated she told Housekeeper #1 that would be fine and continued into the adjoined room. She stated she was able to hear slight moaning coming from Resident #3's room but added that as she exited the room she was in, she could hear that Resident #3 was agitated and got the sense something had "escalated." Nurse #1 reported she was met by Housekeeper #1 who asked the nurse to look at Resident #3's left arm. The nurse explained that when she entered the room the resident was in bed shaking her head, "no, no" and the phlebotomists had finished the blood draw and left the room but the resident was bleeding. Nurse #1 reported she called for Nurse #2 and physician #2 to assess the Resident's arm.

On 04/09/18 at 11:36 AM Nurse #2 was interviewed and reported that on 03/08/18 Nurse #1 stated to her, "I need you!" Nurse #2 described going into Resident #3's room and observed the resident cradling her left arm, her eyes were closed and she was shaking her head saying "no, no, no." In the same interview the nurse reported she calmed the resident down to assess the left arm. Nurse #2 measured a 12 centimeter by 13-centimeter hematoma that covered the resident's left forearm below the ante cube. Nurse #2 also stated that there was the appearance of fresh fingerprints marks on the resident's left wrist. Nurse #2 explained that she called PH #1 into the room to ask her how the resident sustained the injuries. The nurse stated that PH #1 became "belligerent" and defensive stating "you ain't going to blame this on me." Nurse #2 added the PH reported that she had to

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get the blood sample but the resident was being resistant and refusing to let the PH draw her blood so she had to hold the resident's arm down. Nurse #2 stated she informed the phlebotomist that Resident #3 had the right to refuse the blood draw and the phlebotomist denied knowing that a resident had the right to refuse a treatment.

On 04/09/18 at 2:33 PM the Director of Nursing (DON) was interviewed on the telephone and explained that on 03/08/18 she was in a meeting when she made aware of an incident regarding Resident #3 and phlebotomist #1. She stated she instructed staff to have phlebotomist #1 wait in the front of building to meet with her. The DON reported when she spoke with PH #1, the phlebotomist stated she didn't know it was wrong to hold down a resident's arm or that a resident could refuse to have their blood drawn. The DON added she was shocked by the answer and asked the phlebotomists to leave the building. The DON added she proceeded by filing an abuse allegation and notified the lab company that their services were being suspended pending an abuse investigation. The DON explained she conducted a thorough investigation that became apparent the phlebotomist had forced the resident to have a blood draw and was too rough based on the extent of the injuries sustained. The DON concluded Resident #3 had been physically abused and substantiated the allegation stating, Resident #3 was "absolutely abused by the phlebotomist, there was no doubt."

On 04/09/18 at 4:00 PM Phlebotomist (PH) #2 was interviewed on the telephone and explained that it was her first time trying to collect Resident #3's blood on 03/08/18. She described that she entered the room, startled Resident #3 who

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began shaking her head no. The phlebotomist stated she told Resident #3 she wasn't there to get her out of bed just to draw her blood. She stated she realized she was going to need help with the resident and called for phlebotomist #1 to come into the room. She went on to describe that "for the most part the resident was okay until PH #1 stuck the needle in and then she (Resident #3) started to get real cranky." PH #2 was asked to define "cranky" and she stated Resident #3 started pulling her arm away, moaning, yelling and fighting us and PH #1 had to pull the needle out of the resident's wrist because of the risk for injury. Then she went on to describe that Housekeeper #1 entered the room and attended to Resident #3 and calmed the resident down slightly by resting her head on the resident's head and singing in her ear. PH #2 explained that during this time, a second attempt was made to draw blood which upset the resident again and PH #1 had to grab the resident's arm to hold the arm still because the needle was in the arm.

On 04/10/18 at 1:10 PM Phlebotomist (PH) #1 was able to be reached for a telephone interview and described having been a phlebotomist for a long time and had drawn Resident #3's blood before. The PH described Resident #3 as being a "little difficult" at times and understood why phlebotomist #2 asked for help because the resident had "her good days and not good days." She went on to describe that as she entered the room Resident #3 was whining and moaning "a lot" and "did not want to be bothered." The PH reported that she told the resident she needed to draw her blood. The phlebotomist proceeded to draw the blood and reported that "things were going fine" until the resident became anxious and started fighting the needle so she held the

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resident's arm because the resident was trying to "jerk the needle out." The PH acknowledged Housekeeper #1 came in the room and calmed the resident but denied that she stuck the resident twice in the arm. The PH offered no explanation why the resident was bleeding from two separate sticks on her left arm. The PH added that it was very important that she got Resident #3's blood sample because later she found out the INR was critical.

