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	345213	A. BUILDING _____ B. WING _____	C 06/08/2018

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F 000	INITIAL COMMENTS A recertification & complaint survey was conducted from 6/04/18 through 6/08/18 Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity J CFR 483.12 at tag F607 at a scope and severity J CFR 483.70 at tag F835 at a scope and severity J The tags F600 and F607 constituted Substandard Quality of Care. Immediate Jeopardy began on 6/04/18 and was removed on 6/07/18. An extended survey was conducted.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.	F 565		7/10/18

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

Electronically Signed | 07/04/2018

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F 565	Continued From page 1 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews with Resident Council members and review of Resident Council minutes the facility failed to resolve concerns voiced by the Resident Council members during the previous 5 of 8 monthly meetings. The findings included: Resident Council Meeting minutes from October 2017, November 2017, December 2017, January 2018, February 2018, March 2018, April 2018, and May 2018 were reviewed. A review of Resident Council minutes dated October 31, 2017 indicated residents voiced concerns regarding not receiving ice as requested. The Resident Council minutes from November 2017, January 2018, February 2018, April 2018, and May 2018 indicted not receiving ice primarily on 2nd shift. The Resident Council minutes for November 2017, January 2018, and May 2018 indicated that snacks or ice were not received by residents.	F 565	The creation of this Plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth by the surveyors on-site. This plan is solely prepared 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. F565 ROOT CAUSE Root cause analysis conducted by the facility Executive director, Director of nursing, Activities director and the Chief Clinical Officer from the management and consulting Company overseeing the facility concluded that; the repeated	

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F 565	Continued From page 2 An interview was conducted on 6/6/18 at 3:04 PM with the facility's resident council. There were ten residents present in the meeting. During the meeting residents expressed a concern with the resolution of grievances. The residents in the meeting reported not all grievances were acted on promptly by the facility and there was no explanation given as why the grievances were not resolved. The residents stated at each meeting they discussed the same concerns. Several of the members indicated they were advised staff received reeducation regarding their assigned tasks but there was no consistent change. Residents stated that they have repeatedly requested for snacks and ice to be provided. The residents reported they were told that snacks and ice would be provided on evening shift. Residents stated a staff member was present at Resident CouncCouncil meetings and communicated their concerns to Administration. An interview was conducted with the Activities Director on June 8, 2018 at 10:15 AM. She reported that she is present during monthly Resident Council meetings and recorded resident concerns. She indicated she discusses the concerns with the Department Heads in the next morning's daily clinical meeting. She reported that she received a response to the concern from the Department Heads within 3-5 days. The Activities Director stated she informed the Resident Council members of the resolution verbally at the next meeting. She stated she was aware some complaints were repeated each month. The Activities Director stated that she was unsure why the same concerns were voiced each month by the residents at the resident council meetings. She indicated the resolution to	F 565	unresolved resident complaints are due to the employee culture within the facility. Among other factors it was concluded that lack of resident centered care delivery culture, customer service culture and lack of consistent staffing who provide care for residents in the facility play a role in this alleged non-compliance. IMMEDIATE ACTION No resident named in this alleged non-compliance. Resident council minutes dated October 31st, 2017, November 2017, January, 2018, February 2018, April 2018, and May 2018 reviewed by the facility Executive Director and Activity Director on 7/2/2018. New grievances related to Ice completed by the facility Activity Director. Director of nursing ensured residents received ice appropriately on 7/2/2018. Resident council minutes dated October 31st, 2017, November 2017, January, 2018, and May 2018 reviewed by the facility Executive Director and Activity Director on 7/2/2018. New grievances related to snacks or Ice completed by the facility Activity Director. Director of nursing ensured residents received ice appropriately on 7/2/2018 and moving forth. IDENTIFICATION OF OTHERS All residents in the facility has a potential to be affected by this alleged noncompliance.	

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F 565	Continued From page 3 the ice and snack concern was staff education by the Director of Nursing that snacks and ice were to be offered. An interview with the Director of Nursing was conducted on June 5, 2018 at 10:45 AM. He reported each time he was advised of a concern he provided reeducation to his staff. He stated it was his expectation ice and snacks were passed to residents each shift. An interview was conducted with the Chief Clinical Officer on June 8, 2018 at 10:50 AM. He stated he believed the reason for repeated resident complaints is due to the employee culture within the facility. He stated the facility was working towards a culture change to improve their services by recruiting and retaining capable staff. An interview was conducted with the Administrator on June 8, 2018 at 11:00 AM. He stated he was aware that concerns regarding ice and snacks were frequently repeated in the Resident Council meetings. The Administrator stated that these concerns were shared in the morning meeting after Resident Council meetings. He stated that the facility was working to address this issue through the facility's quality improvement process. The Administrator stated that it was his expectation that department heads follow up and respond to issues brought up at the meetings to resolve the issues.	F 565	100% audit for Resident Council minutes from January, 2018 to June 2018 was completed on 7/2/2018 by the Activity Director to identify any other unresolved repeated grievances. One other area was noted to be repeated and unresolved. The Resident council minutes reveals that Housekeeping area, specifically cleanliness of the facility was identified as unresolved repeated grievance February, 2018, March, 2018, April, 2018, May, 2018 and June, 2018. New grievances related facility cleanliness completed by the facility Activity Director on 7/2/2018. Director of House Keeping and Laundry Services cleaned the identified areas on 7/2/2018.Findings of this audit is documented on "Resident council minutes audit tool located in the facility compliance binder. SYSTEMIC CHANGES Effective 7/10/2018 resident council minutes will be discussed on the daily stand up meeting by the Activity Director or designated staff daily (Monday through Friday) until the resolution is obtained. Stand up meeting consist of members of each department in the facility and led by the facility Executive Director. Effective 7/10/2018; Concerns voiced during the resident council meeting will be addressed using Performance Improvement Process (PIP) with monitoring process in place until the resolution is obtained. Findings and resolution of resident council Effective 7/2/2018 all active residents in	

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F 565	Continued From page 4	F 565		

the facility receive ice and are offered bedtime nutritional snack as appropriate by the facility certified nursing staff to include licensed nurses, Medication aides and/or certified nursing assistants.

Effective 7/2/2018 nutritional snacks are kept available in the two nourishment rooms in the facility to accommodate any requests for snacks from any facility resident.

Facility Director of Nursing (DON), Assistant Director of Nursing and/or Unit manager will complete 100% education on the importance of delivering ice every shift for resident who are appropriate to receive ice per physician orders, offering bedtime snacks for all active residents as appropriate based on individual resident diet restrictions, and the location of snacks on the units to be offered. This education will be provided for all licensed nurses, medication aides and nursing assistant to include full time, part time and as needed licensed nursing staff. This education will be completed by 7/10/2018. Any nursing employee not educated by 7/10/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses and nursing aides effective 7/10/2018, and will also be provided annually.

MONITORING PROCESS
Effective 7/10/2018, Director of Nursing, Assistant Director of Nursing, Unit manager and or designated licensed

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F 565	Continued From page 5	F 565	nurse , will monitor compliance with resident resident's ice delivery and offering of snacks to residents by randomly checking ten randomly selected residents in different halls on each shift to ensure ice is offered as appropriate as well as bedtime snacks. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a "Snack & Ice monitoring tool "and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily for two weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 7/10/2018, 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 7/10/2018, 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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F 600	Continued From page 6	F 600		
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 record review, staff, resident, physician, and Department of Social Services staff interviews, the facility failed to protect 1 of 3 residents (Resident #84) from physical abuse when Resident #84 was witnessed by facility staff being hit and kicked by his spouse in his facility room. Immediate jeopardy began on 6/4/18 when 2 witnesses observed Resident #84 seated in his room in a wheelchair speaking loudly and shaking both arms in front of his head. A female visitor, identified as his wife, was observed seated on the bed close to Resident #84 hitting, kicking and stomping on Resident #84. No physical injuries were assessed. Immediate jeopardy was removed on 6/7/18 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility	F 600	F600 ROOT CAUSES This alleged noncompliance resulted from the center's failure to protect one resident with prior history of suspected domestic abuse from a spouse. On 4/25/2018 the facility admitted resident #84 for rehabilitation and long term care placement. Resident #84 had a protective order named "Ex parte order" filed in Harnett County Clerk of Superior Court on 4/24/2018. The protective order was presented to the facility at the time of admission on 4/25/2018 by the assigned Social worker from the Department of Social Services. The protective order included information that the "department of Social services is concerned with the possibility of physical abuse and neglect",	7/10/18

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F 600	Continued From page 7	F 600		

remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.

Findings included:

Resident #84 was originally admitted to the facility 4/25/18 under an order of protection (known as a Petition for Ex Parte Order) provided by the Department of Social Services (DSS), Adult Protective Services (APS). The order read, in part, "The undersigned petitioner (DSS Director of the county DSS) and through his representative (APS Social Worker-SW #1) having sufficient knowledge to believe the respondent (Resident #84) is in need of protective services alleges: 3. The respondent (Resident #84) is a disabled adult who is in need of protective services based on the following specific facts, j. without a protective order DSS is concerned the wife will remove respondent (Resident #84) from the hospital/rehab (rehabilitation)."

The hospital discharge summary dated 4/25/18 read, in part, "Problems: (2) closed fracture of pubic ramus; (3) fracture of radius, distal right, closed (forearm); (4) nasal fracture; (5) assault; (7) neglected elder. Suspected abuse by pt.'s (Resident #84) wife."

An incident report dated 6/4/18 revealed an allegation of visitor to resident abuse was witnessed by 2 staff members in the resident's room. A narrative of the incident read, "Staff was walking past resident's room at 4:42 PM when they noted resident with his hands in the air and it also added that "Without a protective order department of Social Services is concerned the wife will remove respondent from the hospital/rehab."

The root cause analysis, concluded that, the systemic failure that resulted onto resident #84 incident on 6/4/2018 includes, broken communication process from admission for necessary information to include protective orders for resident #84. As a result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions to protect resident #84. The broken communication process resulted from a lack of a systemic process set forth on how protective orders was to be communicated by the admission Director to the rest of the IDT.

Although the facility received the documentation on admission on 4/25/2018, and was notified by the DSS social worker of the protective orders of this resident, there is no indication that the facility put forth measures to protect Resident #84 from his wife. Admission Director failed to communicate the pertinent information to the interdisciplinary team necessary to insure resident #84 was protected while in the facility from his wife.

On 6/4/2018 the resident's spouse was witnessed by the facility Activity Aide, & Central Supply Aide #1 in the room with the Resident #84. Activity Aide and Central Supply Aide stated they witnessed

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F 600	Continued From page 8 yelling. The resident's spouse was noted kicking him on the legs and stepping on his feet. Resident denied pain and no bruising was evident. Resident was supervised for safety and police were notified and responded. The resident's wife spouse was escorted from the building and is not to return until further notice." A nursing note dated 6/4/18 at 7:27 PM read, "Staff was walking past resident's room at 4:42 PM when they noted resident with his hands in the air and yelling. The resident's spouse was noted kicking him on the legs and stepping on his feet. Resident denied pain and no bruising was evident. Resident was supervised for safety and police were notified and responded. The resident's wife spouse was escorted from the building and is not to return until further notice." A statement provided on 6/4/18 to the facility by Witness #1 read, in part, "I witnessed (Resident #84) being physically abused by his wife. I was walking down (the hall Resident #84 resided on) when I noticed (Resident #84) yelling with his hands held high. (Resident #84's) wife was physically abusing him by kicking his legs and stomping on his feet. This incident happened approximately at 4:42 PM." An interview was conducted 6/5/18 at 11:50 AM with Witness #1. She stated as she walked down the hall Resident #84 resided on she heard him speaking loudly and saw his hands up and shaking. She stated he was in his wheelchair and his wife was observed kicking his legs and stomping his feet. She also stated, "She was abusing him." She stated she intervened and asked Resident #84 if he was alright, but received no response. She stated she removed Resident	F 600	resident's spouse kicking resident's leg and stepping on his feet. Resident and the spouse were immediately separated by the Central Supply Aide. A Complete Head to toe body assessment was completed by the Registered nurse Supervisor #1. No injuries noted, resident denied any signs and symptoms of pain or discomforts. Initial report for the alleged abuse was completed and sent on 6/4/2018, DSS social worker and the attending Physician notified. IMMEDIATE ACTION TAKEN On 6/04/2018 at approximately 5:00PM the Central supplies aide separated resident #84 from his wife by pushing him out of the room to the hallway. The central supplies aide remained with resident #84 on the hallway, and notified Assistant Director of nursing who was standing in the proximity at the nurse's station #2. ADON walked towards the resident accompanied by the Unit Manager #1 who relieved the central supplies aide and took over supervision and protection of resident #84. Unit Manager #1 completed a head to toe assessment of the resident and noted no injuries. Resident denied pain or discomforts. Central supplies aide notified a Medical records supervisor who was standing at the nurse station #1. Medical records aide walked to the resident's room immediately and met Unit Manager #1 in the room. Medical records aide assisted Unit manager #1 while the Unit manager was assessing the patient. Unit Manager #1	

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F 600	Continued From page 9 #84 from the room and brought him to the common area where she and another staff member (Medical Records Director) stayed with him until police arrived. She also stated, "This is his second or third admission here. I think he was here under a protective order the second time because his wife physically abused him. This is his third admission and I believe he's under protective custody now." She stated the wife visited frequently during the second admission, but had not visited as often this admission. She also stated she made a positive identification 6/4/18. A statement provided on 6/4/18 to the facility by Witness #2 read, in part, "I, (Witness #2) walked by resident room (Resident #84) and saw him and his wife hitting each other." An interview was conducted on 6/5/18 at 1:10 PM with Witness #2. She stated she walked by Resident #84's room and observed Resident #84 and his wife hitting each other. She stated, "I have seen his wife visit quite often but I had never seen a physical interaction before. When he was on the rehab (rehabilitation) hall she stayed with him all the time, but this admission she wasn't here so much. When we (Witness #1 and Witness #2) saw her hitting him we took him out of the room immediately. We put him in the TV room, she followed, and had (Medical Records Director) stay with them." An interview was conducted with Resident #84 on 6/5/18 at 1:30 PM. The resident stated he had known his wife for 64 years and she was not abusing him. He stated, "All this talk about her hitting me is baloney."	F 600	and Medical Records supervisor transferred resident #84 to the wheel chair and moved the resident to the dining area. Medical Records supervisor remained with resident #84 until the police arrived with a brief period when she was relieved by the transportation aide who stayed with the resident when Medical Records supervisor departed. Likewise, the ADON who left Unit Manager #1 with resident#84 walked to the Executive Director's office for notification. On 06/04/2018 the 24 hour initial report was sent to the Department of Health and Human Services related to resident #84's witnessed abuse by the spouse. These reports were completed and submitted by the Director of Nursing. The Five day report was completed on 6/7/2018 after a detail investigation was conducted by the Center Executive Director, Director of Social Services and Director of Nursing. The incident on 6/4/2018 against resident #84 was substantiated based on findings of the investigation conducted by the Facility, Department of Social Services, and Harnett county Police Department. Resident #84's spouse is ordered by the court not to visit or be in contact with the resident effective 6/5/2018. Facility has yet to receive a confirmation of actions taken legally against the spouse. Facility will keep resident on 1 on 1 until confirmation is obtained of the spouse's inability to come to the facility. The photograph of the alleged perpetrator	

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F 600	Continued From page 10 No care plan related to safety measures for Resident #84 was initiated until after the witnessed physical abuse. An interview was conducted on 6/5/18 at 3:00 PM with APS SW #1. She stated she was called to the hospital in April related to (r/t) (Resident #84's) 3rd admission to the hospital since October 2017 for multiple fractures and bruises. She also stated they (APS) suspected his wife was harming him. She stated, "The facility was aware at the time of his admission in April (4/25/18) of the potential for his wife to physically abuse him. I spoke with the Admission's Coordinator (AC #1) at the time of his admission. I signed him in because we had a protective order in place for him. This was his 3rd admission to (facility). His wife signed him out against medical advice in October 2017 and tried to do the same thing in April (his second admission) but she couldn't because of the protective order. So in the beginning of April he improved tremendously and because we didn't have concrete evidence of abuse he went home with her. He was re-admitted to the hospital with multiple fractures again in April, and re-admitted to the facility. The facility and hospital speculated his wife was physically abusing him. I explained to the facility at the time of his last admission he was not to be left alone with her for his protection. (AC #1) told me they would only be allowed to meet in common areas, his door was to be kept open, he was put in a room up front near the Administrator's office (his room was approximately 100 feet from the Administrator's office) so it would be easy to hear if something was going on, and he was put in a semi-private room with an alert and oriented roommate." APS SW #1 also stated, "(The AC #1) said to me, 'You	F 600	(resident#84 wife) is currently posted at the front desk, and at each nurse's station for easy identification and notification effective 6/6/18. The photograph is located on the pertinent location where all employees can identify resident #84's wife. Facility Executive Director, Director of Nursing, and Social worker from Department of Social Services met briefly on 6/5/2018 to discuss the incident that happened on 6/4/2018. The team discussed the possible actions necessary to protect the resident from the spouse. Multiple ideas were discussed, such as room change, identify the resident with a different name, or transfer resident #84 to another location that the spouse will not be aware of. On 6/5/2018, the facility as well as the DSS social worker reached a conclusion that, the best course of action that will protect resident #84 from his spouse, while maintaining his dignity, self-determination, and reduce risk for deterioration from this event is to relocate resident #84 to another part of the facility. Resident #84's name was changed on 6/5/2018 to an alias to ensure his protection by the facility Director of Nursing, Executive Director and Admission Director. Resident #84 was relocated to another room in the facility on 6/5/2018 and the posted name in the facility was changed. Resident #84 was placed on every 15 minutes watch from 7pm on 6/4/2018 to 9am. One on one supervision was	

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F 600	Continued From page 11 know that woman is hurting him.' I told her I didn't disagree, but we needed proof of abuse. His room assignment and those protective measures were put into place before he was admitted last time. So the facility was well aware of the situation. When I asked them today what happened they told me they couldn't monitor him all the time. Now we are in the process of getting a Domestic Violence Protective Order, the (local) police are pressing assault charges, and she will be arrested this afternoon." An interview was conducted on 6/5/18 at 3:55 PM with AC #1. She stated she had no recall of any safety discussions with APS SW #1, just that he was under APS for "some type of on-going investigation." She stated Resident #84 was admitted in September 2017 and signed out against medical advice by his wife in October of 2017. He was re-admitted 3/8/18 by APS SW #1 and discharged home 4/5/18. He was admitted a third time by APS SW #1 on 4/25/18. She said they had suspicions of domestic violence but both Resident #84 and his wife denied it. An additional interview was conducted with AC#1 on 6/6/18 at 9:05 AM. She stated there were no plans in place for Resident #84's safety when he was admitted because APS had not told the facility what to do. She stated she knew there was a suspicion of neglect and abuse, but it was just a suspicion and denied any recall of safety details being discussed with APS SW #1 at the time of his last admission. An additional interview was conducted on 6/6/18 at 3:35 PM with APS SW #1 and AC #1. APS SW #1 stated she had spoken to AC #1 on the day of admission (4/25/18) and explained why Resident	F 600	initiated on 6/5/2018 in which an employee observe the resident at all times while in the facility. One on one supervision was discontinued on 6/27/2018, after the facility Quality Assurance and Improvement Committee determine that resident #84 is safe and protected from his wife with the other measures in place such as locking the means of egress, resident relocation to another room and change resident□s name. IDENTIFICATION OF OTHERS 100% audit of current residents financial files was completed by the Facility Admission Director and Business office manager on 6/6/2018 to identify any other resident with protective orders and validated the facility has measures in place to protect the resident from the alleged perpetrator. The audit revealed no other resident has protective orders related to abuse/neglect. Findings of this audit are documented on the "financial files audit tool" located in the facility compliance binder. On 06/06/2018, 100% interviews was completed by Director of Rehabilitation Center, Business office Manager, Activity Director, Medical Records Supervisor and MDS for all current alert and oriented residents in the facility to identify any other resident with an allegation of Abuse and/or Neglect. Two other residents, Resident #2, and Resident #3 voiced allegation of abuse and/or neglect.	