On 04/10/18 at 4:10 PM the Medical Director (MD) was interviewed on the telephone and stated she had been made aware of an unfortunate incident with Resident #3 which resulted in traumatic bruising. The MD described that she assessed the resident on 03/08/18 later in the day and noted the bruising was consistent with a traumatic event and noted the bruising to be "deep, deep, purple."

On 04/10/18 at 4:25 PM physician #2 was interviewed on the telephone and described being called into Resident #3's room after the incident and seeing a "huge traumatic bruise caused by the blood draw."

On 04/11/18 at 5:05 PM the facility provided an corrective action plan.

Plan for correcting specific area of concern identified, include the process that led to the concern:

· On 03/08/18 a housekeeper witnessed phlebotomist (PH) #1 use unnecessary force to obtain a blood specimen from Resident #3 who was resisting the procedure. A second phlebotomist (PH) #2 was in the room during the

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incident. Housekeeper #1 immediately reported the incident to the nurse. The DON was notified of the incident.

· Resident #3 was assessed by nurse #2 and the physician for injuries.

· PH #1 had no further interaction with residents following the incident and was asked about the bruising sustained during the blood draw.

· PH #1 stated she was unaware a resident had a right to refuse. Nurse #1 educated the PH on Resident Rights. The PH left the facility.

· On 03/08/18 the facility filed a 24-hour abuse allegation and notified the lab company of the incident.

· On 03/09/18 the facility temporarily suspended the lab company from entering the facility pending an investigation.

· Facility staff assumed, trained on resident rights and abuse, were allowed to perform blood draws on residents with orders for laboratory testing.

· On 03/09/18 a meeting was held with the lab company to notify them of the temporary suspension of services until the following terms were met:

· Full Names of both Phlebotomists involved in the incident. We have to provide this to the Health Care Personnel Registry. (Name, Full Social Security, DOB, Job Title, Date of Hire, Last known mailing address, Phone number)

· Statements from both Phlebotomists as to what occurred.

· A copy of the training the lab company will provide for all their staff members who will be at any of our facilities with first priority being the facility.

This training should include Abuse prevention,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 25 what an employee should do when a resident refuses to get services done, what to do with a combative resident, how and when to report incidents to the facility receiving the service. · Please note-the two accused Phlebotomists cannot return to the facility and any other company facility going forward to provide any services. You will have to send any other phlebotomists to the facility, who have received the above training after our review of the education/ training you provide us. · The facility will need documentation from the lab company indicating when this education was done and also completed. This will be included in our investigation report which we will send to the Health care Personnel Registry. Representatives from the lab company met with the Director of Nursing and Administrator on 03/09/2018 to discuss the event. The housekeeper and nurse was interviewed by the representatives. It was determined that the root cause was lack of knowledge. This is due to the fact that the phlebotomist reported to the nurse that she did not know that the patient had the right to refuse treatment and she did not recognize that the resident pushing her hand away was a refusal. Procedure for implementing an acceptable Quality Improvement Plan. Systematic Changes and Education provided: The lab company was contacted and notified on 3/8/2018 by the Quality Assurance Nurse Consultant and informed that: Phlebotomist #1 and Phlebotomist #2 will not be allowed to return to the facility to provide any services moving forward. Phlebotomist # 1 and Phlebotomist # 2 have not been allowed to provide any direct patient care services since 3/8/18. On 3/8/18 the	F 600		

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facility determined that all services provided by the lab company would be suspended pending investigation. The lab company provided education to phlebotomists regarding resident rights and abuse. The lab company provided the facility with a copy of the education provided:

This training included:

Phlebotomy Continuing Education

As defined by the Centers for Medicare and Medicaid Services:
"Abuse. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."

Restraint. "As described under Definitions, a physical restraint is any manual method, physical or mechanical device/equipment or material that limits a resident ' s freedom of movement and cannot be removed by the resident in the same manner as it was applied by staff.

For example: Holding down a resident in

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response to a behavioral symptom or during the provision of care if the resident is resistive or refusing the care;

As defined above by the Centers for Medicare and Medicaid Services any act of restraint is considered abuse of a patients ' rights.

Procedure
1. Patient refuses to have venipuncture started by any means including a verbal indication or a physical behavior.
2. Phlebotomist will not proceed with the procedure and will locate a nurse at that time.
3. The patient consents to the venipuncture and if at any time during the venipuncture the patient refuses to continue by verbally requesting the needle be removed or becoming combative the phlebotomist will immediately stop the procedure, bandage the site, safely dispose of the venipuncture device and locate a nurse.
4. Once the nurse is notified the phlebotomist may return to the room with the nurse. If the patient consents to the nurse ' s request for the phlebotomist to perform the venipuncture, then the phlebotomist may only continue with the nurse present in the room.
5. If the patient still refuses the phlebotomist will document the refusal in the lab company Phlebotomy log at the facility. The refusal along with the nurse ' s name who assisted will be documented. The facility will follow their Standard Operating Procedure to inform the patient ' s physician.

At no time will a phlebotomist restrain a patient by any manual or physical method in order to obtain blood. At any time a patient appears agitated or combative a nurse will be informed and it will be

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their decision as to whether to try to continue with the procedure. The phlebotomist will document all decisions in the lab company phlebotomy manual along with informing their phlebotomy manager. The phlebotomy manager will then follow up with the facilities unit manager or DON about the incident to ensure that all policies and procedures of both the lab company and the facility have been appropriately followed.

The lab company operates on the belief that the best standards of care can only be maintained with consistent, complete and accurate communicate between themselves and the facilities they serve. Phlebotomy contractors, phlebotomy managers and laboratory staff will immediately inform the facility of any matter that could be considered an incident. All incidents are documented in the lab company Phlebotomy Manual and will include documenting the incident itself and who it was reported to. All incidents will be reported to the phlebotomy manager for follow up with facility supervisors.

The lab company provided signed attestations on 03/12/2018 of receiving resident rights and resident abuse education. The lab company phlebotomists were allowed to resume services to the facility on 03/13/2018.

On 3/8/2018 Director of Nursing and Nurse Manager interviewed all alert and oriented residents and asked if they had felt abused by staff, residents, or anyone else in the facility. No new allegations were reported.

On 03/09/2018-there were no incidents reported of new bruising, skin tears, abuse or neglect on any of the facility residents. No new skin issues

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such as bruising were found during weekly skin checks.

03/09/2018-during daily clinical there were no staff reports or notes of any concerns of abuse or neglect of any of the facility Residents. Daily clinical meeting is a part of the facility ' s quality assurance program and is held daily Monday thru Friday. It is attended by the director of nursing, assistant director of nursing, and the MDS nurse. During the meeting the electronic health record is reviewed. This review would have included incident reports, progress notes, new orders, and newly completed abnormal skin assessments. This information would have assisted the nurse managers identify any new bruises or skin tears that could have indicated that an abuse or neglect investigation should be initiated.

On 4/11/18, the nurse managers completed skin checks on all non interviewable residents to determine if there was any unreported bruising that could indicate that a patient was forcibly restrained or abused. It was determined that one out of thirty-seven patients has a bruise that was not previously address. The bruise in on the forearm of a patient who is able to move on his own. An investigation as to the etiology of the bruise and a 24-hour report injury of unknown origin was initiated by the Director of Nursing on 4/11/18.

On 3/8/2018 Director of Nursing initiated education to staff at the facility in reference to abuse, resident rights, and also what to do in the event of a resident refusing care such as lab services or blood work. Education was completed for all staff on 3/15/18. This training was incorporated into the general orientation

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program and will be discussed during all general orientation programs that is completed for identified staff.

Monitoring Procedure to ensure that the identified areas for improvement are effective and change is sustained.

As of 4/11/18 the Director of Nursing and /or Administrator will monitor compliance by: interviewing 5 alert and oriented residents weekly in reference to: Have they felt abused by staff, residents, or anyone else in the facility, and if yes did they report it to staff. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee.

As of 4/12/18 the support nurse will monitor compliance by: observing the phlebotomist obtain lab specimens for 5 non- alert and oriented residents weekly to ensure that residents are not abused. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee.

Phlebotomist routinely come to the facility to obtain specimens on Monday and Thursday. As of 4/12/18 the Support Nurse will validate that the phlebotomist who arrive to obtain specimens have received the training by comparing their names to those listed on the attestation forms. If the lab company employee who is not on the list arrives at the facility, they will not be allowed to obtain specimens and the lab company leadership will be notified that the education should be completed and that labs need to be obtained by another staff member. Before any new phlebotomists are sent to the facility---Lab

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F 600	Continued From page 31 Manager has been requested to send their name as well as a signed attestation to the DON. As of 4/12/18 reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The corrective action plan was validated on 04/12/18.	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to accurately code that a resident had a life expectancy of less than 6 months for 1 of 1 sampled Hospice resident (Resident #3). The findings included: Resident #3 was admitted to the facility on 06/12/17 with diagnoses that included chronic diastolic heart failure, paroxysmal atrial fibrillation, presence of a pacemaker, history of a Deep Vein Thrombosis (DVT) and others. Review of the medical record revealed on 12/29/17 a contract was signed for Resident #3 to	F 641	F641 483.20 Accuracy of Assessments The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: A significant change in status Minimum Data Set (MDS) was completed with ARD (Assessment Reference Date) of 1/10/18 for Resident #3 who was receiving hospice care and services. The MDS nurse who completed the assessment failed to code in section J1400 of the MDS that Resident # 3 had a life expectancy of less than 6 months. On 4/11 /18 the MDS	4/17/18