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F 600	Continued From page 12 #84 was admitted under a protective order and from whom he was being protected. It had always been a concern his wife was abusing him, but he had always been cognitively intact, until this admission, and had always denied abuse. He admitted to APS SW #1 his wife was the abuser on 6/5/18. APS SW #1 Stated, "On the day of admission (AC #1) told me she had concerns the wife was abusing him, but we had never been able to substantiate the abuse. We discussed putting him in a semi-private room for safety, on the main hall for more traffic and (AC #1) and I agreed to keep his door open when the wife visited. We talked about keeping visits to the common area, but realized she could hit him just as easily in the common area as in his room. I told them not to allow visits with the wife behind closed doors. The protective order I gave them stated he was to be protected from his wife related to neglect, but I needed proof of physical abuse and I never had that until Monday. Now there's a Domestic Violence Order of Protection (DVPO) in place." A review of the DVPO revealed it was issued 6/5/28 at 3:05 PM and named Resident #84's wife the defendant. An interview was conducted with MDS Nurse #1 (Minimum Data Set) on 6/6/18 at 11:20 AM. She stated, "I know APS was involved when (Resident #84) was placed here, but I didn't know there was a protective order in place until after the incident. I just did a care plan for safety today." No care plans related to the interventions APS SW #1 and AC #1 agreed to on 4/25/18 (the day of admission). An interview was conducted on 6/6/18 at 12:50	F 600	Alleged perpetrators identified were suspended while the investigation is conducted by the facility Executive director and/or Director of Nursing. 24 hour reports were submitted on 6/6/2018. A thorough investigation initiated. The resident's attending Physician and Responsible Party were notified of the allegation. Resident #2 and #3, 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. The Director of Social services, Assistant Director of Nursing, Unit manager, Admission Director and Director of Rehabilitation Services interviewed the responsible parties for residents who were not able to answer questions during this interview due to mental capacity. SYSTEMIC CHANGES Effective 6/7/2018, 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 month to identify any allegation of Abuse and/or Neglect. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse, and/or neglect 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. The Director of Social services, Assistant Director of Nursing, Unit manager,	

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F 600	Continued From page 13 PM with the Administrator and Director of Nursing (DON). They stated their expectations were all residents would be protected at all times from harm and abuse, but behavior could not be predicted. The Administrator stated systems were in place which helped protect residents (rounds, wander guards). Staff were in serviced on abuse at the time of hire and annually, and after an incident. The Administrator stated, "I don't feel our systems failed (Resident #84) because we couldn't predict the wife's behavior. There's a possibility she wasn't who he needed protection from. If I had concrete evidence it was her we would have had interventions in place. I had no suspicion he was being abused." An additional interview was conducted with the Administrator on 6/6/18 at 4:00 PM. He stated the Admission's Coordinator had not informed him of the APS protective order at the time of admission. An interview was conducted on 6/6/18 at 9:15 AM with the Medical Records Director. She stated the staff were in serviced on abuse annually and as needed. The 1st thing done was the resident in danger was removed and brought to safety. They stayed with resident until told by administration to do otherwise. She stated, at the time of Resident #84's admission the safety measures in place included to keep him in a room with high traffic, his door and curtains remained open when his wife visited, and they were kept in the common areas as often as possible. She stated there was 'hearsay' and suspicion he was being abused by his wife at admission. She also stated when she asked Resident #84 if he was alright he said yes and, "She didn't mean to hurt me." The Medical Records Director also stated the facility had kept Resident #84's door and curtain open whenever	F 600	Admission Director and Director of Rehabilitation Services will interview the responsible parties for residents who will not able to answer questions during the interview related to allegation of Abuse and/or Neglect due to mental capacity deficit. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse, and/or neglect 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 6/7/2018 a copy of any resident□s protective orders received on admission or readmission by the admission director or designated person during the admission process, will be placed in the medical file under the advance directive tab for easy identification and accessibility by the nursing staff. Effective 6/7/2018, the center nursing administrative team, which includes DON, Nurse supervisors, Unit Managers, and/or SDC, added reviewing of DSS protective orders to an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours. By adding the review of DSS protective orders to this process, it will ensure that any resident with prior history of allegation of abuse, neglect, and/or injuries of unknown sources has appropriate measures in place to protect	

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F 600	Continued From page 14 his wife visited him in his room since his 2nd admission. An interview was conducted on 6/6/18 at 9:30 AM with the facility physician (MD). He stated he was not aware resident #84 was here under APS protective order, but he was notified of the resident's assault on Tuesday (6/5/18) morning. He also stated, "If the facility was aware he was here under APS protection they never should have let the wife visit him alone under any circumstances. Today he is remarkably alert and oriented. He told me his wife in no way abused him, but the court order he came in with is very clear. He should not have been left alone with any visitors, except (the APS SW #1). It was the facility's responsibility to protect this man from being abused. Even if they could not prevent her from visiting him, they never should have left them alone. A staff member should have been present during all visits. I was notified Tuesday morning that his wife was seen abusing him. I was told the facility assessed him for injuries, and I saw him today." An interview was conducted with Resident #84's roommate on 6/6/18 at 11:30 AM. He stated, "I was in the room when his wife was shoving and hitting him. I saw her hit him before too. When she hit him before I told the Nursing Assistants (NA's), but she still came in closed the door and curtain all the time. When she's in here, and I'm in here the door is supposed to be open. I don't like what she did to him." The roommate was not able to state which NA's he told or when he told them about what he saw. The Administrator, DON and Corporate Consultant were notified of the immediate	F 600	the resident from the alleged perpetrator, effective 6/7/2018. This process with take place daily Monday through Fridays effective 6/7/2018. The result of this systemic process will be documented on the clinical meeting form maintained in the Daily Clinical meeting binder. Effective 6/7/2018, the 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 and/or injuries of unknown sources reported/documented is investigated thoroughly, the alleged perpetrator is suspended pending investigation, and ensure the event is reported to the facility Executive Director. This process will also incorporate reviewing of any DSS protective orders to ensure the facility put measures in place to address such orders. 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 6/7/2018. Effective 6/7/2018 the Admission Director (AD) will print any protective order for any referral to the facility before bed is offered. The AD will then provide copies of the protective order to the facility Executive Director, Director of Nursing, Director of social services and/or designated licensed nurse. The IDT team will then review all referrals with DSS protective orders prior	

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F 600	Continued From page 15 jeopardy on 6/6/18 at 2:55 PM. On 6/7/18 at 10:48 PM the facility provided the following credible allegation of compliance and immediate jeopardy removal: "This alleged noncompliance resulted from the center's failure to protect one resident with prior history of suspected domestic abuse from a spouse. On 4/25/2018 the facility admitted resident #84 for rehabilitation and long term care placement. Resident #84 had a protective order named "Ex parte order" filed in Harnett County Clerk of Superior Court on 4/24/2018. The protective order was presented to the facility at the time of admission on 4/25/2018 by the assigned Social worker from the Department of Social Services. The protective order included information that the "department of Social services is concerned with the possibility of physical abuse and neglect", it also added that "Without a protective order department of Social Services is concerned the wife will remove respondent from the hospital/rehab." The root cause analysis, concluded that, the systemic failure that resulted onto resident #84 incident on 6/4/2018 includes, broken communication process from admission for necessary information to include protective orders for resident #84. As a result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions to protect resident #84. The broken communication process resulted from a lack of a systemic process set forth on how protective orders was to be communicated by the admission Director to the rest of the IDT. Although the facility received the documentation on admission on 4/25/2018, and was notified by	F 600	to admitting resident to the facility to ensure measures are put in place to protect the resident when admitted to the facility. Effective 6/7/2018; received protective orders will be added to resident□s care plan by the Admitting nurse and/or Nursing supervisor and nursing aide care guide for accessibility by both license nurses and nurse aides. If the protective order includes guidelines such as supervised visits, no visitation, or not allowed on the premises such measures will be added to resident□s face sheet and appropriate information posted such as the perpetrator picture and/or description in a readily accessible location in the facility. Facility Director of Nursing (DON), Assistant Director of Nursing and/or Unit manager will complete 100% education on the location of protective orders in each resident□s medical charts and the location of intervention necessary to protect the resident with protective orders. This education will also cover process to be taken if the protective order to include adding the protective order interventions to resident□s care plan and to nursing aide care guide for accessibility by both license nurses and nurse aides. Guidelines such as supervised visits, no visitation, or not allowed on the premises will also be covered in this education. The education will also emphasize on the process that such information will be added to resident□s face sheet and appropriate information posted such as the perpetrator picture and/or description	

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F 600	Continued From page 16 the DSS social worker of the protective orders of this resident, there is no indication that the facility put forth measures to protect Resident #84 from his wife. Admission Director failed to communicate the pertinent information to the interdisciplinary team necessary to insure resident #84 was protected while in the facility from his wife. On 6/4/2018 the resident's spouse was witnessed by the facility Activity Aide, & Central Supply Aide #1 in the room with the Resident #84. Activity Aide and Central Supply Aide stated they witnessed resident's spouse kicking resident's leg and stepping on his feet. Resident and the spouse were immediately separated by the Central Supply Aide. A Complete Head to toe body assessment was completed by the Registered nurse Supervisor #1. No injuries noted, resident denied any signs and symptoms of pain or discomforts. Initial report for the alleged abuse was completed and sent on 6/4/2018, DSS social worker and the attending Physician notified. IMMEDIATE ACTION TAKEN On 6/04/2018 at approximately 5:00PM the Central supplies aide separated resident #84 from his wife by pushing him out of the room to the hallway. The central supplies aide remained with resident #84 on the hallway, and notified Assistant Director of nursing who was standing in the proximity at the nurse's station #2. ADON walked towards the resident accompanied by the Unit Manager #1 who relieved the central supplies aide and took over supervision and protection of resident #84. Unit Manager #1 completed a head to toe assessment of the	F 600	to be a readily accessible location in the facility. This education will be provided for all licensed nurses, nursing assistant to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses and nursing aides effective 6/7/2018, and will also be provided annually. Effective 6/7/2018 the facility Executive Director, Director of Nursing, and/or Director of social services will discuss new admits and re-admits to the facility during their daily department head meeting to validate that any admitted or readmitted resident with protective orders has measures in place to protect the resident against the alleged perpetrators. Effective 6/7/2018 any alleged perpetrator with restraining orders for visitation will not be allowed to visit the facility. All the facility exit doors are locked and can only be accessed using an approved card. Visitors will utilize the facility main entrance to enter the premises, effective 6/7/18. All the facility exit doors are locked using a magnetized lock that releases in case of fire. In case of any other emergency, each locked facility exit door is equipped with an emergency release override switch located beside each exit door to allow the door to demagnetize and open from the inside. The magnetic lock	

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F 600	Continued From page 17 resident and noted no injuries. Resident denied pain or discomforts. Central supplies aide notified a Medical records supervisor who was standing at the nurse station #1. Medical records aide walked to the resident's room immediately and met Unit Manager #1 in the room. Medical records aide assisted Unit manager #1 while the Unit manager was assessing the patient. Unit Manager #1 and Medical Records supervisor transferred resident #84 to the wheel chair and moved the resident to the dining area. Medical Records supervisor remained with resident #84 until the police arrived with a brief period when she was relieved by the transportation aide who stayed with the resident when Medical Records supervisor departed. Likewise, the ADON who left Unit Manager #1 with resident#84 walked to the Executive Director's office for notification. On 06/04/2018 the 24 hour initial report was sent to the Department of Health and Human Services related to resident #84's witnessed abuse by the spouse. These reports were completed and submitted by the Director of Nursing. The Five day report was completed on 6/7/2018 after a detail investigation was conducted by the Center Executive Director, Director of Social Services and Director of Nursing. The incident on 6/4/2018 against resident #84 was substantiated based on findings of the investigation conducted by the Facility, Department of Social Services, and Harnett county Police Department. Resident #84's spouse is ordered by the court not to visit or be in contact with the resident effective 6/5/2018. Facility has yet to receive a confirmation of actions taken legally against the spouse. Facility will keep resident on 1 on 1 until confirmation is obtained of the spouse's inability	F 600	system is also equipped with a master override switch located at each nurse□s station. This is in compliance with North Carolina life safety code. Signs have been posted on all exit doors to direct visitors to the main entrance, effective 6/7/18. Facility Executive Director, Director of Nursing (DON), Assistant Director of Nursing and/or Director of Social Services will complete 100% re-education on the location of protective orders in each resident□s medical charts and the importance of implementing approaches to ensure the resident□s protection. This education will be provided for all licensed nurses, to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses effective 6/7/2018, and will also be provided annually. MONITORING PROCESS Effective 6/7/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with resident protection, thorough investigation, injuries of unknown sources and resident neglect by conducting clinical meeting daily. This meeting will allow the team to review all allegation of abuse, incidents or accidents that occurred from the prior clinical meeting. Any DSS protective orders and any documented information that indicate	

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F 600	Continued From page 18 to come to the facility. The photograph of the alleged perpetrator (resident#84 wife) is currently posted at the front desk, and at each nurse's station for easy identification and notification effective 6/6/18. The photograph is located on the pertinent location where all employees can identify resident #84's wife. Facility Executive Director, Director of Nursing, and Social worker from Department of Social Services met briefly on 6/5/2018 to discuss the incident that happened on 6/4/2018. The team discussed the possible actions necessary to protect the resident from the spouse. Multiple ideas were discussed, such as room change, identify the resident with a different name, or transfer resident #84 to another location that the spouse will not be aware of. On 6/5/2018, the facility as well as the DSS social worker reached a conclusion that, the best course of action that will protect resident #84 from his spouse, while maintaining his dignity, self-determination, and reduce risk for deterioration from this event is to relocate resident #84 to another part of the facility. Resident #84's name was changed on 6/5/2018 to an alias to ensure his protection by the facility Director of Nursing, Executive Director and Admission Director. Resident #84 was relocated to another room in the facility on 6/5/2018 and the posted name in the facility was changed. Resident #84 was placed on every 15 minutes watch from 7pm on 6/4/2018 to 9am. One on one supervision was initiated on 6/5/2018 in which an employee observe the resident at all times while in the facility. One on one care will continue until the	F 600	suspicion of abuse will be reviewed to ensure measures are in place to protect the resident. 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 the clinical meeting binder after proper follow up is done. This monitoring process will take place daily for 4weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 6/7/2018, 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 6/7/2018, 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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facility receives confirmation that resident #84's wife is arrested.

IDENTIFICATION OF OTHERS

100% audit of current residents financial files was completed by the Facility Admission Director and Business office manager on 6/6/2018 to identify any other resident with protective orders and validated the facility has measures in place to protect the resident from the alleged perpetrator. The audit revealed no other resident has protective orders related to abuse/neglect. Findings of this audit are documented on the "financial files audit tool" located in the facility compliance binder.

On 06/06/2018, 100% interviews was completed by Director of Rehabilitation Center, Business office Manager, Activity Director, Medical Records Supervisor and MDS for all current alert and oriented residents in the facility to identify any other resident with an allegation of Abuse and/or Neglect. Two other residents, Resident #2, and Resident #3 voiced allegation of abuse and/or neglect. Alleged perpetrators identified were suspended while the investigation is conducted by the facility Executive director and/or Director of Nursing. 24 hour reports were submitted on 6/6/2018. A thorough investigation initiated. The resident's attending Physician and Responsible Party were notified of the allegation. Resident #2 and #3, 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.
The Director of Social services, Assistant Director of Nursing, Unit manager, Admission Director and Director of Rehabilitation Services interviewed the

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responsible parties for residents who were not able to answer questions during this interview due to mental capacity.

MONITORING PROCESS

Effective 6/7/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with resident protection, thorough investigation, injuries of unknown sources and resident neglect by conducting clinical meeting daily. This meeting will allow the team to review all allegation of abuse, incidents or accidents that occurred from the prior clinical meeting. Any DSS protective orders and any documented information that indicate suspicion of abuse will be reviewed to ensure measures are in place to protect the resident. 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 the clinical meeting binder after proper follow up is done. This monitoring process will take place daily for 4weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.

Effective 6/7/2018, 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

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F 600	Continued From page 21 Effective 6/7/2018, 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." The credible allegation for immediate jeopardy removal was validated on 6/8/18, which removed the IJ on 06/07/18, as evidenced by staff interviews, in-service record reviews, and observations. The in service included information r/t Resident #84's new alias, new room number, and what action was to be taken if his wife was observed on the facility property. Other observations included one on one (1:1) staff with Resident #84, monitored entry and exits from the facility's main entrance, and a photograph of Resident #84's wife posted at every nursing station and ante room. A care plan was initiated 6/6/18 and focused on "Safety: At risk for injury and social isolation r/t spousal abuse." The stated goals included maintained safety from his wife. Interventions included, but were not limited to, relocation to another room, identify by a different name, 1:1 supervision, staff education on name change, room change, safety interventions, monitoring for changes in mood or behavior, and an approved visitor list.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and	F 607		7/10/18

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F 607	Continued From page 22 misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed implement the policy to screen the resident, prevent abuse and protect 1 of 3 residents (Resident #84) from visitor to resident physical abuse. The facility failed to implement measures specified by the Department of Social Services Adult Protective Services Social Worker prior to Resident #84's admission on 4/25/18 to protect him from being physically abused. Following the physical assault Resident #84 was assessed and did not have any physical injuries and did not require medical treatment. Immediate jeopardy began on 6/4/18 when 2 witnesses observed Resident #84 seated in his room in a wheelchair speaking loudly and shaking both arms in front of his head. A female visitor, identified as his wife, was observed seated on the bed close to Resident #84 hitting, kicking and stomping on Resident #84. No physical injuries were assessed. Immediate jeopardy was removed on 6/7/18 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.	F 607	F607 This alleged noncompliance resulted from the center's failure to follow the abuse policy and procedures that led to not protecting one resident with prior history of suspected domestic abuse from a spouse. On 4/25/2018 the facility admitted resident #84 for rehabilitation and long term care placement. Resident #84 had a protective order named "Ex parte order" filed in Harnett County Clerk of Superior Court on 4/24/2018. The protective order was presented to the facility at the time of admission on 4/25/2018 by the assigned Social worker from the Department of Social Services. The protective order included information that the "department of Social services is concerned with the possibility of physical abuse and neglect", it also added that "Without a protective order department of Social Services is concerned the wife will remove respondent from the hospital/rehab." This alleged noncompliance resulted from the facility failure to implement abuse policies and procedures on the area of proper screening, identification, protection and reporting that resulted from the broken communication process from	

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F 607	Continued From page 23 Findings included: The facility's Abuse Prevention, intervention, Reporting and Investigation policy dated 11/2016 and revised June 2017 read, in part, "Purpose: The purpose of this policy is to ensure all residents have the right to be free from abuse. The facility will ensure the prevention, protection, in response to alleged, suspected, or witnessed abuse." The policy also read, in part, "Definitions: 1. Abuse-willful infliction of injury, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition cause physical harm, pain, or mental anguish. Abuse may be resident to resident, staff to resident, or visitor to resident. Physical Abuse-defined as non-accidental use of physical force that may result in bodily injury, physical pain, or impairment. Examples include, but are not limited to hitting, slapping, pinching, and kicking." The policy also read, in part, "The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention. The seven key components of an abuse prevention system can potentially detect, reduce, and prevent abuse from occurring. Overview of seven components: screening, training, prevention, identification, investigation, protection, reporting and response." The policy also read, in part, "Protection: It is our policy that the resident(s) will be protected from the alleged offender(s). 4. Patient protection actions include immediately removing the patient from contact with the alleged abuser during the investigation. If the alleged abuser is not an employee, measures are taken to provide a safe, secure environment for the patient. Actions may include: patient room change, patient daily	F 607	resident's admission to the facility for necessary information to include protective orders for resident #84. As the result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions to protect resident #84. Root cause analysis also concluded that the facility miss-interpreted regulatory requirements that requires the facility to protect each resident while in the facility, and reporting any allegation of abuse immediately but no later than two hours after the allegation is made. The facility also failed to follow the policies and procedures to put measures in place to protect residents while in the facility even when they are under the custody of DSS. The root cause analysis, concluded that, the systemic failure that resulted onto resident #84 incident on 6/4/2018 includes, broken communication process from admission for necessary information to include protective orders for resident #84. As a result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions to protect resident #84. The broken communication process resulted from a lack of a systemic process set forth on how protective orders was to be communicated by the admission Director to the rest of the IDT. Although the facility received the documentation on admission on 4/25/2018, and was notified by the DSS	

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F 607	Continued From page 24 schedule change, visitor restrictions, reporting to other agencies or law enforcement." Review of Resident #84's hospital discharge summary dated 4/25/18 read, in part, "Problems: (2) closed fracture of pubic ramus; (3) fracture of radius, distal right, closed (forearm); (4) nasal fracture; (5) assault; (7) neglected elder. Suspected abuse by pt.'s (Resident #84) wife." Review of the order of protection (known as a Petition for Ex Parte Order) dated 4/24/18 provided to the facility on 4/25/18 by the Department of Social Services (DSS), Adult Protective Services (APS)read, in part, "The undersigned petitioner (DSS Director of the county DSS) and through his representative (APS Social Worker-APS SW #1) having sufficient knowledge to believe the respondent (Resident #84) is in need of protective services alleges: 3. The respondent (Resident #84) is a disabled adult who is in need of protective services based on the following specific facts, j. without a protective order DSS is concerned the wife will remove respondent (Resident #84) from the hospital/rehab (rehabilitation)." Review of Resident #84's medical record revealed he was admitted from the hospital to the facility on 04/25/18 with admitting diagnoses including: Colles' fracture of right radius (forearm), fracture of nasal bones, fracture of right pubis, history of falling, Parkinson's, unspecified dementia with behavioral disturbances, displaced fracture of head of right radius, and cognitive communication deficit. A 5 day MDS (Minimum Data Set-a tool used for resident assessment) dated 5/2/18 revealed	F 607	social worker of the protective orders of this resident, there is no indication that the facility put forth measures to protect Resident #84 from his wife. Admission Director failed to communicate the pertinent information to the interdisciplinary team necessary to insure resident #84 was protected while in the facility from his wife. On 6/4/2018 the resident's spouse was witnessed by the facility Activity Aide, & Central Supply Aide #1 in the room with the Resident #84. Activity Aide and Central Supply Aide stated they witnessed resident's spouse kicking resident's leg and stepping on his feet. Resident and the spouse were immediately separated by the Central Supply Aide. A Complete Head to toe body assessment was completed by the Registered nurse Supervisor #1. No injuries noted, resident denied any signs and symptoms of pain or discomforts. Initial report for the alleged abuse was completed and sent on 6/4/2018, DSS social worker and the attending Physician notified. IMMEDIATE ACTION TAKEN The Chief Clinical officer from the Management and consulting company that manages the center, re-educated the Center Executive Director and the Director of Nursing 6/7/2018 on the center Abuse Prohibition and Investigation policies and procedures, and emphasized the importance of screening, identification, protecting and reporting to the regulatory required agencies immediately but no	

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F 607	Continued From page 25 Resident #84 was admitted 4/25/18 from an acute care hospital. He was cognitively intact and required extensive to total assistance for all activities of daily living. He had 1 upper limb (arm) impairment and active diagnoses included other fracture, non-Alzheimer's dementia, and Parkinson's disease. Review of Resident #84's medical record revealed a nursing note dated 6/4/18 at 7:27 PM which read, "Staff was walking past resident's room at 4:42 PM when they noted resident with his hands in the air and yelling. The resident's spouse was noted kicking him on the legs and stepping on his feet. Resident denied pain and no bruising was evident. Resident was supervised for safety and police were notified and responded. The resident's wife spouse was escorted from the building and is not to return until further notice." An incident report dated 6/4/18 indicated the incident type was an allegation of abuse, which occurred in the resident's room. A narrative of the incident read, "Staff was walking past resident's room at 4:42 PM when they noted resident with his hands in the air and yelling. The resident's spouse was noted kicking him on the legs and stepping on his feet. Resident denied pain and no bruising was evident. Resident was supervised for safety and police were notified and responded. The resident's wife spouse was escorted from the building and is not to return until further notice." A statement provided on 6/4/18 to the facility by Witness #1 read, "I witnessed (Resident #84) being physically abused by his relative. I was walking down (the hall Resident #84 resided on)	F 607	later than two hours from the time the allegation is made. The education also emphasized on the importance of ensuring residents are screened for potential abuse and measures are put forth to protect them while residing in the facility. The Chief Clinical officer from the Management and consulting company that manages the center, re-educated facility management team that consist of the department supervisors on the center's Abuse Prohibition and Investigation policies and procedures, and emphasized on the importance of screening patients and employees before hire, protecting resident(s), and reporting any allegation of abuse or Neglect to their Direct supervisor and the Executive Director in a timely manner as well as to the Regulatory required agencies immediately but no later than 2 hours after forming suspicion, witness the abuse and/or after a resident, another staff and/or family member alleged abuse. On 6/04/2018 at approximately 5:00PM the Central supplies aide separated resident #84 from his wife by pushing him out of the room to the hallway. The central supplies aide remained with resident #84 on the hallway, and notified Assistant Director of nursing who was standing in the proximity at the nurse's station #2. ADON walked towards the resident accompanied by the Unit Manager #1 who relieved the central supplies aide and took over supervision and protection, per	

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F 607	Continued From page 26 when I noticed (Resident #84) yelling with his hands held high. (Resident #84) relative whom is his wife was physically abusing him by kicking his legs and stomping on his feet. This incident happened approximately at 4:42 PM." An interview was conducted 6/5/18 at 11:50 AM with Witness #1 (Central Supply Clerk) She stated on 06/04/18 as she walked down the hall Resident #84 resided on she heard him speaking loudly and saw his hands up and shaking. She stated he was in his wheelchair and his wife was observed kicking his legs and stomping his feet. She also stated, "She was abusing him." She stated she intervened and asked Resident #84 if he was alright, but received no response. She stated she removed Resident #84 from the room and brought him to the common area where she and another staff member (Medical Records Director) stayed with him until police arrived. She also stated, "This is his second or third admission here. I think he was here under a protective order the second time because his wife physically abused him. This is his third admission and I believe he's under protective custody now." She stated the wife visited frequently during the second admission, but had not visited as often this admission. A statement provided on 6/4/18 to the facility by Witness #2 read, "I, (Witness #2) walked by resident room (Resident #84) and saw him and his wife hitting each other. Ask her to step out and told (nurse) about it." An interview was conducted on 6/5/18 at 1:10 PM with Witness #2 (Activities Aide). She stated on 06/04/18 she walked by Resident #84's room and observed Resident #84 and his wife hitting each	F 607	facility abuse prohibition process of resident #84, per the facility abuse policy and procedures. Unit Manager #1 completed a head to toe assessment of the resident and noted no injuries. Resident denied pain or discomforts. Central supplies aide notified a Medical records supervisor who was standing at the nurse station #1. Medical records aide walked to the resident's room immediately and met Unit Manager #1 in the room. Medical records aide assisted Unit manager #1 while the Unit manager was assessing the patient. Unit Manager #1 and Medical Records supervisor transferred resident #84 to the wheel chair and moved the resident to the dining area. Medical Records supervisor remained with resident #84 until the police arrived with a brief period when she was relieved by the transportation aide who stayed with the resident when Medical Records supervisor departed. Likewise, the ADON who left Unit Manager #1 with resident#84 walked to the Executive Director's office for notification. On 06/04/2018 the 24 hour initial report was sent to the Department of Health and Human Services related to resident #84's witnessed abuse by the spouse. These reports were completed and submitted by the Director of Nursing. The Five day report was completed on 6/7/2018 after a detail investigation was conducted by the Center Executive Director, Director of Social Services and Director of Nursing. The incident on	

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F 607	Continued From page 27 other. She stated, "I have seen his wife visit quite often but I had never seen a physical interaction before. When he was on the rehab (rehabilitation) hall she stayed with him all the time, but this admission she wasn't here so much. When we (Witness #1 and Witness #2) saw her hitting him we took him out of the room immediately. We put him in the TV room, she followed, and had (Medical Records Director) stay with them." Witness #2 was not aware of any visitor restrictions for Resident #84. Review of Resident #84's care plans since the date of admission (4/25/18) revealed no care plan related to safety measures for Resident #84 was initiated until after the witnessed physical abuse on 06/04/18. An interview was conducted on 6/5/18 at 3:00 PM with APS SW#1. She stated she was called to the hospital in April related to (r/t) (Resident #84's) 3rd admission to the hospital since October 2017 for multiple fractures and bruises. She also stated they (APS) suspected his wife was harming him. She stated, "The facility was aware at the time of his admission in April (4/25/18) of the potential for his wife to physically abuse him. I spoke with the Admission's Coordinator (AC #1) at the time of his admission. I signed him in because we had a protective order in place for him. This was his 3rd admission to (facility). His wife signed him out against medical advice in October 2017 and tried to do the same thing in April (his second admission) but she couldn't because of the protective order. So in the beginning of April he improved tremendously and because we didn't have concrete evidence of abuse he went home with her. He was re-admitted to the hospital with multiple fractures again in April, and re-admitted	F 607	6/4/2018 against resident #84 was substantiated based on findings of the investigation conducted by the Facility, Department of Social Services, and Harnett county Police Department. Resident #84's spouse is ordered by the court not to visit or be in contact with the resident effective 6/5/2018. The photograph of the alleged perpetrator (resident#84 wife) is currently posted at the front desk, and at each nurse's station for easy identification and notification effective 6/6/18. The photograph is located on the pertinent location where all employees can identify resident #84's wife. Facility Executive Director, Director of Nursing, and Social worker from Department of Social Services met briefly on 6/5/2018 to discuss the incident that happened on 6/4/2018. The team discussed the possible actions necessary to protect the resident from the spouse. Multiple ideas were discussed, such as room change, identify the resident with a different name, or transfer resident #84 to another location that the spouse will not be aware of. On 6/5/2018, the facility as well as the DSS social worker reached a conclusion that, the best course of action that will protect resident #84 from his spouse, while maintaining his dignity, self-determination, and reduce risk for deterioration from this event is to relocate resident #84 to another part of the facility. Resident #84's name was changed on 6/5/2018 to an alias to ensure his	

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F 607	Continued From page 28 to the facility. The facility and hospital speculated his wife was physically abusing him. I explained to the facility at the time of his last admission he was not to be left alone with her for his protection. (AC #1) told me they would only be allowed to meet in common areas, his door was to be kept open, he was put in a room up front near the Administrator's office (his room was approximately 100 feet from the Administrator's office) so it would be easy to hear if something was going on, and he was put in a semi-private room with an alert and oriented roommate." APS SW #1 also stated, "(The AC #1) said to me, 'You know that woman is hurting him.' I told her I didn't disagree, but we needed proof of abuse. His room assignment and those protective measures were put into place before he was admitted last time. So the facility was well aware of the situation. When I asked them today what happened they told me they couldn't monitor him all the time. Now we are in the process of getting a Domestic Violence Protective Order, the (local) police are pressing assault charges, and she will be arrested this afternoon." A copy of the DVPO was reviewed and revealed it was put in place, against Resident #84's wife, on 6/5/18 at 3:08 PM and read, in part, "4. The Defendant (wife) has attempted to cause or has intentionally caused me bodily injury, or has placed me in fear of imminent bodily injury. 4 June 2018- An aid at (facility name) heard a commotion coming from the Plaintiffs (Resident #84) room, then observed the Plaintiff seated I his wheelchair with his arms raised in an attempt to protect himself from the Defendant who was slapping him, punching him, kicking him about the kneecaps & (and) stomping on his feet. The facility had previously been instructed by HCDSS	F 607	protection, per facility abuse prohibition process by the facility Director of Nursing, Executive Director and Admission Director. This measure is in alignment with the facility abuse policy and procedure. Resident #84 was relocated to another room in the facility on 6/5/2018 and the posted name in the facility was changed. Resident #84 was placed on every 15 minutes watch from 7pm on 6/4/2018 to 9am. One on one supervision was initiated on 6/5/2018 in which an employee observe the resident at all times while in the facility. One on one supervision was discontinued on 6/27/2018, after the facility Quality Assurance and Improvement Committee determine that resident #84 is safe and protected from his wife with the other measures in place such as locking the means of egress, resident relocation to another room and change resident□s name. 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 documentation in any resident medical records that indicate allegation of abuse, neglect, or injury of unknown sources, 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	

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F 607	Continued From page 29 (Harnett County Department of Social Services) to not allow any supervised contact between Plaintiff & Defendant." The facility's Abuse Prevention, intervention, Reporting and Investigation policy dated 11/2016 and revised June 2017 read, in part, "The center has developed a system (Seven Key Components which included screening and protection) for identifying, preventing, and reporting any incident or suspected incident of any type of abuse." The Abuse Policy further read, in part, "Protection- Patient protection actions include immediately removing the patient from contact with the alleged abuser. If the alleged abuser is not an employee, actions may include: patient room change, patient daily schedule change, visitor restrictions." An interview was conducted on 6/5/18 at 3:55 PM with AC #1. She stated she had no recall of any safety discussions with APS SW #1, just that he (Resident #84) was under APS for "some type of on-going investigation." She stated Resident #84 was admitted in September 2017 and signed out against medical advice by his wife in October of 2017. He was re-admitted 3/8/18 by APS SW #1 and discharged home 4/5/18. He was admitted a third time by APS SW #1 on 4/25/18. She said they had suspicions of domestic violence but both Resident #84 and his wife denied it. An additional interview was conducted with AC #1 on 6/6/18 at 9:05 AM. She stated there were no plans in place for Resident #84's safety when he was admitted on 4/25/18 because APS had not told the facility what to do. She stated she knew there was a suspicion of neglect and abuse, but it was just a suspicion and denied any recall of	F 607	and/or Elder Justice Act. The audit revealed two other documented allegation of abuse, and/or neglect documented in resident medical records. This audit was completed on 6/6/18 & 6/7/18. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. 100% audit was completed by the Center executive Director for all allegation of abuse and/or neglect submitted in the past from 1/24/2018 to 6/7/2018 determine if the alleged perpetrator was suspended during investigation to protect the resident, 24 hours completed within 2 hours of the allegation and 5 days completed and submitted to the state agency as required by regulation and Elder Justice Act in a timely manner. The audit revealed 5 of 5 completed abuse/neglect reports indicated the alleged perpetrator was suspended pending investigation per abuse prohibition policy and procedure, however all 5 of 5 initial 24 hour reports were not submitted within two hours of the allegation. 2 months noted with detail investigation and the Alleged Perpetrator(s) were suspended. This audit was completed on 6/7/2018. On 06/06/2018, 100% interviews was completed by Director of Rehabilitation Center, Business office Manager, Activity Director, Medical Records Supervisor and MDS for all current alert and oriented residents in the facility to identify any other resident with an allegation of Abuse	

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F 607	Continued From page 30 safety details being discussed with APS SW #1 at the time of his last admission. An additional interview was conducted on 6/6/18 at 3:35 PM with APS SW #1 and AC #1. APS SW #1 stated she had spoken to AC #1 on the day of Resident #84's admission to the facility (4/25/18) and explained why Resident #84 was admitted under a protective order and from whom he was being protected. It had always been a concern his wife was abusing him, but he had always been cognitively intact until this admission and had always denied abuse. He admitted his wife was the abuser on 6/5/18. APS SW #1 Stated, "On the day of admission (AC #1) told me she had concerns the wife was abusing him, but we had never been able to substantiate the abuse. We discussed putting him in a semi-private room for safety, on the main hall for more traffic and (AC #1) and I agreed to keep his door open when the wife visited. (This occurred) We talked about keeping visits to the common area, but realized she could hit him just as easily in the common area as in his room. I told them not to allow visits with the wife behind closed doors. The protective order I gave them stated he was to be protected from his wife related to neglect, but I needed proof of physical abuse and I never had that until Monday (6/4/18). Now there's a Domestic Violence Order of Protection (DVPO) in place." An interview was conducted with MDS Nurse #1 (Minimum Data Set) on 6/6/18 at 11:20 AM. She stated, "I know APS was involved when (Resident #84) was placed here (4/25/18), but I didn't know there was a protective order in place until after the incident on 06/04/18. I just did a care plan for safety today."	F 607	and/or Neglect. Two other residents, Resident #2, and Resident #3 voiced allegation of abuse and/or neglect. Alleged perpetrators identified were suspended while the investigation is conducted by the facility Executive director and/or Director of Nursing. 24 hour reports were submitted on 6/6/2018. A thorough investigation initiated. The resident's attending Physician and Responsible Party were notified of the allegation. Resident #2 and #3, 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. The Director of Social services, Assistant Director of Nursing, Unit manager, Admission Director and Director of Rehabilitation Services interviewed the responsible parties for residents who were not able to answer questions during this interview due to mental capacity deficit on 6/7/18. No family member voiced any allegation of abuse and/or neglect. SYSTEMIC CHANGES Effective 6/7/2018, all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation is made to the administrator of the facility and to other officials to include; the State Survey Agency, adult protective services, the state Ombudsmen in accordance with	

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F 607	Continued From page 31 An interview was conducted on 6/6/18 at 12:50 PM with the Administrator and Director of Nursing (DON). They stated their expectations were all residents would be protected at all times from harm and abuse, but behavior could not be predicted. The Administrator stated systems were in place which helped protect residents (rounds, wander guards). Staff were in serviced on abuse at the time of hire and annually and after an incident. The Administrator stated, "I don't feel our systems failed (Resident #84) because we couldn't predict the wife's behavior. There's a possibility she wasn't who he needed protection from. If I had concrete evidence it was her we would have had interventions in place. I had no suspicion he was being abused." An additional interview was conducted with the Administrator on 6/6/18 at 4:00 PM. He stated AC #1 had not informed him of the APS protective order at the time of admission on 4/25/18. An interview was conducted on 6/6/18 at 9:15 AM with the Medical Records Director. She stated the staff were in serviced on abuse annually and as needed. The first thing done was the resident in danger was removed and brought to safety. They stayed with resident until told by administration to do otherwise. She stated, at the time of Resident #84's admission to the facility on 4/25/18, the safety measures in place included to keep him in a room with high traffic (it was), his door and curtains remained open when his wife visited (they were), and they were kept in the common areas as often as possible. She stated there was 'hearsay' and suspicion he was being abused by his wife at admission. She also stated when she asked Resident #84 on the day of the assault (6/4/18) if he was alright he said yes and, "She	F 607	State law through established facilities policies and procedures. Effective 6/7/2018, The facility 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 6/7/2018, the facility interdisciplinary team to include Executive Director, Director of Nursing, Director of Social services and at least three other department supervisors will attend a monthly mandatory training that will be conducted by contracted management and consulting company that oversees the facility. This training will put an emphasis on all seven components of abuse prohibition to include screening, training, prevention, identification, investigation, protection, reporting and responses. This training will take place monthly for next twelve months or until the pattern of compliance is maintained. Effective 6/7/2018, the Center Director of Human Services, and/or employee direct supervisor 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. The interview process will be	