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F 641	Continued From page 32 receive end of life Hospice services. A significant change Minimum Data Set (MDS) dated 01/10/18 was completed that specified the resident was receiving Hospice Care. The MDS failed to acknowledge that in Section J1400 the resident had a life expectancy of less than 6 months. On 03/13/18 Resident #3 died. On 04/11/18 at 2:15 PM the MDS Coordinator was interviewed and stated that a significant change MDS had been completed for Resident #3 to reflect Hospice services being initiated. The MDS Coordinator added it was an oversight that Section J1400 did not specify the resident had a life expectancy of less than 6 months to live.	F 641	Coordinator corrected the coding on the MDS via a modification. On 4/12/18 the MDS nurses reviewed the MDS assessments for all the residents who were receiving hospice care and services to ensure that section J1400 of the MDS was accurately coded to reflect that the residents had life expectancy of 6 months. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 4/12 /18 the MDS nurse consultant re-educated the MDS nurses on accurately coding section J1400 of the MDS assessments for all residents receiving hospice care and services as having a prognosis of life expectancy of less than 6 months. There were a total of 7 residents receiving hospices services and all were audited. 3 of the 7 audited MDS assessments were found to have section J1400 not coded accurately. The 3 inaccurate MDS assessments were corrected via modifications on 4/12/18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The DON and the MDS nurses will complete 3 residents using the QA MDS Accuracy audit tool weekly x 4 then monthly x 3. Reports will be presented to the Administrator weekly that in turn will	

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F 641	Continued From page 33	F 641	be shared with the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy Manager, Medical Records, Dietary Manager, Administrator and Medical Director. Deficiencies that are identified during the monitoring process will be addressed through the facility QA process. The title of the person responsible for implementing the acceptable plan of correction: The MDS Nurses and the Director of Nursing. Completion date: 4/17/18	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff, family and physician interviews and record review the facility failed to follow manufacturer's recommendations for using a	F 689	F 689 Plan for correcting specific area of concern identified:	4/17/18

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F 689	Continued From page 34 mechanical lift when transferring a resident from a wheelchair to a commode. The resident was in a standing position, not secured in the lift and fell striking the back of her head on the commode and sustained a brain bleed for 1 of 4 sampled residents (Resident #6). Immediate Jeopardy began on 03/20/18 when nurse aide #1 failed to use a mechanical lift according to manufacturer's recommendations. A resident fell, struck the back of her head on a commode and suffered a brain bleed. Immediate Jeopardy was removed on 04/16/18 when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: Manufacturer's recommendations for a Sit-to-Stand lift (a mechanical lift used to assist residents with transfers) specified the following: - Fit the sling to the resident ensure chest strap is fastened securely and resident's arms are outside the sling. - Using the handset raise the resident to a standing position. - Close legs and transport resident to bed, toilet or chair. - Position the resident in front of the bed, toilet or chair with the back of their legs gently touching the chair and lower to a sitting position. - Release the tension on the sling and remove the sling from the Sit-to-Stand. - Remove the sling from around the resident.	F 689	On 03/20/2018 a resident family member of resident NP asked that resident be toileted. CNA-1 brought the sit-to-stand lift (referred to as lift) into the resident□s room□buckled the waist strap□but failed to buckle the leg straps. Once in the doorway of restroom in resident room□CAN-1 unbuckled the waist strap prior to ensuring resident safely on the toilet. Resident let go of the lift and subsequently fell to the floor hitting head. CNA-1 notified assigned Nurse-1 immediately at 4:36 PM. Nurse then notified family member as well as the Assistant Director of Nursing ADON and Director of Nursing DON at 4:40 PM as well as on site clinician. All times verified by video footage. Orders were received to send resident to ED for evaluation. Resident has not been readmitted to this facility. Procedure for implementing an acceptable Quality Improvement Plan. Systematic Changes and Education provided (education should continue until all relevant employees are trained) All residents who require the use of a mechanical lift have the potential to be effected by this practice. On 3/20/18 an audit of all residents requiring use of a mechanical lift was done to assure that each resident□s kardex and care plan accurately reflected use of the appropriate lift. Re-education with return demonstration of appropriate use of mechanical lifts, along with accessing the mechanical lift/sling type via the kardex prior to the initiation of	