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F 607	Continued From page 32 didn't mean to hurt me." The Medical Records Director also stated the facility had kept Resident #84's door and curtain open whenever his wife visited him since his 2nd admission. An interview was conducted on 6/6/18 at 9:30 AM with the facility physician (MD). He stated he was not aware resident #84 was here under APS protective order, but he was notified of the resident's assault on Tuesday (6/5/18) morning. He also stated, "If the facility was aware he was here under APS protection they never should have let the wife visit him alone under any circumstances. Today he is remarkably alert and oriented. He told me his wife in no way abused him, but the court order he came in with is very clear. He should not have been left alone with any visitors, except (the APS SW #1). It was the facility's responsibility to protect this man from being abused. Even if they could not prevent her from visiting him, they never should have left them alone. A staff member should have been present during all visits. I was notified Tuesday morning that his wife was seen abusing him. I was told the facility assessed him for injuries, and I saw him today." An interview was conducted with Resident #84's roommate on 6/6/18 at 11:30 AM. He stated, "I was in the room when his wife was shoving and hitting him. I saw her hit him before too. When she hit him before I told the Nursing Assistants (NA's), but she still came in closed the door and curtain all the time. When she's in here, and I'm in here the door is supposed to be open. I don't like what she did to him." The roommate was not able to state which NA's he told or when he told them about what he saw.	F 607	incorporated to the annual employee evaluating. Any staff member not interviewed by the anniversary date will not be allowed to work until educated. Effective 6/7/2018, 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 month to identify any allegation of Abuse and/or Neglect. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse, and/or neglect 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. The Director of Social services, Assistant Director of Nursing, Unit manager, Admission Director and Director of Rehabilitation Services will interview the responsible parties for residents who are not able to answer questions during the interview due to mental capacity deficit effective 6/7/18. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse, and/or neglect 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 6/7/2018 a copy of any resident's	

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F 607	Continued From page 33 The Administrator, Director of Nursing, and Corporate Consultant were notified of the immediate jeopardy on 6/6/18 at 2:55 PM. On 6/7/18 at 10:48 PM the facility provided the following credible allegation of compliance and immediate jeopardy removal: "This alleged noncompliance resulted from the center's failure to follow the abuse policy and procedures that led to not protecting one resident with prior history of suspected domestic abuse from a spouse. On 4/25/2018 the facility admitted resident #84 for rehabilitation and long term care placement. Resident #84 had a protective order named "Ex parte order" filed in Harnett County Clerk of Superior Court on 4/24/2018. The protective order was presented to the facility at the time of admission on 4/25/2018 by the assigned Social worker from the Department of Social Services. The protective order included information that the "department of Social services is concerned with the possibility of physical abuse and neglect", it also added that "Without a protective order department of Social Services is concerned the wife will remove respondent from the hospital/rehab." This alleged noncompliance resulted from the facility failure to implement abuse policies and procedures on the area of proper screening, identification, protection and reporting that resulted from the broken communication process from resident's admission to the facility for necessary information to include protective orders for resident #84. As the result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions to protect resident #84.	F 607	protective orders received on admission or readmission by the admission director or designated person during the admission process, will be placed in the medical file under the advance directive tab for easy identification and accessibility by the nursing staff. Effective 6/7/2018; received protective orders will be added to resident's care plan by the Admitting nurse and/or Nursing supervisor and nursing aide care guide for accessibility by both license nurses and nurse aides. If the protective order includes guidelines such as supervised visits, no visitation, or not allowed on the premises such measures will be added to resident's face sheet and appropriate information posted such as the perpetrator picture and/or description in a readily accessible location in the facility. Facility Director of Nursing (DON), Assistant Director of Nursing and/or Unit manager will complete 100% education on the location of protective orders in each resident's medical charts and the location of intervention necessary to protect the resident with protective orders. This education will also cover process to be taken if the protective order to include adding the protective order interventions to resident's care plan and to nursing aide care guide for accessibility by both license nurses and nurse aides. Guidelines such as supervised visits, no visitation, or not allowed on the premises will also be covered in this education. The education	

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F 607	Continued From page 34 Root cause analysis also concluded that the facility miss-interpreted regulatory requirements that requires the facility to protect each resident while in the facility, and reporting any allegation of abuse immediately but no later than two hours after the allegation is made. The facility also failed to follow the policies and procedures to put measures in place to protect residents while in the facility even when they are under the custody of DSS. The root cause analysis, concluded that, the systemic failure that resulted onto resident #84 incident on 6/4/2018 includes, broken communication process from admission for necessary information to include protective orders for resident #84. As a result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions to protect resident #84. The broken communication process resulted from a lack of a systemic process set forth on how protective orders was to be communicated by the admission Director to the rest of the IDT. Although the facility received the documentation on admission on 4/25/2018, and was notified by the DSS social worker of the protective orders of this resident, there is no indication that the facility put forth measures to protect Resident #84 from his wife. Admission Director failed to communicate the pertinent information to the interdisciplinary team necessary to insure resident #84 was protected while in the facility from his wife. On 6/4/2018 the resident's spouse was witnessed by the facility Activity Aide, & Central Supply Aide #1 in the room with the Resident #84. Activity	F 607	will also emphasize on the process that such information will be added to resident's face sheet and appropriate information posted such as the perpetrator picture and/or description to be a readily accessible location in the facility. This education will be provided for all licensed nurses, nursing assistant to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses and nursing aides effective 6/7/2018, and will also be provided annually. Effective 6/7/2018, the center nursing administrative team, which includes DON, Nurse supervisors, Unit Managers, and/or SDC, added reviewing of DSS protective orders to an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours. By adding the review of DSS protective orders to this process, it will ensure that any resident with prior history of allegation of abuse, neglect, and/or injuries of unknown sources has appropriate measures in place to protect the resident from the alleged perpetrator, effective 6/7/2018. This process with take place daily Monday through Fridays effective 6/7/2018. The result of this	

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F 607	Continued From page 35 Aide and Central Supply Aide stated they witnessed resident's spouse kicking resident's leg and stepping on his feet. Resident and the spouse were immediately separated by the Central Supply Aide. A Complete Head to toe body assessment was completed by the Registered nurse Supervisor #1. No injuries noted, resident denied any signs and symptoms of pain or discomforts. Initial report for the alleged abuse was completed and sent on 6/4/2018, DSS social worker and the attending Physician notified. IMMEDIATE ACTION TAKEN The Chief Clinical officer from the Management and consulting company that manages the center, re-educated the Center Executive Director and the Director of Nursing 6/7/2018 on the center Abuse Prohibition and Investigation policies and procedures, and emphasized the importance of screening, identification, protecting and reporting to the regulatory required agencies immediately but no later than two hours from the time the allegation is made. The education also emphasized on the importance of ensuring residents are screened for potential abuse and measures are put forth to protect them while residing in the facility. The Chief Clinical officer from the Management and consulting company that manages the center, re-educated facility management team that consist of the department supervisors on the center's Abuse Prohibition and Investigation policies and procedures, and emphasized on the importance of screening patients and employees before hire, protecting resident(s), and reporting any allegation of abuse or Neglect to their Direct supervisor and the Executive Director in a timely	F 607	systemic process will be documented on the clinical meeting form maintained in the "Daily Clinical meeting binder." Effective 6/7/2018, the 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 and/or injuries of unknown sources reported/documented is investigated thoroughly, the alleged perpetrator is suspended pending investigation, and ensure the event is reported to the facility Executive Director. This process will also incorporate reviewing of any DSS protective orders to ensure the facility put measures in place to address such orders. 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 6/7/2018. Effective 6/7/2018 the Admission Director (AD) will print any protective order for any referral to the facility before bed is offered. The AD will then provide copies of the protective order to the facility Executive Director, Director of Nursing, Director of social services and/or designated licensed nurse. The IDT team will then review all referrals with DSS protective orders prior to admitting resident to the facility to ensure measures are put in place to	

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F 607	Continued From page 36 manner as well as to the Regulatory required agencies immediately but no later than 2 hours after forming suspicion, witness the abuse and/or after a resident, another staff and/or family member alleged abuse. On 6/04/2018 at approximately 5:00PM the Central supplies aide separated resident #84 from his wife by pushing him out of the room to the hallway. The central supplies aide remained with resident #84 on the hallway, and notified Assistant Director of nursing who was standing in the proximity at the nurse's station #2. ADON walked towards the resident accompanied by the Unit Manager #1 who relieved the central supplies aide and took over supervision and protection, per facility abuse prohibition process of resident #84, per the facility abuse policy and procedures. Unit Manager #1 completed a head to toe assessment of the resident and noted no injuries. Resident denied pain or discomforts. Central supplies aide notified a Medical records supervisor who was standing at the nurse station #1. Medical records aide walked to the resident's room immediately and met Unit Manager #1 in the room. Medical records aide assisted Unit manager #1 while the Unit manager was assessing the patient. Unit Manager #1 and Medical Records supervisor transferred resident #84 to the wheel chair and moved the resident to the dining area. Medical Records supervisor remained with resident #84 until the police arrived with a brief period when she was relieved by the transportation aide who stayed with the resident when Medical Records supervisor departed. Likewise, the ADON who left Unit Manager #1 with resident#84 walked to the Executive	F 607	protect the resident when admitted to the facility. Effective 6/7/2018 the facility Executive Director, Director of Nursing, and/or Director of social services will discuss new admits and re-admits to the facility during their daily department head meeting to validate that any admitted or readmitted resident with protective orders has measures in place to protect the resident against the alleged perpetrators. Effective 6/7/2018 any alleged perpetrator with restraining orders for visitation will not be allowed to visit the facility. All the facility exit doors are locked and can only be accessed using an approved card. Visitors will utilize the facility main entrance to enter the premises, effective 6/7/18. All the facility exit doors are locked using a magnetized lock that releases in case of fire. In case of any other emergency, each locked facility exit door is equipped with an emergency release override switch located beside each exit door to allow the door to demagnetize and open from the inside. The magnetic lock system is also equipped with a master override switch located at each nurse's station. This is in compliance with North Carolina life safety code. Signs have been posted on all exit doors to direct visitors to the main entrance, effective 6/7/18. Facility Executive Director, Director of Nursing (DON), Assistant Director of Nursing and/or Director of Social Services will complete 100% re-education on the	

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F 607	Continued From page 37 Director's office for notification. On 06/04/2018 the 24 hour initial report was sent to the Department of Health and Human Services related to resident #84's witnessed abuse by the spouse. These reports were completed and submitted by the Director of Nursing. The Five day report was completed on 6/7/2018 after a detail investigation was conducted by the Center Executive Director, Director of Social Services and Director of Nursing. The incident on 6/4/2018 against resident #84 was substantiated based on findings of the investigation conducted by the Facility, Department of Social Services, and Harnett county Police Department. Resident #84's spouse is ordered by the court not to visit or be in contact with the resident effective 6/5/2018. Facility has yet to receive a confirmation of actions taken legally against the spouse. Facility will keep resident on 1 on 1 until confirmation is obtained of the spouse's inability to come to the facility. The photograph of the alleged perpetrator (resident#84 wife) is currently posted at the front desk, and at each nurse's station for easy identification and notification effective 6/6/18. The photograph is located on the pertinent location where all employees can identify resident #84's wife. Facility Executive Director, Director of Nursing, and Social worker from Department of Social Services met briefly on 6/5/2018 to discuss the incident that happened on 6/4/2018. The team discussed the possible actions necessary to protect the resident from the spouse. Multiple ideas were discussed, such as room change, identify the resident with a different name, or	F 607	location of protective orders in each resident's medical charts and the importance of implementing approaches to ensure the resident's protection, per facility abuse prohibition process. This education will be provided for all licensed nurses, to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses effective 6/7/2018, and will also be provided annually. MONITORING PROCESS Effective 6/7/2018, 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 6/7/2018, the facility will conduct a quality assurance and performance improvement meeting monthly with an agent from the contracted management	

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F 607	Continued From page 38 transfer resident #84 to another location that the spouse will not be aware of. On 6/5/2018, the facility as well as the DSS social worker reached a conclusion that, the best course of action that will protect resident #84 from his spouse, while maintaining his dignity, self-determination, and reduce risk for deterioration from this event is to relocate resident #84 to another part of the facility. Resident #84's name was changed on 6/5/2018 to an alias to ensure his protection, per facility abuse prohibition process by the facility Director of Nursing, Executive Director and Admission Director. This measure is in alignment with the facility abuse policy and procedure. Resident #84 was relocated to another room in the facility on 6/5/2018 and the posted name in the facility was changed. Resident #84 was placed on every 15 minutes watch from 7pm on 6/4/2018 to 9am. One on one supervision was initiated on 6/5/2018 in which an employee observe the resident at all times while in the facility. One on one care will continue until the facility receives confirmation that resident #84's wife is arrested. 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 documentation in any resident medical records that indicate allegation of abuse, neglect, or injury of unknown sources, 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 two other documented	F 607	and consulting company that oversees the company to ensure that the facility systematically identify and address areas related to resident's abuse and neglect and ensuring the abuse policies and procedures is implemented. This will take place for the next twelve months or until the facility shows the pattern of compliance. Effective 6/7/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with resident protection, per facility abuse prohibition process, thorough investigation, injuries of unknown sources and resident neglect by conducting clinical meeting daily. This meeting will allow the team to review all allegation of abuse, incidents or accidents that occurred from the prior clinical meeting. Any DSS protective orders and any documented information that indicate suspicion of abuse will be reviewed to ensure measures are in place to protect the resident. 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 the clinical meeting binder after proper follow up is done. This monitoring process will take place daily for 4weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 6/7/2018, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and	

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F 607	Continued From page 39 allegation of abuse, and/or neglect documented in resident medical records. This audit was completed on 6/6/18 & 6/7/18. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. 100% audit was completed by the Center executive Director for all allegation of abuse and/or neglect submitted in the past from 1/24/2018 to 6/7/2018 determine if the alleged perpetrator was suspended during investigation to protect the resident, 24 hours completed within 2 hours of the allegation and 5 days completed and submitted to the state agency as required by regulation and Elder Justice Act in a timely manner. The audit revealed 5 of 5 completed abuse/neglect reports indicated the alleged perpetrator was suspended pending investigation per abuse prohibition policy and procedure, however all 5 of 5 initial 24 hour reports were not submitted within two hours of the allegation. 2 months noted with detail investigation and the Alleged Perpetrator(s) were suspended. This audit was completed on 6/7/2018. On 06/06/2018, 100% interviews was completed by Director of Rehabilitation Center, Business office Manager, Activity Director, Medical Records Supervisor and MDS for all current alert and oriented residents in the facility to identify any other resident with an allegation of Abuse and/or Neglect. Two other residents, Resident #2, and Resident #3 voiced allegation of abuse and/or neglect. Alleged perpetrators identified were suspended while the investigation is conducted by the facility Executive director and/or Director of Nursing. 24 hour reports were submitted on 6/6/2018. A thorough investigation initiated. The resident's attending Physician and Responsible	F 607	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 6/7/2018, 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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Party were notified of the allegation. Resident #2 and #3, 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.

The Director of Social services, Assistant Director of Nursing, Unit manager, Admission Director and Director of Rehabilitation Services interviewed the responsible parties for residents who were not able to answer questions during this interview due to mental capacity deficit on 6/7/18. No family member voiced any allegation of abuse and/or neglect.

SYSTEMIC CHANGES

Effective 6/7/2018, all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation is made to the administrator of the facility and to other officials to include; the State Survey Agency, adult protective services, the state Ombudsmen in accordance with State law through established facilities policies and procedures.

Effective 6/7/2018, The facility 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 6/7/2018, the facility interdisciplinary team to include Executive Director, Director of Nursing, Director of Social services and at least

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three other department supervisors will attend a monthly mandatory training that will be conducted by contracted management and consulting company that oversees the facility. This training will put an emphasis on all seven components of abuse prohibition to include screening, training, prevention, identification, investigation, protection, reporting and responses. This training will take place monthly for next twelve months or until the pattern of compliance is maintained.

Effective 6/7/2018, the Center Director of Human Services, and/or employee direct supervisor 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. The 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.

Effective 6/7/2018, 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 month to identify any allegation of Abuse and/or Neglect. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse, and/or neglect will be reportedto the Center Executive Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and reported according to the regulatory requirements.

The Director of Social services, Assistant Director of Nursing, Unit manager, Admission Director and

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Director of Rehabilitation Services will interview the responsible parties for residents who are not able to answer questions during the interview due to mental capacity deficit effective 6/7/18. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse, and/or neglect 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 6/7/2018 a copy of any resident's protective orders received on admission or readmission by the admission director or designated person during the admission process, will be placed in the medical file under the advance directive tab for easy identification and accessibility by the nursing staff.

Effective 6/7/2018; received protective orders will be added to resident's care plan by the Admitting nurse and/or Nursing supervisor and nursing aide care guide for accessibility by both license nurses and nurse aides. If the protective order includes guidelines such as supervised visits, no visitation, or not allowed on the premises such measures will be added to resident's face sheet and appropriate information posted such as the perpetrator picture and/or description in a readily accessible location in the facility.

Facility Director of Nursing (DON), Assistant Director of Nursing and/or Unit manager will complete 100% education on the location of protective orders in each resident's medical charts and the location of intervention necessary to protect the resident with protective orders. This education will also cover process to be taken if

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the protective order to include adding the protective order interventions to resident's care plan and to nursing aide care guide for accessibility by both license nurses and nurse aides. Guidelines such as supervised visits, no visitation, or not allowed on the premises will also be covered in this education. The education will also emphasize on the process that such information will be added to resident's face sheet and appropriate information posted such as the perpetrator picture and/or description to be a readily accessible location in the facility.
This education will be provided for all licensed nurses, nursing assistant to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses and nursing aides effective 6/7/2018, and will also be provided annually.

Effective 6/7/2018, the center nursing administrative team, which includes DON, Nurse supervisors, Unit Managers, and/or SDC, added reviewing of DSS protective orders to an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours. By adding the review of DSS protective orders to this process, it will ensure that any resident with prior history of allegation of abuse, neglect, and/or injuries of unknown sources has appropriate measures in place to protect the resident from the alleged perpetrator, effective 6/7/2018. This process with take place daily Monday through Fridays effective 6/7/2018. The

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result of this systemic process will be documented on the clinical meeting form maintained in the "Daily Clinical meeting binder."

Effective 6/7/2018, the 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 and/or injuries of unknown sources reported/documented is investigated thoroughly, the alleged perpetrator is suspended pending investigation, and ensure the event is reported to the facility Executive Director. This process will also incorporate reviewing of any DSS protective orders to ensure the facility put measures in place to address such orders. 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 6/7/2018.

Effective 6/7/2018 the Admission Director (AD) will print any protective order for any referral to the facility before bed is offered. The AD will then provide copies of the protective order to the facility Executive Director, Director of Nursing, Director of social services and/or designated licensed nurse. The IDT team will then review all referrals with DSS protective orders prior to admitting resident to the facility to ensure measures are put in place to protect the resident when admitted to the facility.

Effective 6/7/2018 the facility Executive Director, Director of Nursing, and/or Director of social services will discuss new admits and re-admits to

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the facility during their daily department head meeting to validate that any admitted or readmitted resident with protective orders has measures in place to protect the resident against the alleged perpetrators.

Effective 6/7/2018 any alleged perpetrator with restraining orders for visitation will not be allowed to visit the facility. All the facility exit doors are locked and can only be accessed using an approved card. Visitors will utilize the facility main entrance to enter the premises, effective 6/7/18. All the facility exit doors are locked using a magnetized lock that releases in case of fire. In case of any other emergency, each locked facility exit door is equipped with an emergency release override switch located beside each exit door to allow the door to demagnetize and open from the inside. The magnetic lock system is also equipped with a master override switch located at each nurse's station. This is in compliance with North Carolina life safety code. Signs have been posted on all exit doors to direct visitors to the main entrance, effective 6/7/18.

Facility Executive Director, Director of Nursing (DON), Assistant Director of Nursing and/or Director of Social Services will complete 100% re-education on the location of protective orders in each resident's medical charts and the importance of implementing approaches to ensure the resident's protection, per facility abuse prohibition process. This education will be provided for all licensed nurses, to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on

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the new hire orientation process for all new licensed nurses effective 6/7/2018, and will also be provided annually.

MONITORING PROCESS
Effective 6/7/2018, 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 6/7/2018, the facility will conduct a quality assurance and performance improvement meeting monthly with an agent from the contracted management and consulting company that oversees the company to ensure that the facility systematically identify and address areas related to resident's abuse and neglect and ensuring the abuse policies and procedures is implemented. This will take place for the next twelve months or until the facility shows the pattern of compliance.

Effective 6/7/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with resident protection, per facility abuse prohibition process, thorough investigation, injuries of unknown sources and resident neglect by conducting

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clinical meeting daily. This meeting will allow the team to review all allegation of abuse, incidents or accidents that occurred from the prior clinical meeting. Any DSS protective orders and any documented information that indicate suspicion of abuse will be reviewed to ensure measures are in place to protect the resident. 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 the clinical meeting binder after proper follow up is done. This monitoring process will take place daily for 4weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.

Effective 6/7/2018, 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 6/7/2018, 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.

The credible allegation for immediate jeopardy removal was validated on 6/8/18, which removed the IJ on 06/07/18, as evidenced by staff interviews, in-service records reviewed for the Administrator, DON, Admissions Coordinator and

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F 607	Continued From page 48 administrative staff in services, and observations. The in services included information r/t Resident #84's new alias, new room number, and what action was to be taken if his wife was observed on the facility property, and the 2 hour time frame for reporting allegations of abuse. Other observations included one on one (1:1) staff with Resident #84, monitored (locked) entry and exits from the facility's main entrance, and a photograph of Resident #84's wife posted at every nursing station and ante room. A care plan was initiated 6/6/18 and focused on "Safety: At risk for injury and social isolation r/t spousal abuse." The stated goals included maintained safety from his wife. Interventions included, but were not limited to, relocation to another room, identify by a different name, 1:1 supervision, staff education on name change, room change, safety interventions, monitoring for changes in mood or behavior, and an approved visitor list.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(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	F 609		7/10/18

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F 609	Continued From page 49 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. §483.12(c)(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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility staff, Nurse Practitioner and Medical Director interviews, the facility failed to submit a 24-hour and 5-day report to the State Agency for 1 of 1 residents who was observed with a bruise of unknown origin to the left eye (Resident #19). Findings included: Record review revealed Resident #19 was admitted to the facility on 3/4/2015 with diagnoses which included Parkinson's Disease and Dementia. Review of the Quarterly Minimum Data Set (MDS) dated 3/14/2018 revealed Resident #19 was severely cognitively impaired and required extensive to total assistance of 1 staff member for all activities of daily living. The MDS indicated the resident displayed no rejection of care. Review of an incident report dated 5/6/2018 at 7:00AM by Nurse #4 revealed Resident #19 was noted with an ecchymotic/bruised area under the	F 609	F609 ROOT CAUSE This alleged noncompliance was resulted from the Center's Director of Nursing misinterpretation of regulatory requirements related to thoroughly investigation of an injury of unknown source. The DON stated that he noted the bruise on resident #19 and based on the location and the type of injury he concluded that the bruise was resulted from resident hitting her face against the bedside table. DON added that he did not consider the injury as unknown since he was able to conclude how the injury happen. Root cause analysis also concluded that the DON reached the conclusion without thoroughly investigating the causative factors as he did not interview other employees, a resident involved and/or any other staff member who noticed the injury to gain the perspective on how the injury might have happened. On the interview conducted on	

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F 609	Continued From page 50 left eye. The report revealed the area was approximately 3 centimeters (cm) in length by 4 cm in width and there was no laceration noted. The nurse documented that due to the resident's behavior the bruise was likely self-inflicted with the bed-side table which was at eye level. The incident report listed the immediate actions taken were an assessment was completed, the bruise was noted, vital signs were taken and the physician and responsible party were notified. A review of an Incident 24 hour follow up report with Resident #19's name indicated the immediate post-incident actions taken were the bed was moved away from the bedside table and the room was rearranged. The report indicated based on the size and the location of the bruise and the location of the bedside table, it was concluded the resident hit her head against the bedside table which caused the bruise. There was no date or signature documented on the follow up report. A nursing note dated 5/6/2018 at 6:31PM for Resident #19 was reviewed. The note was signed by Nurse #4. The note revealed the resident had a hematoma under her left eye and her providers and responsible party were informed. The note indicated Nurse #4 was "asking around" and there were no witnesses to any injury or altercation. The note further indicated the resident was not somnolent or agitated and the resident was "getting around" by wheelchair. Physician's orders were reviewed and revealed an order written on 5/7/2018 for Resident #19. The orders were to discontinue aspirin and restart aspirin on 5/14/2018, portable x-ray of bilateral facial and orbit (eye socket) for hematoma. The	F 609	6/8/2018 at 9:48am with the state survey agency staff while on site; “The DON indicated there was a misunderstanding/miscommunication about the bedside table”. DON also did not report the injury of unknown source before completing the investigation of causative factors; something that should have been done after the reporting of injury of unknown source to the State Agency, Adult Protective Services and other officials as required by the state within two hours of the occurrence. Chief Clinical Officer from the Consulting and Management Company contracted by the facility re-educated the Center Executive director and the Director of Nursing on 7/2/2018 on reporting expectation if there is an injury of unknown origin noted for any resident in the facility. IMMEDIATE ACTION On 6/4/2018, the 24 hour report and 5 day report were sent to the Department of Health and Human Services, for resident #19s injury of unknown source identified. These reports were completed and submitted by the Director of Nursing. No further actions taken for resident #19. IDENTIFICATION OF OTHERS 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 injuries of unknown source documented in any residents medical records, and if any determine whether an initial; report within two hours and 5 days investigation reports were completed and reported to the state	

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	345213	A. BUILDING _____ B. WING _____	C 06/08/2018

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F 609	Continued From page 51 orders were signed by Nurse Practitioner (NP) #1. A nursing note for Resident #19 dated 5/7/2018 at 7:16 PM by Nurse #1 was reviewed. The note revealed the resident was awake and alert with bruising to her left eye. The note indicated the resident was seen by NP#1 earlier in the day and x-rays were ordered. The note further indicated the resident resisted the x-ray and it was not completed. An observation of Resident #19 was completed on 6/5/2018 at 4:40 PM. The resident was observed in her wheelchair at the nursing station. The resident was well kept with no visible injuries noted. There was no discoloration observed under her left eye. An interview was conducted with the facility Medical Director on 6/6/2018 at 9:38 AM. The Medical Director stated his expectation was the facility would investigate and follow policy for reporting injuries of unknown origin. An interview was conducted with Nurse #1 on 6/6/2018 at 10:38 AM. Nurse #1 stated she remembered the bruising to Resident #19's left eye. She described the bruising as crescent shaped under the eye and blueish/black in color. Nurse #1 indicated she first saw the bruise when she reported to work on 5/7/2018. Nurse #1 said she asked the off going nurse what caused the bruise and was told no one knew. She stated the off going nurse stated an x-ray was ordered. Nurse #1 said when the resident was in bed it was always in the low position and the bedside table was on either side of the bed. She stated the bedside table would not lower more than	F 609	agency and other officials as required by regulation and/or Elder Justice Act. The audit revealed no other incident of injury of unknown source documented in residents medical records. This audit was completed on 06/07/2018. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. 100% audit was completed by the Director of Nursing of all incidents reports completed within the last 30 days to identify any injuries of unknown source and ensure that a proper investigation was completed and a an initial report within two hours as well as 5 days reports are completed and submitted to the state agency as required by regulation and Elder Justice Act. The audit revealed no other incident of injury of unknown source noted. This audit was completed on 6/7/2018. Findings of this audit is documented on incident reports audit tool located at the facility compliance binder. 100% skin assessments of all active residents completed by the Director of Nursing, Assistant Director of Nursing and/or Unit Manager to identify any other resident with an injury of unknown source. The audit revealed no other incidents of injury of unknown source noted. This audit was completed on 6/6/18. SYSTEMIC CHANGES Effective 7/10/2018, Facility will report any injury of unknown source immediately but m=not later than two hours after the injury being noted to the facility Executive Director and to other state officials including the State Survey Agency and to	

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F 609	Continued From page 52 approximately 30 inches from the floor and the resident would not be able to hit her eye on the table if she were in bed. Nurse #1 indicated she never saw the bedside table at eye level with the resident. An interview was conducted with Nurse #4 on 6/6/2018 at 11:18 AM. Nurse #4 confirmed she was the nurse who observed the bruise to Resident #19's left eye and completed the Incident Report on 5/6/2018. Nurse #4 indicated when she entered the resident's room, the resident was sitting in her wheelchair beside the bed and the bedside table was positioned in front of the resident. Nurse #4 reported she did not remember if the resident was eating breakfast or if she was using the bedside table for activities. Nurse #4 stated she saw the bruised area under the resident's left eye which was not there the day before. Nurse #4 reported the bruise was new appearing and bluish/black in color. Nurse #4 indicated she assessed the resident's eye and there were no open areas and it was not bleeding. Nurse #4 reported she called the physician on call (she did not remember which physician), notified the responsible party and notified the Director of Nursing (DON). Nurse #4 indicated Resident #19 could be very active at times but the resident was not agitated the morning she discovered the bruise. Nurse #4 stated the bedside table was not at the resident's eye level and did not recall a time she observed the bedside table at eye level of Resident #19. Nurse #4 stated she asked the "localized people like the nursing assistants" who were working with the resident if they knew what caused the resident's bruised eye and no one knew anything. Nurse #4 stated since no one knew what happened she came to the reasonable conclusion	F 609	the Adult Protective Services in the accordance with State law. Effective 7/10/2018, the center nursing administrative team, which includes DON, ADON, Unit Manager, Nurse supervisors, Unit Managers, and/or SDC will review in details any noted injury on completed skin assessment reports and/or incident report to ensure that such injuries has a known source and if not, ensure the proper procedure for reporting and investigating is followed based on the facility Abuse Policy and Procedures. This process of thorough review will be added on an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours. This process will take place daily Monday through Fridays effective 7/10/2018. The result of this systemic process will be documented on the clinical meeting form maintained in the “Daily Clinical meeting binder.” Effective 7/10/2018, the week end Registered Nurse supervisor and/or designated licensed nurse will review in details any noted injury on completed skin assessment reports and/or incident report to ensure that such injuries has a known source and if not, ensure the proper procedure for reporting and investigating is followed based on the facility Abuse Policy and Procedures. This process of thorough review will be added on an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin	

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F 609	Continued From page 53 the resident hit her eye on the bedside table. Nurse #4 stated the resident probably bent down to pick up something off the floor and hit her eye on the corner of the bedside table. Nurse #4 indicated she told the DON her conclusion of the cause of the resident's bruised eye. A telephone interview was conducted with Nurse Practitioner (NP) #1 on 6/7/2018 at 12:44 PM. NP#1 reported she was in the facility on the morning of 6/7/2018 and saw Resident #19 sitting in her wheelchair at the nurse's station. NP#1 stated she immediately noticed the bruised area under the resident's left eye and asked nursing what happened (NP#1 did not recall who she asked). NP#1 indicated the bruise was significant and since no one knew the source of the injury she ordered x-rays to ensure there were no fractures. NP#1 stated she recalled talking to the responsible party about the bruised area and the responsible party reported the resident always bruised easily. NP#1 said she followed up with Resident #19 several times and there were no issues associated with the bruise. An interview was conducted with the Director of Nursing (DON) on 6/8/2018 at 9:48 AM. The DON indicated there was a misunderstanding/miscommunication about the bedside table. The DON stated he understood Resident #19 hit her eye on the nightstand and not the bedside table and if the bed was in the low position, the resident could have hit her eye on the nightstand. The DON stated the nurse's conclusion seemed logical so he did not see a reason to report it to the State Agency. The DON indicated if he had been aware it was the bedside table not the nightstand he would have initiated an investigation and completed a 24 hour and	F 609	assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours. 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 7/10/2018. Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% re-education on the facility's abuse/neglect policy and procedures including notification protocols. This education will emphasize on reporting any injury of unknown source immediately but not later than two hours to the facility Executive Director and to other state officials including the State Survey Agency and to the Adult Protective Services in the accordance with State law. This education will be provided for all employees, to include full time, part time and as needed staff. This education will be completed by 7/10/2018. Any employee not educated by 7/10/2018 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 7/10/2018, and will also be provided semi-annually. MONITORING PROCESS Effective 7/10/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with investigation and reporting of injuries of unknown sources by conducting clinical meeting daily (M-F).	

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F 609	Continued From page 54 5-day report and provided these reports to the State Agency. An interview was conducted with the Chief Clinic Officer (CCO) on 6/8/2018 at 9:48 AM during the interview with the DON. The CCO stated the expectation was the facility would thoroughly investigate injuries of unknown origin and complete the required documentation per policy for reporting and report the resident's injury of unknown origin to the State Agency.	F 609	This meeting will allow the team to review the daily clinical meeting checklist to ensure completion and proper follow through, incidents or accidents occurred from the prior clinical meeting to ensure any injury of unknown source was noted 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 weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 7/10/2018, 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 the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 7/10/18, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction	

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F 609	Continued From page 55	F 609	for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility staff, Nurse Practitioner and Medical Director interviews, the facility failed to investigate an injury of unknown origin for 1 of 1 residents who was observed with a bruise to the left eye (Resident #19). Findings included: Record review revealed Resident #19 was admitted to the facility on 3/4/2015 with diagnoses which included Parkinson's Disease and	F 610	F610 ROOT CAUSE: This alleged noncompliance was resulted from the Center's Director of Nursing misinterpretation of regulatory requirements related to thoroughly investigation of an injury of unknown source. The DON stated that he noted the bruise on resident #19 and based on the location and the type of injury he concluded that the bruise was resulted from resident hitting her face against the	7/10/18

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F 610	Continued From page 56 Dementia. Review of the Quarterly Minimum Data Set (MDS) dated 3/14/2018 revealed Resident #19 was severely cognitively impaired and required extensive to total assistance of 1 staff member for all activities of daily living. The MDS indicated the resident displayed no rejection of care and other behaviors not directed towards others. Review of an incident report dated 5/6/2018 at 7:00AM by Nurse #4 revealed Resident #19 was noted with an ecchymotic/bruised area under the left eye. The report revealed the area was approximately 3 centimeters (cm) in length by 4 cm in width and there was no laceration noted. The nurse documented that due to the resident's behavior the bruise was likely self-inflicted with the bed-side table which was at eye level. The incident report listed the immediate actions taken were an assessment was completed, the bruise was noted, vital signs were taken and the physician and responsible party were notified. A review of an Incident 24 hour follow up report with Resident #19's name indicated the immediate post-incident actions taken were the bed was moved away from the bedside table and the room was rearranged. The report indicated based on the size and the location of the bruise and the location of the bedside table, it was concluded the resident hit her head against the bedside table which caused the bruise. There was no date or signature documented on the follow up report. A nursing note dated 5/6/2018 at 6:31PM for Resident #19 was reviewed. The note was signed by Nurse #4. The note revealed the resident had	F 610	bedside table. DON added that he did not consider the injury as unknown since he was able to conclude how the injury happen. Root cause analysis also concluded that the DON reached the conclusion without thoroughly investigating the causative factors as he did not interview other employees, a resident involved and/or any other staff member who noticed the injury to gain the perspective on how the injury might have happened. On the interview conducted on 6/8/2018 at 9:48am with the state survey agency staff while on site; “The DON indicated there was a misunderstanding/miscommunication about the bedside table”. DON also did not report the injury of unknown source before completing the investigation of causative factors; something that should have been done after the reporting of injury of unknown source to the State Agency, Adult Protective Services and other officials as required by the state within two hours of the occurrence. Chief Clinical Officer from the Consulting and Management Company contracted by the facility re-educated the Center Executive director and the Director of Nursing on 7/2/2018 on reporting expectation if there is an injury of unknown origin noted for any resident in the facility. IMMEDIATE ACTION: On 6/4/2018, the 24 hour report and 5 day report were sent to the Department of Health and Human Services, for resident #19s injury of unknown source identified. These reports were completed and submitted by the Director of Nursing. No	

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F 610	Continued From page 57 a hematoma under her left eye and her providers and responsible party were informed. The note indicated Nurse #4 was "asking around" and there were no witnesses to any injury or altercation. The note further indicated the resident was not somnolent or agitated and the resident was "getting around" by wheelchair. Physician's orders were reviewed and revealed an order written on 5/7/2018 for Resident #19. The orders were to discontinue aspirin and restart aspirin on 5/14/2018, portable x-ray of bilateral facial and orbit (eye socket) for hematoma. The orders were signed by Nurse Practitioner (NP) #1. A nursing note for Resident #19 dated 5/7/2018 at 7:16 PM by Nurse #1 was reviewed. The note revealed the resident was awake and alert with bruising to her left eye. The note indicated the resident was seen by NP#1 earlier in the day and x-rays were ordered. The note further indicated the resident resisted the x-ray and it was not completed. An observation of Resident #19 was completed on 6/5/2018 at 4:40 PM. The resident was observed in her wheelchair at the nursing station. The resident was well kempt with no visible injuries noted. There was no discoloration observed under her left eye. An interview was conducted with the facility Medical Director on 6/6/2018 at 9:38 AM. The Medical Director stated his expectation was the facility would thoroughly investigate any injuries of unknown origin. The Medical Director indicated any facial/eye injuries with no explanation was particularly concerning to him and immediate	F 610	further actions taken for resident #19. IDENTIFICATION OF OTHERS: 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 injuries of unknown source documented in any residents medical records, and if any determine whether an initial; report within two hours and 5 days thorough 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 incident of injury of unknown source documented in residents medical records. This audit was completed on 06/07/2018. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. 100% audit was completed by the Director of Nursing of all incidents reports completed within the last 30 days to identify any injuries of unknown source and ensure that a proper investigation was completed and a an initial report within two hours as well as 5 days reports are completed and submitted to the state agency as required by regulation and Elder Justice Act. The audit revealed no other incident of injury of unknown source noted. This audit was completed on 6/7/2018. Findings of this audit is documented on incident reports audit tool located at the facility compliance binder. 100% skin assessments of all active residents completed by the Director of Nursing, Assistant Director of Nursing	