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F 689	Continued From page 35 Resident #6 was admitted to the facility on 11/03/15 and readmitted on 12/06/17 with diagnoses that included hemiplegia with hemiparesis affecting the left side, Alzheimer's disease, atrial fibrillation and others. A document titled "Nursing Referral for Rehab Screening" dated 01/02/18 specified the resident needed extensive assistance to stand and required the sit-to-stand lift (a mechanical lift) for transfers. The document was signed by the physician on 01/29/18. The most recent Minimum Data Set (MDS) dated 03/12/18 specified the resident's cognition was moderately impaired, the resident required extensive two-person assistance with transfers, was always incontinent, had two or more falls since the prior assessment and took an anticoagulant medication daily. Review of the Medication Administration Record (MAR) for March 2018 revealed the resident took the following medications daily as ordered by the physician: - Aspirin 81 milligrams daily for stroke prevention - Eliquis 5 milligrams twice daily for stroke prevention The resident's Kardex (instructions for staff specific to each resident) specified the Resident #6 required 2 staff for the sit-to-stand lift. Further review of the medical record revealed on 03/20/18 the resident was sent by the physician to the Emergency Department for evaluation of a head injury from a fall.	F 689	the transfer was initiated on 03/21/18, by the DON/ADON/SDC and Maintenance Director. As of 04/12/2018, 90% of the nurses, nursing aides, medication aides and therapists have been observed and 100% by 4/15/18 with 100% demonstrating competency. Beginning 3/20/18 all nursing staff including: LPNs, RNs, Nursing Managers, CNAs and Med. Aides were in-serviced on the importance of checking the resident Kardex prior to initiating any transfers in order to ensure that the safest transfer technique is used. All staff were in-serviced on the importance of always having 2 staff members present when utilizing lift. Any in-house nursing staff who did not receive in-service training by 03/26/2018 will not be allowed to work until training is completed. All staff had been called and verbally given the education with the expectation of the attestation being signed on next work date. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. During the Weekly QA (04/12/13)---the REQ (Review to Ensure Quality) and education were reviewed---and although education had been verbalized in the earlier training concerning the 2nd staff member be in place in the bathroom to ensure the safety of the resident□it had not been documented in the written education. A decision was made to	

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F 689	Continued From page 36 An incident report dated 03/20/18 made by Nurse #3 specified Resident #6 had fallen in the floor of the bathroom after being assisted by one nurse aide that used the sit-to-stand lift. The nurse assessed Resident #6 and documented the resident had "slurred speech, inability to have small conversation." The resident had an injury to the back of her head. The nurse noted that family was present in the room after the fall and physician #3 was called in the room. Physician #3 documented on 03/20/18 that Resident #6 was being seen after a fall and had slurred speech. The physician documented that according to nursing staff, the resident fell out of a lift, hit the back of her head against the toilet and was initially confused. The progress note specified the resident had a head injury status post fall and had a high risk for intracranial hemorrhage due to anticoagulant usage and ordered an "urgent" evaluation at the Emergency Department. On 03/20/18 Resident #6 underwent a computerized tomography (CT) scan that revealed a hematoma of the right frontal lobe (blood in the brain) which measured 3.2 centimeters by 2.8 centimeters. The resident was admitted to the hospital and the resident's anticoagulant medications were discontinued because of the brain bleed. The resident was transferred to a trauma center and after arrival had two tonic seizures and was treated with Ativan (antianxiety) and intramuscular Keppra (anti-seizure) medications. According to the hospital reports, no further seizure activity was noted.	F 689	initiate additional training to ensure that the training was formalized in writing. Secondary training was initiated on 04/13/2018 and completed on 04/15/2018. New education was given either in person or verbalized over phone to all staff members. Monitoring Procedure to ensure that the identified areas for improvement are effective and change is sustained. The DON, ADON, SDC, RD and Maintenance Director have reviewed proper lift protocols and checked each staff member as part of their yearly skills check by 04/15/2018. As of 4/15/18 100% of education has been completed. A weekly audit beginning the week of 03/26/2018 will be completed by DON, ADON and Maintenance Director or appointed designee x 2 months and then monthly x 2 months. The audit will include ensuring that staff are checking the kardex prior to transferring a resident for proper transfer method as well as watching staff during a transfer to ensure that policy and procedures are being followed. A minimum of 3 transfers will be monitored. The DON will present findings to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Unit Managers, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Health Information Management and meets weekly.	

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F 689	Continued From page 37 Resident #6's care plan for falls was updated on 03/20/18 that specified "staff re-educated on use of lift and required 2 two-person assistance with all lift transfers." A document titled "Investigation Report" dated 03/23/18 specified the facility substantiated neglect for nurse aide (NA) #1's failure to follow safety precautions when transferring Resident #6. The report also specified the actions of NA #1 resulted in harm to the resident and the NA was terminated. The report was completed by the Director of Nursing (DON) who documented that the NA failed to use two people to operate the lift when transferring Resident #6, failed to use the legs straps and then released the waist strap before sitting the resident on the toilet. The resident fell from a standing position and hit the back of her head on the toilet. According to hospital records, on 03/29/18 Resident #6 was discharged to another skilled nursing facility. Additional hospital paperwork dated 04/02/18 revealed the resident was found unresponsive and sent to the Emergency Department for evaluation. Resident #6 was diagnosed with bowel and renal ischemia and trial clots which could not be safely reversed due to recent brain bleed. The resident remained in rapid atrial fibrillation. The family was notified of poor prognosis and decided to place resident on comfort care. Resident #6 was discharged from the hospital on 04/06/18 and died on 04/10/18. On 04/16/18 at 10:31 AM nurse aide (NA) #1 was interviewed on the telephone and explained she no longer worked at the facility. She reported that	F 689	Title of the Person responsible for implementing the acceptable plan of correction: Director of Nursing, Unit Directors, Support Nurses Completion Date: 4/17/18	

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on 03/20/18 she was assigned Resident #6 and was asked by the family to help the resident go to the bathroom. The NA described that she was familiar with the resident and knew she was transferred with a sit-to-stand lift but sometimes she transferred the resident by picking her up underneath her armpits. The NA went on to state, she was trained to have two staff to use the sit-to-stand lift but felt she didn't always need two people because several of the nurse aides only used one person, including herself. So, she decided to transfer the resident without the assistance of another staff member. NA #1 stated that on 03/20/18 she proceeded to use a sit-to-stand lift by securing the waist strap around the resident and rolled the resident into the narrow bathroom and had her in front of the toilet. The NA reported that before seating the resident on the toilet, she removed the waist strap, assuming the resident would be able to bear her own weight but instead, the resident fell backwards and hit her head on the toilet.

On 04/16/18 at 10:50 AM a family member of Resident #6 was interviewed on the telephone and described that on 03/20/18 in the afternoon she was visiting her mother. During the visit, she requested for a nurse aide to assist Resident #6 with incontinence care. The family member explained that she left the room while the resident received care and within minutes of leaving the room, heard a call for help and learned Resident #6 had fallen.

On 04/16/18 at 11:16 AM the Maintenance Director was interviewed and stated that he trained all new employees how to safely use mechanical lifts per manufacturer's recommendations. He explained that the facility's

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policy was to have two staff to assist with all lift transfers.

On 04/16/18 at 11:20 AM the Director of Nursing (DON) was interviewed and stated Resident #6's family member was in her office when the fall occurred. The DON stated that she had instructed the ADON and Maintenance Director to pull the lift and mark it out of order to be inspected. The DON stated she obtained a statement from NA #1 and asked her to reenact the way she transferred Resident #6. The DON stated that in the reenactment the nurse aide demonstrated she used the lift incorrectly by not having two staff present to assist with the transfer, the legs straps were not utilized and the waist strap was released before the resident was seated on the toilet. The DON explained she suspended the nurse aide and started an investigation. She added it did not take long to complete the investigation because the evidence was clear the nurse aide did not safely transfer the resident, the nurse aide was terminated and the DON substantiated neglect. The DON explained that the facility immediately started educating all staff to make sure that an incident of this "magnitude" never happened again.

On 04/16/18 at 1:02 PM the medical director was interviewed on the telephone and stated she was made aware of the incident with Resident #6 and that she learned a staff member failed to follow safety guidelines for transfers. The MD stated that the biggest problem when using a lift would be risk for injury. The MD explained that Resident #6 was on anticoagulant medication for atrial fibrillation and discontinuation of the medications would place the resident at risk for ischemic stroke.

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F 689	Continued From page 40 On 04/16/18 at 3:06 PM Nurse #3 was interviewed and stated she was on the hall when the fall occurred and entered Resident #6's room to see the resident in the floor. Nurse #3 explained that NA #1 used the sit-to-stand lift by herself and dropped the resident from the lift. Nurse #3 stated she assessed the resident to have signs and symptoms of a head injury because her speech was slurred and cognitive difficulties following commands. The nurse added she called for physician #3. Physician #3 was unable to be reached for an interview. On 04/16/18 at 1:15 PM the Administrator was notified of immediate jeopardy. On 04/16/18 at 4:34 PM the facility provided an acceptable credible allegation of compliance that included: Plan for correcting specific area of concern identified, include the process that led to the concern: (Include RCA) On 03/20/2018 a resident family member of resident NP asked that resident be toileted. CNA-1 brought the sit-to-stand lift (referred to as lift) into the resident ' s room-buckled the waist strap-but failed to buckle the leg straps. Once in the doorway of restroom in resident room - CNA 1 unbuckled the waist strap prior to ensuring resident safely on the toilet. Resident let go of the lift and subsequently fell to the floor hitting head. CNA-1 notified assigned Nurse-1 immediately at 4:36 PM. Nurse then notified family member as well as the Assistant Director of Nursing ADON and Director of Nursing DON at	F 689		