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F 610	Continued From page 58 investigation should be conducted. An interview was conducted with Nurse #1 on 6/6/2018 at 10:38 AM. Nurse #1 stated she remembered the bruising to Resident #19's left eye. She described the bruising as crescent shaped under the eye and blueish/black in color. Nurse #1 indicated she first saw the bruise when she reported to work on 5/7/2018. Nurse #1 said she asked the off going nurse what caused the bruise and was told no one knew. She stated the off going nurse stated an x-ray was ordered. Nurse #1 said when the resident was in bed it was always in the low position and the bedside table was on either side of the bed. She stated the bedside table would not lower more than approximately 30 inches from the floor and the resident would not be able to hit her eye on the table if she were in bed. Nurse #1 indicated she never saw the bedside table at eye level with the resident. An interview was conducted with Nurse #4 on 6/6/2018 at 11:18 AM. Nurse #4 confirmed she was the nurse who observed the bruise to Resident #19's left eye and completed the Incident Report on 5/6/2018. Nurse #4 indicated when she entered the resident's room, the resident was sitting in her wheelchair beside the bed and the bedside table was positioned in front of the resident. Nurse #4 reported she did not remember if the resident was eating breakfast or if she was using the bedside table for activities. Nurse #4 stated she saw the bruised area under the resident's left eye which was not there the day before. Nurse #4 reported the bruise was new appearing and bluish/black in color. Nurse #4 indicated she assessed the resident's eye and there were no open areas and it was not	F 610	and/or Unit Manager to identify any other resident with an injury of unknown source. The audit revealed no other incidents of injury of unknown source noted. This audit was completed on 6/6/18. SYSTEMIC CHANGES Effective 7/10/2018, Facility will thoroughly investigate any injury of unknown source immediately but not later than two hours after the injury being noted to the facility Executive Director and to other state officials including the State Survey Agency and to the Adult Protective Services in the accordance with State law. Effective 7/10/2018, the center nursing administrative team, which includes DON, ADON, Unit Manager, Nurse supervisors, Unit Managers, and/or SDC will review in details any noted injury on completed skin assessment reports and/or incident report to ensure that such injuries has a known source and if not, ensure the proper procedure for reporting and investigating is followed based on the facility Abuse Policy and Procedures. This process of thorough review will be added on an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours. This process will take place daily Monday through Fridays effective 7/10/2018. The result of this systemic process will be documented on the clinical meeting form maintained in the “Daily Clinical meeting binder.” Effective 7/10/2018, the week end Registered Nurse supervisor and/or	

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F 610	Continued From page 59 bleeding. Nurse #4 reported she called the physician on call, notified the responsible party and notified the Director of Nursing (DON). Nurse #4 indicated Resident #19 could be very active at times but the resident was not agitated the morning she discovered the bruise. Nurse #4 stated the bedside table was not at the resident's eye level and did not recall a time she observed the bedside table at eye level of Resident #19. Nurse #4 stated she asked the "localized people like the nursing assistants" who were working with the resident if they knew what caused the resident's bruised eye and no one knew anything. Nurse #4 stated since no one knew what happened she came to the reasonable conclusion the resident hit her eye on the bedside table. Nurse #4 stated the resident probably bent down to pick up something off the floor and hit her eye on the corner of the bedside table. Nurse #4 indicated she told the DON her conclusion of the cause of the resident's bruised eye. Nurse #4 stated she did not see any need for further investigation and relayed that information to the DON. A telephone interview was conducted with Nurse Practitioner (NP) #1 on 6/7/2018 at 12:44 PM. NP#1 reported she was in the facility on the morning of 6/7/2018 and saw Resident #19 sitting in her wheelchair at the nurse's station. NP#1 stated she immediately noticed the bruised area under the resident's left eye and asked nursing what happened (NP#1 did not recall who she asked). NP#1 indicated the bruise was significant and since no one knew the source of the injury she ordered x-rays to ensure there were no fractures. NP#1 stated she recalled talking to the responsible party about the bruised area and the responsible party reported the resident always	F 610	designated licensed nurse will review in details any noted injury on completed skin assessment reports and/or incident report to ensure that such injuries has a known source and if not, ensure the proper procedure for reporting and investigating is followed based on the facility Abuse Policy and Procedures. This process of thorough review will be added on an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours. 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 7/10/2018. Chief Clinical officer completed an education on through investigation of injury of unknown sources to the facility Executive Director, Director of Nursing and Director of Social Services on 7/2/2018. This re-education emphasized on the methodologies to thoroughly investigate an allegation of abuse, neglect or injury of unknown source per the facility's abuse/neglect policy and procedures. This education will also be added on new hires orientation process for all any new Executive Director, Director of Nursing and Social Services Director effective 7/10/2018, and will also be provided annually. Director of Nursing (DON), Assistant	

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F 610	Continued From page 60 bruised easily. NP#1 said she followed up with Resident #19 several times and there were no issues associated with the bruise. NP #1 stated she did not know if the facility completed an investigation but felt the injury was significant enough to warrant an investigation. An interview was conducted with the Director of Nursing (DON) on 6/8/2018 at 9:48 AM. The DON indicated there was a misunderstanding/miscommunication about the bedside table. The DON stated he understood Resident #19 hit her eye on the nightstand and not the bedside table and if the bed was in the low position, the resident could have hit her eye on the nightstand. The DON stated the nurse's conclusion seemed logical so he did not see a reason to investigate it any further. The DON indicated if he had been aware it was the bedside table not the nightstand he would have initiated an investigation. An interview was conducted with the Chief Clinic Officer (CCO) on 6/8/2018 at 9:48 AM during the interview with the DON. The CCO stated the expectation was the facility would thoroughly investigate injuries of unknown origin. The CCO stated an investigation for Resident 19's injury of unknown origin would be conducted.	F 610	Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% re-education on the facility's abuse/neglect policy and procedures including notification protocols, and investigation procedures. This education will emphasize on reporting any injury of unknown source immediately but not later than two hours to the facility Executive Director and to other state officials including the State Survey Agency and to the Adult Protective Services in the accordance with State law. This education will be provided for all employees, to include full time, part time and as needed staff. This education will be completed by 7/10/2018. Any employee not educated by 7/10/2018 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 7/10/2018, and will also be provided semi-annually. MONITORING PROCESS Effective 7/10/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with investigation and reporting of injuries of unknown sources by conducting clinical meeting daily (M-F). This meeting will allow the team to review the daily clinical meeting checklist to ensure completion and proper follow through, incidents or accidents occurred from the prior clinical meeting to ensure any injury of unknown source was noted investigated and reported per abuse policy. The nursing administrative team in will also review completion of skin	

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F 610	Continued From page 61	F 610	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 7/10/2018, 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 the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 7/10/18, 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 7/10/2018	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		7/10/18

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F 641	Continued From page 62 §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 observations, record review and staff interviews the facility failed to accurately code the MDS (Minimum Data Set) to reflect the behaviors exhibited by 1 of 2 residents (Resident #23) reviewed for wandering behaviors. The findings include: Resident #23 was admitted 12/28/17 with diagnoses that included Dementia and Cognitive Communication Deficit. A review of a social work note dated 1/3/18 read in part: "walks and wanders inside the facility". A review of the resident's most recent comprehensive MDS dated 1/4/18 was coded as an admission assessment. The assessment revealed a wander/elopement alarm was used daily. Wandering was not coded on the assessment. A review of another MDS for the resident dated 4/2/18 was coded as a quarterly assessment. The assessment revealed a wander/elopement alarm was used daily. Wandering was not coded on the assessment. On 6/5/18 at 11:16 AM was observed traveling down various halls of the facility. On 6/7/18 at 1:50 Resident #23 was observed as he attempted to enter the therapy area. He was redirected by staff and went back down the hall.	F 641	F641: ROOT CAUSE MDS nurse #1, Social Worker #1, Director of Nursing, and the facility Executive Director discussed on 6/11/18 to identify the root cause of this alleged noncompliance. The root cause analysis concluded that, Social worker #1 failed to accurately code MDS assessment to reflect the behaviors exhibited by resident #23 reviewed for wandering behaviors was an oversight of documented note that detailed the wandering behaviors. IMMEDIATE ACTION TAKEN The comprehensive MDS assessment for resident #23 Assessment Reference Date (ARD) 1/4/2018 was modified by MDS Nurse #1 on 6/8/2018 to reflect wandering behaviors per RAI guidelines. The quarterly MDS assessment for resident #23 ARD 04/02/18 was modified by MDS nurse #1 on 6/8/2018 to reflect a Wandering behavior per RAI guidelines in section E of MDS. IDENTIFICATION OF OTHERS 100% audit for current wandering behavior residents most recent MDS assessment was completed by the MDS Coordinator on 6/8/18, to determine if any	

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F 641	Continued From page 63 During an interview on 6/7/18 at 1:50 PM, Nurse #6 stated that Resident #23 frequently wandered in the facility. She reported that he will approach the facility doors but is easily redirected. An interview was conducted with Nursing Assistant #9 on 6/7/18 at 2:19 PM. She reported that Resident #23 frequently goes to the building lobby. She indicated that Resident #23 will attempt to exit but is easily redirected. An interview was conducted with the MDS Coordinator on 6/8/18 at 12:31 PM. During this interview, she stated the assessments completed on 1/4/18 and 4/2/18 should have reflected the wandering behaviors. She stated that she must have overlooked the note on 1/3/18 that detailed the wandering behaviors. The MDS Nurse did not explain why the 4/2/18 assessment that did not reflect the behaviors. During an interview with the Director of Nursing on 6/8/18 at 12:32 PM he stated it is his expectation that the MDS was completed accurately. During an interview with the Administrator on 6/8/18 at 1:09 PM he indicated it was his expectation that nursing staff complete the MDS accurately.	F 641	other resident with wandering behaviors in the lookback period was coded appropriately per RAI guidelines in section E of MDS 3.0.The results of the audit indicated 2 other residents with wandering behaviors was coded inaccurately per RAI guidelines in section E of MDS 3.0. MDS nurse #1 modified the assessments for both identified residents to reflect wandering behaviors per RAI guidelines Findings of this audit is documented on "MDS accuracy audit tool located in the facility compliance binder. SYSTEMIC CHANGES Effective 7/10/2018 , MDS nurse, and/or social worker who complete section E of MDS 3.0 is required to review the documentation completed within seven days of MDS Assessment Reference Date (ARD) to determine supportive documentation for accurate coding of MDS section E. Any documented observation, or documented interviews will also be coded based on RAI guideline. Effective 7/10/2018, Residents who display wandering behaviors will be coded accurately in MDS 3.0 per RAI guidelines. On 6/18/2018, MDS nurse #1 conducted re-education on accurate coding of MDS using Resident Assessment Instruments (RAI) guidelines. This education covers coding requirements and supportive documentation for each item coded in MDS. This education was provided to Social worker #1 who is responsible to complete section E of MDS 3.0.	

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F 641	Continued From page 64	F 641	Effective 7/10/2018; The education on the Accurate coding of MDS is added to new hires orientation education for MDS nurses, Director of Social Services, Activities Director, and Dietary Manager (CDM). This education will also be provided annually for MDS nurses, Director of Social Services, Activities Director, and the Dietary Manager. MONITORING PROCESS Effective 7/10/2018, prior to submission, MDS Nurse #1 will review section E of MDS 3.0 completed by the social worker #1 to ensure that wander behaviors is coded accurately per RAI guidelines. These reviews will take place weekly for 4 weeks before MDS is transmitted, any findings will be addressed promptly. Effective 7/10/2018; MDS nurse #1 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. RESPONSIBLE PARTY Effective 07/10/2018, the Executive Director, Director of Nursing, Director of Social services and MDS nurse #1 will be responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility	

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F 641	Continued From page 65	F 641	remains in substantial compliance. Compliance	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including	F 676		7/10/18

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F 676	Continued From page 66 (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assist and supervise a resident with shaving and nail care for 1 of 1 sampled residents who needed supervision in the form of oversight, encouragement and cuing from one staff (Resident #46). Findings included: Resident #46 was admitted on 4/12/18. He had diagnoses including chronic obstructive pulmonary disease, behavioral disturbance, Parkinson's disease, and other personality disorder. Resident #46 was assessed using the Minimum Data Set on 4/19/18. He was determined to have a moderate impairment in cognition. He had no mood issues. He needed supervision in the form of oversight, encouragement and cuing from one staff for personal hygiene which included shaving. He needed limited assistance with transfer for bathing. A care plan dated 4/19/18 included "I need help with my care r/t (related to) decrease mobility, weakness, dementia, Parkinson." The goal was "I will participate in my care thru next review." Approaches included: "Involve in care provided as much as possible. Break task down into subtask if rest periods would be beneficial ...Provide assist as needed with ...hygiene ...and bathing ...Nail care on shower days and [as needed]." The resident's Medication Administration Records	F 676	F676: ROOT CAUSE Director of Nursing, and the facility Executive Director discussed on 6/08/18 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged non-compliance resulted from failure by an employee to assist and cue resident #46 with shaving and nail care. Resident # needed supervision in the form of oversight, encouragement and cuing from staff. The root cause analysis added that the alleged noncompliance was caused by the employees' culture within the facility that include, but not limited to, lack of residents' centered care delivery culture, lack of good customer service, and lack of consistent staffing who provide care for residents in the facility to assure care is delivered to residents in the facility at all times. IMMEDIATE ACTION On 06/08/2018, Nurse Aide #3 and Director of Nursing (DON) provided nail care and set-up, oversight, and cuing for resident #46 to shave and complete ADL's. Resident #46 was able to shave himself after set up assistance and supervision. IDENTIFICATION OF OTHERS	

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F 676	Continued From page 67 since admission were reviewed. No behaviors were noted. Personal hygiene completed care task documentation for May and June 2018 was reviewed. It did not include notes about provision of nail care or shaving. Resident #46 was initially observed on 6/08/18 at 8:50 AM lying in a bed positioned in a low level. He had one inch long hair growth on side burns and at least 1/4 inch long beard on the rest of his face. He said, "I don't like my face like this. I sure don't." His fingernails were observed to be 1/4 inch long on both hands with jagged edges on some nails. Resident #46 was observed again at 9:25 AM. He was up in the chair next to his bed. His facial hair and nails were the same as before. He was observed a third time at 11:07 AM. He said there was a shaving kit in his cabinet. He said he had shaved since he was admitted. His facial hair and nails were the same as before. Disposable razors and shaving cream were on the counter of the shared bathroom. Interview with Nurse Aide #3 on 6/8/18 at 11:35 AM revealed, "He does for himself. I ask if he is ready for his bath. He washes himself. He is on the second shift shower list." She added, "When he came, the beard was long. He said he could shave himself. I have never used the electric razor. I just give him disposable razors. We are supposed to cut his fingernails." Resident #46's electric razor was observed inside of a black razor bag in the resident's closet at 11:37 AM on 6/8/18. At that time, the resident said the hair on his neck was at least 3/4 inch long. Nurse Aide #3 was present for the	F 676	100% audit of all current residents in the facility was completed by the Director of Nursing, Assistant Director of Nursing and/or Unit Manager on 6/27/2018 & 6/28/2018 to identify any other resident with any ADL care needs to include nails care and facial hair removal/shaving. Six other residents were identifies with need for nail care and five residents were noted with need for cutting facial hair. Assistance with nail care and shaving/removal of facial hair for identified residents provided by Director of Nursing, Assistant Director of Nursing and/or Unit Manager on 6/28/2018. Findings of this audit is documented on the “ADL Assistance audit tool” maintained in the facility compliance binder. SYSTEMATIC CHANGES Effective 7/10/2018; residents will receive assistance with activities of Daily Living (ADL) to include assistance with nail care and assistance with shaving at the minimum during scheduled shower days and as needed. The ADL assistance to include nail care and assistance with shaving will be provided by certified nursing assistance with an oversite of the licensed nurses, based on each resident’s plan of care. Effective 07/10/2018, the facility will provide proper set-up, oversight, cuing and nail care to all current residents that need supervision, to ensure hygiene, mobility, elimination, dining and communication are maintained and do not diminish unless circumstances of the individual’s clinical condition demonstrate that such diminution is unavoidable	

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F 676	Continued From page 68 observation and resident's statement. Interview with Nurse #3 at 11:16 AM on 6/8/18 revealed Resident # 46 was very independent. She said she would have to check with the nurse aide about shaving and cutting his nails. Observation at 1:42 PM on 6/8/18 revealed Resident #46 was clean shaven and had trimmed fingernails. He said, "It's a matter of feeling like doing it. I did it. The other woman cut my nails." Interview with the Director of Nurses on 6/08/18 at 2:24 PM revealed he would expect the nurse aide to offer shaving and follow through with shaving. He said we took care of nails this afternoon. He said aides are allowed to trim nails if the resident does not have diabetes.	F 676	On 7/02/2018; Chief Clinical officer from the consulting and Management Company contracted by the facility revised a “bath/shower form” to include area for documentation for nail care, shaving/removal of facial hair. Facility nursing staff will utilize the revised shower sheet effective 7/10/2018. Effective 7/10/2018; certified nursing aide on duty will notify a licensed nurse on duty of any refusal of care specifically related to nail care and shaving/removal of facial hair promptly when it occurs. Licensed nurse will discuss with the resident to validate the refusal. Licensed will sign the Bath/shower forms for individual residents who is scheduled for bath/shower with the reason for refusal added on the form. Completed bath/shower forms will be maintained in the residents’ shower books maintained at each nursing station effective 7/10 /2018. Director of Nursing, Assistant Director of Nursing and/or Staff development coordinator will complete 100% re-education to all current nursing staff, to include full time, part time and as needed nursing staffs. This education will provide an emphasis on the importance to provide the appropriate treatment and services to maintain or improve resident’s ability to carry out the activities of daily living, to include but not limited to; utilizing proper set-up, oversight and cuing for residents and ensuring maintaining abilities to perform ADL’s. Nursing staff were also re-educated on how to access each resident plan of care to determine the assistance needed for ADL’s. Nurses on	

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F 676	Continued From page 69	F 676		

duty were re-educated to follow up with residents on shower days to make sure that nail and facial care was provided, and signing the bath/shower sheet after the proper follow through. This education will be completed by 07/10/2018, any nursing staff not educated by 07/10/2018 will not be allowed to work until educated. This education will also be added to new hire process for all new nursing employees effective 07/10/2018 and will be provided annually.

MONITORING PROCESS
Effective 07/10/2018, the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will complete the random audit of nursing aides and/or nurses providing set-up for residents needing supervision to ensure care was provided correctly.

Effective 06/29/2018, 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.

Effective 7/10/2018, Director of Nursing, Assistant Director of Nursing, Unit manager and/or designated licensed nurse, will monitor compliance with assistance with ADL care for residents who are capable of performing their ADL

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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 676	Continued From page 70	F 676	by randomly checking five randomly selected residents in different halls on each shift to ensure ADL assistance is provided to include nail care and shaving as appropriate based on each resident's plan of care. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on an "ADL Assistance monitoring tool "and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily for two weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 7/10/2018, Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator 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 7/10/2018, 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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	345213	A. BUILDING _____ B. WING _____	C 06/08/2018

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F 676	Continued From page 71	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to provide finger nail care for 3 of 3 dependent residents (Resident # 48, #59 & #62) reviewed for activities of daily living. The findings included: 1) Resident #48 was admitted to the facility on 2/01/17 with diagnoses which included dementia and cerebral infarct with hemiplegia affecting the right dominant side. A review of the most recent Minimum Data Set (MDS), a quarterly review dated 4/23/18, revealed he was cognitively impaired and required extensive to total assistance with all activities of daily living (ADLs). He was able to understand and be understood. He was totally dependent on 2 staff for bathing. A record review of the care plan dated 1/29/18 revealed Resident #48 required extensive to total assistance with bathing, grooming and dressing due to hemiplegia and decreased mobility. The interventions included nail care on shower days and as needed.	F 677	Compliance date 7/10/2018 F677 ROOT CAUSE Director of Nursing, and the facility Executive Director discussed on 6/08/18 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged non-compliance resulted from failure by an employee to provide nail care to 3 of 3 identified residents; resident #48, #59, & #62. Resident #48, #59, &62 are unable to carry out the activities of Daily living on their own, specifically nail care. The root cause analysis added that the alleged noncompliance was caused by the employees' culture within the facility that include, but not limited to, lack of residents' centered care delivery culture, lack of good customer service, and lack of consistent staffing who provide care for residents in the facility to assure care is delivered to residents in the facility at all times. IMMEDIATE ACTION On 06/08/2018, Director of Nursing	7/10/18

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F 677	Continued From page 72 During an observation on 5/4/18 at 11:47 AM Resident #48 was observed to have black debris under his fingernails on both hands. During an observation on 6/5/18 at 11:49 AM Resident #48 was observed sitting in his wheelchair in the hall while being transported to the dining room for lunch. His fingernails were observed and they continued to have black debris under the nails on both hands. During an observation on 6/6/18 at 9:01 AM Resident #48 was in bed. He stated he had not had a bath yet. His finger nails remained dirty. On 6/6/18 at 5:08 PM Nursing Assistant #4 was interviewed. She stated cleaning fingernails was part of any bath and not just part of the twice per week shower. During an interview with the Director of Nursing on 6/8/18 at 1:00 PM he stated cleaning fingernails was part of the daily bath and nails should be cleaned whenever they have debris under them. On 6/8/17 at 1:14 PM his fingernails continued to have black debris caked under the nails. On 6/8/18 at 1:15 PM Nurse #4 observed the fingernails of Resident #48. She observed the black debris under his fingernails on both hands. She stated they needed to be cleaned and she would do it immediately. 2) Resident #59 was admitted to the facility on 7/30/12. Her diagnoses included profound intellectual disabilities, blindness in both eyes, aphasia and contractures of both knees.	F 677	(DON), Assistant director of Nursing and/or Unit manager provided nail care for residents #48, #59 & #62. IDENTIFICATION OF OTHERS 100% audit of all current residents in the facility was completed by the Director of Nursing, Assistant Director of Nursing and/or Unit Manager on 6/25/2018 & 6/26/2018 to identify any other resident with any ADL care needs to include nails care. Six other residents were identified with need for nail care. Nail care for identified residents provided by Director of Nursing, Assistant Director of Nursing and/or Unit Manager on 6/28/2018. Findings of this audit is documented on the “ADL care audit tool” maintained in the facility compliance binder. SYSTEMATIC CHANGES Effective 7/10/2018; residents will receive the necessary to maintain good grooming to include but not limited to, nail care during daily ADL care. The ADL care to include nail care will be provided by certified nursing assistance with an oversite of the licensed nurses, based on each resident’s plan of care. Effective 7/10/2018, facility will establish consistent assignment for licensed nurses and nursing aides. This will aide on improving residents’ centered care delivery and customer centered approach. Staff members will be familiar with the residents under their care as the result each resident needs will be anticipated to include ADLs care specifically nail care. Effective 6/7/18 the facility will conduct an interdisciplinary weekly team building meeting that with the department	

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F 677	Continued From page 73 A review of the annual Minimum Data Set (MDS) dated 4/27/18 revealed she was severely cognitively impaired, required extensive to total assistance with all activities of daily living (ADLs) and had impaired range of motion on both sides of both the upper and lower extremities. The care plan dated 4/28/17 stated Resident #59 required help with care related to immobility of both upper extremities and both lower extremities, relied on staff for all care needs with an intervention to receive nail care on shower days. An observation on 6/5/18 at 5:03 PM revealed her fingernails had back debris under them. On 6/6/18 at 5:08 PM Nursing Assistant (NA) #4 was interviewed. She stated cleaning fingernails was considered part of the daily bath and not just completed with the shower on the scheduled shower days. On 6/7/18 at 11:22 AM Resident #59 was observed up in the chair. NA #5 was in the room and stated she had given Resident #59 at bath today and cleaning the fingernails was part of the bath. She observed the nails and reported they were dirty and needed trimming. She said she did not clean Resident #59 ' s nails today during the bath but would clean and trim them later in the afternoon before the end of her shift. She did not explain why she did not clean the nails during the resident's bath. During an interview with the Director of Nursing on 6/8/18 at 1:00 PM he stated cleaning fingernails was part of the daily bath and nails should be cleaned whenever they have debris	F 677	supervisors to discuss culture change initiatives to be implemented in the facility. These meetings will be held without affecting resident care activities. These meetings are intended to improve employee culture in the facility and hence improve quality of care to all our residents. Effective 6/7/2018 the facility established an Employee Appreciation Committee (EAC) chaired by the Director of Human Resources. Initial members of this committee were selected by the facility Executive Director and Director of Nursing Services. Members include the Activity Director, Director of Social Services, Nurse Aide #1, Dietary Aide #1 and Laundry aide #1. This committee will meet monthly to discuss ways to improve employees' morale in order to reduce staff turnover and improve work place culture effective 6/7/2018. Effective 07/10/2018, the facility will provide proper set-up, oversight, cuing and nail care to all current residents that need supervision, to ensure hygiene, mobility, elimination, dining and communication are maintained and do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution is unavoidable On 7/02/2018; Chief Clinical officer from the consulting and Management Company contracted by the facility revised a "bath/shower form" to include area for documentation for nail care. Facility nursing staff will utilize the revised shower sheet effective 7/10/2018. Effective 7/10/2018; certified nursing aide on duty will notify a licensed nurse on duty	

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F 677	Continued From page 74 under them. 3) Resident #62 was readmitted to the facility on 11/2/17 with diagnoses which included heart failure, dementia and contractures of both knees. A review of the quarterly Minimum Data Set (MDS) dated 4/30/18 revealed Resident #62 was severely cognitively impaired and required extensive to total assistance with all ADLs including bathing which required the assistance of 2 staff. During an observation on 6/5/18 at 2:30 PM Resident #62 was observed in the day room sitting in his wheelchair. An observation of his fingernails revealed there was debris under his nails which was most obvious under the thumb nails on both hands. On 6/6/18 at 5:08 PM Nursing Assistant (NA) #4 was interviewed. She stated cleaning fingernails was considered part of the daily bath and not just completed with the twice a week shower. On 6/8/18 at 9:43 AM Resident #62 was up in a wheelchair in his room. An observation of his nails revealed the thumb nails on both hands were long and contained dark debris under the nails. On 6/8/18 at 10:53 AM an additional observation of the fingernails for Resident #62 revealed his fingernails continued to contain dark debris under the thumb nails. During an interview with the Director of Nursing on 6/8/18 at 1:00 PM he stated cleaning fingernails was part of the daily bath and nails	F 677	of any refusal of care specifically related to nail care promptly when it occurs. Licensed nurse will discuss with the resident to validate the refusal. Licensed will sign the Bath/shower forms for individual residents who is scheduled for bath/shower with the reason for refusal added on the form. Completed bath/shower forms will be maintained in the residents' shower books maintained at each nursing station effective 7/10 /2018. Director of Nursing, Assistant Director of Nursing and/or Staff development coordinator will complete 100% re-education to all current nursing staff, to include full time, part time and as needed nursing staffs. This education will provide an emphasis on the importance to provide the appropriate treatment and services to maintain or improve resident's ability to carry out the activities of daily living, to include but not limited to; utilizing proper set-up, oversight and cuing for residents and ensuring maintaining abilities to perform ADL's. Nursing staff were also re-educated on how to access each resident plan of care to determine the assistance/services needed for ADL's. Nurses on duty were re-educated to follow up with residents on shower days to make sure that nail and facial care was provided, and signing the bath/shower sheet after the proper follow through. This education will be completed by 07/10/2018, any nursing staff not educated by 07/10/2018 will not be allowed to work until educated. This education will also be added to new hire process for all new nursing employees	

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F 677	Continued From page 75 should be cleaned whenever they have debris under them.	F 677	effective 07/10/2018 and will be provided annually. MONITORING PROCESS Effective 07/10/2018, the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will complete the random audit of nursing aides and/or nurses providing set-up for residents needing supervision to ensure care was provided correctly. Effective 06/29/2018, 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. Effective 7/10/2018, Director of Nursing, Assistant Director of Nursing, Unit manager and/or designated licensed nurse, will monitor compliance with ADL care for residents who are unable to perform their ADL by randomly checking five randomly selected residents in different halls on each shift to ensure ADL care is provided to include nail care as appropriate based on each resident's plan of care. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on an "ADL Care monitoring tool "and filed in the facility compliance binder after proper	

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F 677	Continued From page 76	F 677	follow up is done. This monitoring process will take place daily for two weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 7/10/2018, Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator 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 7/10/2018, 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 7/10/2018	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		7/10/18

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F 690	Continued From page 77 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to keep a catheter bag from coming in contact with the floor for 1 of 2 residents (Resident #16) reviewed for catheter care. The findings included: Resident #16 was admitted to the facility on	F 690	F690 ROOT CAUSE Director of Nursing, Dietary Manager, Staff Development Coordinator, ADON, Unit Manager and the facility Executive Director discussed on 6/08/18 to identify the root cause of this alleged	

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F 690	Continued From page 78 2/15/17. His diagnoses included right lower leg amputation, contractures of the right and left knees, dementia and stage 4 pressure ulcer. A review of the quarterly Minimum Data Set (MDS) dated 3/23/18 revealed Resident #16 was cognitively intact with no behaviors. He required extensive to total assistance with all activities of daily living (ADLs) except he was independent with eating. He had an indwelling urinary catheter. The care plan dated 1/13/18 addressed interventions for the indwelling catheter which included use of a privacy bag, observe for signs and symptoms of urinary tract infections and to follow orders for catheter care. During an interview with Resident #16 on 6/5/18 at 12:42 PM his urinary catheter privacy bag was observed touching the floor. During an observation on 6/6/18 at 8:55 PM Resident #16 was self-propelling his wheelchair in the hall. His catheter bag was observed strapped under the wheelchair with the bottom of the collection bag cover dragging on the floor. On 6/7/18 at 2:47 PM Resident #16 was observed sitting in his wheelchair in the court yard. His urinary catheter privacy bag was observed touching the concrete sidewalk. During an interview with Resident #16 on 6/7/18 at 2:47 PM he stated he was not aware the privacy bag was touching the concrete because he could not see it. On 6/8/18 at 4:08 PM Nursing Assistant (NA) #6 observed the urinary catheter privacy bag and	F 690	noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from Nurse Aide #6 not properly securing privacy, concluding that the facility failed to keep a catheter privacy bag from coming in contact with the floor. IMMEDIATE ACTION On 6/08/18, DON adjusted catheter bag under resident # 16 wheelchair to prevent from coming in contact with floor. IDENTIFICATION OF OTHERS This deficiency practice has the potential of affecting all resident that have Foley catheters. On 6/08/2018 facility wide audit was conducted by the Director of Nursing, Assistant Director of Nursing and/or Unit manager for all residents with Foley catheters to ensure the catheter privacy bags are being properly secured above the ground but below resident's bladder. Eight other residents were identified with Foley catheters in place. All eight resident's catheters were properly secured and not touching the floor. Findings of this audit is documented on the "Foley Catheter Audit Tool" maintained in the facility compliance binder. SYSTEMATIC CHANGES Effective 7/10/2018; any resident with a Foley Catheter will have a privacy bag located below the bladder and secured to	

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F 690	Continued From page 79 stated Resident #16 the catheter collection bag should remain below the bladder level but should not be in contact with the floor. She stated if it was tied to the wheelchair correctly it would not touch the floor. She said the NA was responsible to secure the urinary catheter privacy bag so it did not touch the floor. On 6/8/18 at 2:30 PM Nurse #4 stated the resident's urinary catheter bag should be secured to his wheelchair so it does not touch the floor.	F 690	ensure it doesn't touch the ground. Director of Nursing, Assistant Director of Nursing and/or Staff development coordinator will complete 100% re-education to all current nursing staff, to include full time, part time and as needed nursing staffs. This education will provide an emphasis on ensuring any resident with a Foley Catheter has a privacy bag in place below the bladder and secured above the ground. This education will be completed by 07/10/2018, any nursing staff not educated by 07/10/2018 will not be allowed to work until educated. This education will also be added to new hire process for all new nursing employees effective 07/10/2018 and will be provided annually. MONITORING PROCESS Effective 07/10/2018, the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will observe all current resident with catheters ensure the catheter bags are placed below the bladder and secured above the floor/ground for each resident with a Foley catheter. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on the "Foley catheter Monitoring tool" and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily for two weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is	

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F 690	Continued From page 80	F 690	maintained. Effective 7/10/2018, Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator 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 7/10/2018, 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 7/10/2018	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		7/10/18

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F 692	Continued From page 81 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, observation, the facility failed to provide a therapeutic diet consistent with renal diet restrictions for 1 of 1 resident who was prescribed a renal diet (Resident #90). Findings included: Resident #90 was admitted on 5/8/18. His diagnoses, in part, included end stage renal dialysis and hypertension. Review of Resident #90's medical record revealed he had a diet order to receive a renal regular diet. A renal diet limits phosphorus, potassium and sodium. His orders included dialysis on Tuesday, Thursday and Saturday. He was ordered calcium acetate with meals. Calcium acetate is a medication that helps prevent people with kidney disease from retaining too much phosphate, which could cause bone malformations and calcium deposits in tissues. Resident #90 was comprehensively assessed on 5/15/18 using the Minimum Data Set. His diagnoses included end stage renal disease and diabetes mellitus. He was determined to need a therapeutic diet and dialysis treatments. He had no long or short term memory problems.	F 692	ROOT CAUSE Director of Nursing, Dietary Manager, Registered Dietitian, and the facility Executive Director discussed on 6/08/18 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from inadequate training/understanding of dietary staff, as the result the facility failed to provide a therapeutic diet consistent with renal diet restrictions for resident #90, who is prescribed a renal diet. The root cause analysis also concluded that the lack of effective communication in the tray-line caused the error for a resident therapeutic diet to be served with items that resident #90 should have not received based on physician order. IMMEDIATE ACTION Resident #90 was assessed by the Director of Nursing on 6/8/2018 to	

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F 692	Continued From page 82 Resident #90 was care planned (date of care plan?) for nutritional decline and weight and fluid fluctuations due to end stage renal disease and receiving hemodialysis. Review of the facility's menu for 6/6/18, revealed a resident receiving a renal diet was to receive baked chicken, rice or noodles, green beans, dinner roll, margarine, white cake, fruit punch, beverage of choice. According to the USDA Food Composition Databases ½ cup of rice contains 28 milligrams (mg) of potassium and ½ cup of green beans does not contain phosphorus. On 6/6/18 at 4:43 PM, Resident #90 received his supper meal which consisted of; baked chicken, cubed potatoes, succotash (corn and lima beans), dinner roll, margarine, white cake, tea and 2 pepper packets. According to the USDA Food Composition Databases ½ cup of potatoes contains 158 mg of potassium and ½ cup of succotash contains 112 mg of phosphorus. The diet slip served with the resident's meal tray specified he was on a renal diet. On 6/07/18 at 8:22 AM, Resident #90 received his breakfast meal which consisted of; cranberry juice, coffee, eggs, white toast, grits, sweetener, salt packet, pepper packet, creamer and jelly. According to the USDA Food Composition Databases, one packet of salt contains 290 mg of sodium. Interview on 6/8/18 at 9:01 AM, with cook #1 revealed residents on renal diets should not be served salt packets with their meals. A telephone interview with the registered dietitian	F 692	determine if resident had any complication resulted from receiving items on the meal trays on 6/6/2018 and 6/7/2018 that were not compatible with the ordered therapeutic diet. Resident #90 shown no signs or symptoms of any complication. Resident #90's attending physician was notified that resident #90 received food items on the meal tray for both dinner and breakfast on 6/6/2018 and 6/7/2018 consecutively that were not compatible with resident's ordered therapeutic diet. No new orders were received. The notification took place on 6/9/2018. IDENTIFICATION OF OTHERS All residents on therapeutic diet have the potential to be affected by this alleged deficient practice. On 6/27/2018 & 6/28/2018 Dietary Managers, Completed facility audit on residents with therapeutic diets to ensure that diets ordered matches the tray cards system 5 other residents identified with diet orders not matching the tray card. Dietary Manager corrected all identified diet orders in the tray card system on 7/2/2018. Findings of this audit is documented on the "Dietary Roster Report" and maintained in the facility compliance binder. On 6/27/2017 dietary manager observed the tray card process during the lunch meal to identify if any other resident with therapeutic diet received items in the try not compatible with their specific physician ordered diet. No other resident was identified as receiving items on the	

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F 692	Continued From page 83 on 6/8/18 from 11:40 AM- 12:02 PM revealed she would have expected rice to be served instead of potatoes. She did not comment on succotash instead for green beans. Interview with the Director of Nurses on 06/08/18 between 02:09 - 2:21 PM revealed he would not expect potatoes and succotash to be served on the renal diet.	F 692	tray not compatible with the ordered diet. SYSTEMATIC CHANGES Effective 7/10/2018 the facility will proved therapeutic diet as ordered by the physician and will not include items not compatible with each resident's diet. This will be accomplished through systemic modification of dietary meal preparation on tray line. This modification will include changes from the point of calling a diet order, plating food and receiving the tray at the end of the line as outlined below Effective 7/10/2018 the tray line will consist of the minimum of three dietary employees. The first employee will be responsible to call the diet order from a tray card. This employee will read the needed information from both individual resident's tray card and from the menu spreadsheet. Information such as; diet texture, therapeutic restriction, food allergies, resident dislikes, and/or items not allowed on the try based on the therapeutic restriction will be verbally read and mentioned by the first dietary employee at the beginning of the tray line. The second dietary employee will be responsible to plate the food based on information read by the first employee. The third employee will be responsible to receive and verify the accuracy of the tray based on information on the tray card. Effective 7/10/2018, dietary Manager will complete 100% audit pf all residents in the facility once every month by comparing physician orders and each	

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F 692	Continued From page 84	F 692	resident's diet on tray card to ensure no discrepancies are noted on the diet. Any identified discrepancy will be corrected promptly by the Dietary manager. Employed 100% education of all current dietary staff, to include full time, part time and as needed nursing staff, will be completed by Dietary Managers and/or Registered Dietitian. This education will provide an emphasis on proper diets. This education will be completed by 06/29/2018, any staff not educated by 06/29/2018 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 06/29/2018 and will be provided annually. Dietary Manager and/or Registered Dietician will complete 100% re-education to all current dietary staff, to include full time, part time and as needed dietary staffs. This education will focus on the new tray line process to include the three employees on the line duties and responsibilities and will also provide an emphasis on ensuring any resident with a therapeutic diet receive accurate meal items on the tray card comparable with resident's diet orders. The education will also focus on common items not included in each commonly ordered therapeutic diets in the facility. This education will be completed by 07/10/2018, any dietary staff not educated by 07/10/2018 will not be allowed to work until educated. This education will also be added to the new hire process for all new	

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F 692	Continued From page 85	F 692		

dietary employees effective 07/10/2018 and will be provided annually.

MONITORING PROCESS

Effective 07/10/2018, the Dietary Managers and Registered Dietitian will complete audit of one meal a day to assure dietary staff preparing, serving, and/or calling tray line, to ensure all trays match the diet requested per tray ticket. Findings from this monitoring process will be documented on “Tray/Dietary Monitoring Tool” maintained in the facility compliance binder. This monitoring process will take place daily for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained.