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4:40 PM as well as on site clinician. All times verified by video footage. Orders were received to send resident to ED for evaluation. Resident has not been readmitted to this facility.
Root Cause is identified as failure of the CNA to follow facility policies related to transferring a resident with a mechanical lift. The investigation revealed that the NA-1 used the appropriate type of lift for the resident and that the staff responded appropriately to the event. However, the NA-1 admitted that she was working hastily and did not get the necessary assistance -as she had been trained to do-to complete the transfer. In addition-the CNA-1 admitted that again, trained policy was not followed as she did not properly attach the calf strap and unbuckled the waist strap prior to ensuring resident safely on the toilet which resulted in the resident fall. The nurse aide offered no explanation for why she failed to attach the leg strap. She stated she was in a hurry. The nurse aide acknowledged she had been trained to attach them.

Procedure for implementing an acceptable Quality Improvement Plan. Systematic Changes and Education provided (education should continue until all relevant employees are trained)

All residents who require the use of a mechanical lift have the potential to be affected by this practice.
An investigation into the incident was immediately conducted and revealed:
· The Maintenance Director immediately removed the lift and pad from floor and put a stop/watch on until investigation could be completed. DON and Maintenance Director inspected the pad for any signs of fraying or tears-none were found. Lift was tested for

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malfunction-malfunction not found.

· The DON, ADON and Maintenance Director then asked the CNA-1 to give a return demonstration of incident after resident was out of building. All went into an empty room and asked for a staff volunteer to act as resident. CNA-1 verbalized and demonstrated steps taken.

· CNA-1 states the she did not attach the leg straps-no explanation given. CNA-1 did attach the waist straps and instructed resident to place arms on the lift and to hold onto the handles. CNA-1 then pushed the lift and resident towards the bathroom-once to the door---CNA-1 stated that she knew that she would not be able to get into the bathroom around the lift-so she reached in at that time and unbuckled the waist strap.

· CNA-1 states that resident then yelled "my back my back", raised her arm from the lift and immediately fell to the ground. DON asked why there was not a 2nd staff member in the room---and CNA-1 stated that she did not see anyone available to assist

· DON then re asked the question-CNA-1 then stated that she did not get anyone to assist---because she knew that the daughter had wanted resident to be toileted before she left-so she wanted to make sure it was done-and did not go to get another staff member for assistance.

· DON suspended the CNA-1 until investigation could be completed and then assisted the ADON in completing and submitting a 24-hour report.

· On 3/20/2018 the DON observed the camera footage. The DON watched for 1 hour prior to incident up to 30 minutes post incident. At approximately 4:25 PM family member is seen interacting with staff. CNA-1 is seen at approximately at 4:31 PM going towards room

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with lift and at 4:33 PM CNA-1 is seen going into resident room by herself with lift. At that time-multiple staff members are seen including the 400 hall Nurse1 who is walking down the 400 hallways.

· DON then requested the ADON to come and watch the footage as well. Both then went back into the office---and discussed camera findings as well as ADON ' s first hand observations as she had responded to the fall herself.

· DON reviewed resident ' s chart, including care plan to make sure that appropriate transfer had been attempted. Care plan revealed that resident was a stand-assist lift.

· DON interviewed Nurse-1, Nurse-2, Nurse-3, Med Aide-1, NA-2, to ensure that this was the appropriate lift for resident and that she had safely been transferred with this lift prior to incident.

· The investigation revealed: that the CNA-1 used the appropriate type of lift for the resident and that the staff responded appropriately to the event. However, the CNA-1 did not get the necessary assistance to complete the transfer. Additionally, the CNA-1 admitted that they did not properly attach the calf strap.

On 3/20/18 an audit of all residents requiring use of a mechanical lift was done to assure that each resident ' s Kardex and care plan accurately reflected use of the appropriate lift. Results revealed that 18 out of 83 residents requiring transfers via a mechanical lift were in compliance.

Re-education with return demonstration of appropriate use of mechanical lifts, along with accessing the mechanical lift/sling type via the Kardex prior to the initiation of the transfer was initiated on 03/21/18, by the DON/ADON/SDC and Maintenance Director. As of 04/12/2018,

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F 689	Continued From page 44 90% of the nurses, nursing aides, medication aides and therapists have been observed with 100% demonstrating competency. All remaining staff will not be allowed to work until education and return demonstration is given. Beginning 3/20/18 all nursing staff including: LPNs, RNs, Nursing Managers, CNAs and Med. Aides were in-serviced on the importance of checking the resident Kardex prior to initiating any transfers in order to ensure that the safest transfer technique is used. All staff were in-serviced on the importance of always having 2 staff members present when utilizing lift. Any in-house nursing staff who did not receive in-service training by 03/26/2018 will not be allowed to work until training is completed. All staff had been called and verbally given the education with the expectation of the attestation being signed on next work date. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. During the Weekly QA (04/12/13) ---the REQ (Review to Ensure Quality) and education were reviewed---and although education had been verbalized in the earlier training concerning the 2nd staff member be in place in the bathroom to ensure the safety of the resident-it had not been documented in the written education. A decision was made to initiate additional training to ensure that the training was formalized in writing. Secondary training was initiated on 04/13/2018 and completed on 04/15/2018. New education was given either in person or verbalized over phone to all staff members. Monitoring Procedure to ensure that the identified	F 689		

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F 689	Continued From page 45 areas for improvement are effective and change is sustained. The DON, ADON, SDC, RD and Maintenance Director have reviewed proper lift protocols and checked each staff member as part of their yearly skills check by 04/15/2018. As of 4/15/18 100% of education has been completed. A weekly audit beginning the week of 03/26/2018 will be completed by DON, ADON and Maintenance Director or appointed designee x 2 months and then monthly x 2 months. The audit will include ensuring that staff are checking the Kardex prior to transferring a resident for proper transfer method as well as watching staff during a transfer to ensure that policy and procedures are being followed. A minimum of 3 transfers will be monitored. The DON will present findings to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Unit Managers, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Health Information Management and meets weekly. Immediate Jeopardy was removed on 04/16/18 at 5:00 PM when the facility demonstrated that staff had been trained and educated on the use of mechanical lifts.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of	F 867		5/11/18

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F 867	Continued From page 46 action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility ' s quality assurance (QA) process failed to implement, monitor and revise as needed the action plan developed for the recertification survey of May 2017 in order to achieve and sustain compliance. This was for one deficiency cited on the recertification survey. The deficiency was in the area of failure to prevent accidents at CFR 483.25. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Committee. The findings included: F 689: Accidents: Based on staff, family and physician interviews and record review the facility failed to follow manufacturer's recommendations for using a mechanical lift when transferring a resident from a wheelchair to a commode. The resident was in a standing position, not secured in the lift and fell striking the back of her head on the commode and sustained a brain bleed for 1 of 4 sampled residents (Resident #6). This deficiency was cited during a complaint investigation in April 2018. F 483.25: Accidents: in May 2017 the facility failed to implement effective interventions to prevent a resident from injury. On 04/16/18 at 2:22 PM the Administrator was interviewed regarding the deficient practice for supervision to prevent accidents. In the interview, the Administrator explained the facility had	F 867	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F867 QAPI / QAA Improvement Activities The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility'□s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions put in place following the recertification survey of May 25, 2017. This was for one deficiency recited during the complaint survey 4/16/18 in the area of Free of Accidents Hazards/Supervision/Devices F689 (F323). The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 5/8/2018, The QAPI/Quality Assurance Nurse in-serviced the Administrator in reference to facility policy, related to Quality Assessment and Assurance and Improvement Activities. A facility must	

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F 867	Continued From page 47 identified deficient practice, utilized the Quality Assurance Program to correct the deficient practice; and he believed the facility was in compliance with the regulation	F 867	maintain a quality assessment and assurance committee consisting at a minimum of:(i) The Director of Nursing services;(ii) The Medical Director or his/her designee;(iii) At least three other members of the facility□s staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and The Quality assessment and Assurance committee must :(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Effective 5/8/2018, this training has been incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that	

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BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

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F 867	Continued From page 48	F 867	the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; To ensure compliance, the Administrator or Director of Nursing will monitor this issue using a quality assurance (QA) survey tool for the identified tag and area of deficiency. The facility will monitor compliance of QA for F689. This will be done on a weekly basis for 4 weeks then monthly for 3 months by the Administrator and reviewed monthly by the Quality Assurance Nurse Consultant to ensure compliance. Reports will be presented to the weekly QA Committee by the Administrator or Director of Nursing to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Assistant Director of Nurses, Therapy, Health Information Manager, Dietary Manager, Activities Director, Social Worker, Admission Coordinator, Business Office Manager and Facility Services Director. The title of the person responsible for implementing the acceptable plan of correction; The Administrator Date of Compliance: May 11, 2018	