Effective 7/10/2018, Dietary Manager and/or Executive director 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 7/10/2018, the center Executive Director, Dietary Manager 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

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F 692	Continued From page 86	F 692	remains in substantial compliance.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, dialysis staff interview and observation, the facility failed to transport a resident to dialysis at the scheduled time, for 1 of 1 resident who received hemodialysis (Resident #90). This resulted in refusal of care at the dialysis center and a long wait to return to the nursing home. Findings included: Resident #90 was admitted on 5/8/18. His diagnoses, included end stage renal dialysis (ESRD), altered mental status, difficulty in walking, muscle weakness, schizophrenia, heart failure, and extrapyramidal and movement disorder. His admission physician orders included dialysis on Tuesday, Thursday and Saturday. Resident #90 was comprehensively assessed on 5/15/18 using the Minimum Data Set. His diagnoses included end stage renal disease. He was determined to need dialysis treatments. He had no problems with long or short term memory. He had not refused care in the assessment	F 698	F698: ROOT CAUSE Director of Nursing, Medical Records Director, Transportation Aide, and the facility Executive Director discussed on 6/07/18 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from a good faith attempt by the facility staff to accommodate a second resident who had a scheduled appointment outside facilities transportation limitation zone, without considering the negative outcome of such to resident #90 who had a regularly scheduled dialysis. IMMEDIATE ACTION Resident #90 was reassess by the Director of Nursing on 6/8/2018 to identify any signs or symptoms of any distress caused by the extended period of time he spent at the Dialysis center. Resident shown no signs or symptoms of any distress.	7/10/18

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F 698	Continued From page 87 period. Resident #90 was care planned on 5/15/18 for hemodialysis and alteration in comfort related to decreased mobility. Resident #90 was interviewed on 6/6/18 at 4:49 PM. He said he went to dialysis via ambulance. He said he went on Mondays, Wednesdays and Fridays at 4:00 PM. These statements could not be corroborated with the physician's orders or scheduling book. He said he had no concerns with dialysis treatments and had not missed any treatments. The Appointment book located at the nurse's station indicated Resident #90's dialysis appointments were on Tuesday, Thursday and Saturdays and transportation was planned for 11:00 AM. A nurse's note dated 6/6/18 indicated the dialysis center faxed a note indicating Resident #90 complained about left groin pain and he refused examination. On 6/07/18 at 09:30 AM Nurse #2 said Resident #90 went to dialysis at 9:20 AM. Interview with the dialysis nurse at the dialysis clinic on 6/07/18 at 11:56 AM revealed Resident #90's scheduled time was at 12:30 PM. He said he usually completed the treatment at 4:30 PM. He said he arrived at 10:00 AM today. The dialysis nurse stated Resident #90 was in the lobby and explained Resident #90 refused treatment today. He said Resident #90 rambled off lots of reasons for his refusal to get into the treatment chair. The dialysis nurse said he was	F 698	IDENTIFICATION OF OTHERS On 6/29/2018 Medical Records, Director of Nursing, Transported, and Executive Director completed 100% audit of all residents transported to outside appointment to for the last 2 months to identify any other resident who was transported to their appointment earlier than plan (target 30 minutes or more before the appointment time without proper reason). No other resident identified as being sent to the appointment 30 minutes or earlier before the appointment time. Findings of this audit is documented on the “transportation audit tool” maintained in the facility compliance binder. SYSTEMATIC CHANGES Effective 07/10/2018, the facility will ensure a proper transport for resident to dialysis at the scheduled time, residents will be scheduled to arrive at the appointment location no more than 30 minutes before the appointment unless specified otherwise. Effective 07/10/2018; to accommodate other residents with the outside the facility medical appointment scheduled at the same time or close by together, the facility will schedule transportation with a contracted non-emergency transportation company to ensure residents are not arriving to the appointment earlier that 30 minutes before the scheduled appointment.	

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F 698	Continued From page 88 agitated. He said he reported the refusal to the nursing home. He said it was the first time he had refused to be dialyzed. He had confusion. He said the dialysis center informed the responsible party and would reschedule the appointment. Interview with the Medical Records Manager on 6/7/18 at 12:12 PM revealed she was responsible for scheduling transportation. She said Resident #90 was scheduled for dialysis at noon. She said Resident #90 usually left the nursing home around 11:00 - 11:30 AM. The Medical Records Manager said the Transportation Aide called her and said the clinic called the Transportation Aide and said Resident #90 refused to get in the chair. Telephone interview with the Transportation Aide on 6/7/18 at 12:19 PM revealed the reason why she left earlier than planned was because she did not want Resident #90 to be late for dialysis. She explained that she needed to transport another resident for an eye surgery appointment out of town that was not anticipated. The Medical Records Manager added, "We did our best to accommodate. If he missed dialysis today, they will try to schedule him tomorrow." Interview with Nurse #2 on 6/7/18 at 12:21 PM revealed Resident #90 did not want to go to dialysis and he had to coach him. He said the reason he did not want to go was because he thought he went yesterday. On 6/7/18 at 4:38 PM, Resident #90 was observed to be wheeled back into the nursing home. Approximately seven hours had elapsed since he left at 9:20 AM.	F 698	Effective 07/10/2018 Medical Record, Transportation Aide will maintain a daily log of all residents appointments to include dialysis residents. Medical Records Director and Transportation aide and the Director of Nursing will receive education on proper planning and scheduling for dialysis residents and other medical appointments to ensure residents will arrive to their appointment within 30 minutes of their scheduled appointment unless specified otherwise. This education will be conducted by the facility Executive Director and will be completed by 07/10/2018, any staff not educated by 07/10/2018 will not be allowed to work until educated. This education was also added to new hire process for all new Medical record staff, transportation employees and/or Director of Nursing effective 07/10/2018 and will be provided annually. MONITORING PROCESS Effective 07/10/2018, the Director of Nursing and Executive Director will complete the transportation audits for all residents with scheduled appointment to ensure planning and schedules for each resident with a medical appointment assures each resident arrived at the appointment no earlier than 30 minutes before the appointment time. Any negative findings identified during this monitoring process will be addressed promptly. Findings from this monitoring process will	

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F 698	Continued From page 89 On 6/8/18 at 8:23 AM, the Transportation Aide confirmed Resident #90 left around 9:30 AM on 6/7/18. He arrived at the dialysis center around 10:00 AM. They left early to get another resident to surgery and she wanted him to be on time for his dialysis treatment. They arrived back to the nursing home at 4:36 PM. On 6/8/18 at 8:10 AM the Medical Records Manager said Resident #90 was rescheduled for his dialysis appointment today at noon and that he would be taken at around 11:00 AM. Interview with the Director of Nurses on 06/08/18 between 2:09 PM and 2:21 PM revealed it was not acceptable to send Resident #90 too early for dialysis. He said he was aware of the issue because there was a grievance from dialysis center to the nursing home.	F 698	be documented on the "Transportation audit tool" and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily for two weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 07/10/2018, Director of Nursing, and Executive Director 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. RESPONSIBLE PARTY Effective 06/29/2018, 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 7/10/2018.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental	F 745		7/10/18

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F 745	Continued From page 90 and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to send a resident for an ordered psychiatric evaluation for 1 of 1 resident reviewed for psychiatric evaluations (Resident #64). Findings included: Review of the medical record of Resident #64 indicated she was readmitted to the facility on 06/17/2017 (initial admission in 2012) with diagnoses which included Diabetes Mellitus, Psychosis, Schizophrenia, and Mood Disorder. Review of the resident's annual Minimum Data Set (MDS) dated 02/08/2018 indicated she had no cognitive impairment. Review of the resident's care plan dated 01/31/2018 indicated the resident received psychotropic medications for Schizophrenia, Psychosis and Conduct Disorder. Listed as part of interventions was "Notify MD (Medical Doctor) of abnormalities and psyche (psychiatric) services as needed, and follow up with recommendations as ordered". Review of the resident's medical record indicated a pattern of refusing medications which included psychotropic medications since 01/01/2018. The resident's prescribed antipsychotic mediation was Risperdal Consta 25 milligrams intramuscular injection every 2 weeks for psychotic behavior which was ordered on 02/28/2018. The resident refused the medication on 03/09/2018, 03/23/2018, 04/06/2018, took the medicine on	F 745	ROOT CAUSE Director of Nursing, Social Worker, and the facility Executive Director discussed on 6/08/18 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from communication failure between the facility staff who receive orders for psychiatric services to the facility Social worker who schedule the psychiatric services either on site or off site, as the result the facility failed to arrange services for resident #64 as ordered by physician in one occasion on 4/11/2018. Other factors contributing to this alleged noncompliance include not having reliable contracted psychiatric services to provide services on site for our residents. IMMEDIATE ACTION Resident #64 attending physician was notified of the attempts by the facility to send a resident fr outside psychiatric appointment. The earliest available appointment will be in August 2018. Attending physician for resident #64 approved for resident's psychiatric appointment to be scheduled on the next available appointment. Resident shown no signs or symptoms of any distress. IDENTIFICATION OF OTHERS 100% audit of all current residents in the	

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F 745	Continued From page 91 04/20/2018, took the medication on 05/04/2018, refused it on 05/18/2018 and took the medication on 06/01/2018. The record also indicated numerous refusals of finger stick blood sugars as well as routine insulin refusals from 01/01/2018 through 06/05/2018. Review of a nursing progress note dated 04/11/2018 at 9:08 AM and written by the facility Director of Nursing (DON) indicated "Resident noted to routinely refuse medications. Resident has not had recent behavior incidents or outbursts. Medical Doctor notified and suggested we send resident out for psyche (psychiatric) evaluation due to refusal of Risperdal (antipsychotic medication). Will continue to monitor and assist as indicated." Review of the record revealed no orders for a psychiatic evaluation and no documentation of a psychiatric evaluation visit related to the note of 04/11/2018. The record also indicated the resident's last documented psychiatric visit was in house on 11/08/2017. The Corporate Clinical Officer (CCO) was interviewed on 06/08/2018 at 12:40 PM and stated the facility contract with psychiatric services ended but was unsure of the date this occurred. He also stated the facility had a new contract with a psychiatric service, but at this time, they had not visited the facility. In an interview with the facility DON on 06/08/2018 at 2:04 PM, the DON stated he contacted the Medical Director (MD) on 04/11/2018, and the MD ordered to send the resident out for a psyche evaluation. The DON stated his usual practice was to write a telephone	F 745	facility completed by the facility Social Worker, MDS nurse and Director of Nursing on 6/28/2018 to identify any other resident with orders for psychiatry services that were not carried out. No other resident identified with physician orders written in the last 30 days for psychiatry service that remains outstanding. 100% audit of all current residents in the facility completed by the facility Social Worker, MDS nurse and Director of Nursing on 6/28/2018 to identify any other resident who may benefit from psychiatric services. Attending physician was notified of the resident who may benefit from psychiatric services and referrals given as appropriate SYSTEMATIC CHANGES Effective 07/10/2018, Licensed nurse who receive an order for psychiatry services will document the order in the licensed electronic health record software used by the facility under the “physician order” Section of the software. Effective 07/10/2018, Facility social worker and/or Medical Records Manager will receive notification of the new orders by accessing the licensed electronic health record software used by the facility daily (Monday through Friday) and obtain the orders written by licensed nurses from previous week day and arrange/schedule the services as appropriate and timely based on the physician order.	

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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 745	Continued From page 92 order and communicate this to the facility Social Worker (SW) who then made the appointments. The DON looked through the resident's clinical record and stated he could not find the telephone order, and he may not have done it but also reiterated he should have done this. In an interview with the facility Social Worker (SW) on 06/08/2018 at 2:30 PM, the SW stated all psychiatric referrals came to her, and at that point, she interviewed the referred resident and made the appropriate appointment. The SW also stated she received no referrals for Resident #64 related to the 04/11/2018 phone referral. In an interview with the facility Medical Director (MD) on 06/08/2018, the MD stated when he gave an order for a referral for a psychiatric evaluation, he expected the facility to carry out the order. He also stated the resident suffered no harm as a result of not receiving the psychiatric evaluation. Resident #64 was observed every day at random times during the 5 day investigation. She was interviewed about various things which included her refusal of medications. On 06/07/2018 at 11:00 AM, she stated sometimes she refused her medications and said "I don't need them." She could not recall the last time she was seen by psychiatric services. Review of the record from 11/01/2017 through 06/05/2018 indicated no apparent harmful behaviors occurred as a result of refusal of medications.	F 745	Effective 7/10/2018, the facility has secured a contract with a licensed group to provide necessary medical related psychiatric services for our residents on site in the facility. This group will visit the facility for their initial visit in August 2018. Director of Nursing, Assistant Director of Nursing and/or Staff development coordinator will complete 100% re-education to all current licensed nurses, to include full time, part time and as needed nursing staffs. This education will provide an emphasis on ensuring any psychiatry consult order received is documented in the facility used electronic health record software so that the social worker or Medical records Manager can follow through with it as appropriate. This education will be completed by 07/10/2018, any nursing staff not educated by 07/10/2018 will not be allowed to work until educated. This education will also be added to new hire process for all new licensed nurses effective 07/10/2018 and will be provided annually. Chief Clinical officer will re-educate the facility social worker, Medical records Manager and the Director of nursing on how to access psychiatry orders documented in the facility used electronic health record software. This education will be completed by 7/10/2018 and will be added to the new hire process for all new Social workers, Medical Records Manager and Director of nurses effective 07/10/2018 and will be provided annually.	

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F 745	Continued From page 93	F 745	MONITORING PROCESS Effective 07/10/2018, Social Worker, Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will monitor compliance with arranging/coordinating psychiatrist services as ordered by physician by reviewing physician orders, and clinical documentation from previous day to ensure any psychiatric referrals are documented appropriately in the licensed electronic health record software used by the facility and followed through appropriately by the facility Social worker and/or Medical Records Manager. This audit will be completed daily Monday through Friday. Any negative findings identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on the "Psychiatric services audit tool" and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily (Monday through Friday) for two weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 07/10/2018, Facility Social Worker, Director of Nursing, and Executive Director will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of	

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F 745	Continued From page 94	F 745	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. Effective 07/10/2018, 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 7/10/2018.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		7/10/18

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F 761	Continued From page 95 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to remove an expired medication from 1 of 2 medication refrigerators observed for medication storage. Findings included: A review of the undated facility policy titled, Medication Storage in the Facility included, "When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated if the product has a shortened expiration date. 1) The nurse shall place a 'date opened' sticker on the medication and enter the date opened and the new date of expiration." The policy also included, "All expired medications will be removed from active supply and destroyed in the facility, regardless of amount remaining." On 6/7/18 at 9:04 AM the 500 hall Medication Prep Room was reviewed for medication storage. In the refrigerator there was an opened bottle of Magic Mouthwash with a manufacturer's expiration date of 6/5/18. There was also an adhesive label on the front of the bottle with a handwritten expiration date of 5/30/18. During an interview, on 6/7/18 at 11:58 AM, Nurse #5 stated she had done an audit in that Medication Prep room on 6/5/18 to be sure there were no expired medications. Nurse #5 stated the opened bottle of Magic Mouthwash was not in the	F 761	F761 ROOT CAUSE This alleged noncompliance resulted from the facility failure to have a system of ensuring expired medication are removed from circulation from both medication rooms and medication carts, before the date of expiration. IMMEDIATE ACTION TAKEN No Residents were named in this alleged noncompliance. On 6/7/2018 nurse #5 removed and discarded the identified Magic Mouth Wash identified from 500 hall medication prep room. An identified opened bottle of Magic Mouthwash with a manufacturer□s expiration date of 6/5/2018 and hand written expiration date of 5/30/2018, in 500 hall medication prep room were discarded by the Licensed nurse #5 on 6/7/2018. IDENTIFICATION OF OTHERS All residents who receives medication have the potential to be affected by this alleged non- compliance.	

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F 761	Continued From page 96 refrigerator when she did the audit. She indicated it might have been in the possession of a nurse on the hall at the time she was reviewing the Medication room. On 6/7/18 at 4:39 PM, the Director of Nursing (DON) stated there should be no expired medication in the Medication carts or the Medication rooms. The DON specified that Nurse #5 was responsible for checking the medication rooms and the bottle had not been in the Medication Prep room at the time of the audit on 6/5/18.	F 761	On 06/08/18, the Director of Nursing, Assistant Director of Nursing, Nurse Supervisor checked all medication storage rooms and medication carts to ensure expired medications had been No other expired medication observed in the medication rooms and/or medication carts. SYSTEMIC CHANGES Effective 7/10/2018 an incoming nurse will review the medication cart to ensure all open medication bottles for Magic mouth wash are dated when opened, and not expired at the beginning of the shift. This process will incorporate all other medications will short term expiration dates to ensure no expired medication are stored in the carts. Effective 7/10/2018; licensed nurses or Medication aides on duty during the night shift (from 11pm to 7am) will inspect each medication prep room to include medication refrigerators to ensure any medication with expiration date falling on the next three days of the inspection is removed from circulation to prevent expired medication being circulated. Director of Nursing, Assistant Director of Nursing and/or Staff development coordinator will complete 100% re-education to all current licensed nurses and Medication aides, to include full time, part time and as needed nursing staffs. This education will include the process of checking expiration dates of medication in	

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F 761	Continued From page 97	F 761		

the medication carts at the beginning of the shift and the responsibilities of overnight employees to inspect medication prep rooms and medication refrigerators for any expired medication or those with expiration within three days. This education will be completed by 07/10/2018, any licensed nurse or Medication Aide not educated by 07/10/2018 will not be allowed to work until educated. This education will also be added to new hire process for all new licensed nurses and Medication aides effective 07/10/2018 and will be provided annually.

MONITORING PROCESS

Effective 07/10/2018; The Director of Nursing, Assistant Director of Nursing, and/or Nursing Supervisor will be responsible for checking medication carts and medication rooms to identify any expired medication or medication with expiration within 72 hours of observation and ensure that medication with short expiration are dated, when opened.

Any negative findings identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on the Medication Storage audit tool and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily (Monday through Friday) for two weeks, weekly x 2 more weeks, then monthly x 3 months or until

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F 761	Continued From page 98	F 761	the pattern of compliance is maintained. Effective 07/10/2018, Director of Nursing, and/or Assistant 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 the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 07/10/2018, 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 7/10/2018.	
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes:	F 801		7/10/18

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§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5

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F 801	Continued From page 100 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation and interview with the Registered Dietitian, Dietary Manager and Administrator, the facility failed to employ a dietitian on a full-time basis while the newly employed dietary manager was working to complete the certified dietary manager requirements. Findings included: The Dietary Manager was met on 06/07/18 at 9:33 am. The title on the Dietary Manager's (DM) badge was observed to be Certified Dietary Manager. The DM said he was employed on 5/8/18. He said, "I am going to be certified in July". He said he would take the exam at that time. He said the Registered Dietitian (RD) was here every Monday.	F 801	F801 ROOT CAUSE The facility executive director and Chief Clinical officer met on 6/8/2018 to discuss the root cause of this alleged noncompliance. The root cause analysis concluded that this alleged noncompliance was resulted from the Center's Executive Director Misinterpretation of the revised regulatory requirements related to qualification requirements for food services Director that was in effective November 28, 2017. The root cause analysis concluded that even though the Dietary Manager employed by the center's Executive Director on 5/8/2018 has the appropriate	

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F 801	Continued From page 101 The RD was interviewed on 6/8/18 between 11:40 AM and 12:02 PM. She said she had been consulting at this nursing home for approximately six years. She said she comes one time a week. She said she needed more help keeping up with the new building and that is part of the reason the nursing home tried to get a certified dietary manager (CDM). The CDM would participate on the interdisciplinary care plan team. She confirmed awareness that the current dietary manager was not certified. She said she thought there was an allowance of time to get certified. An interview with the administrator was conducted on 6/8/18 from 2:47 - 3:10 PM. The administrator said the RD did not work full-time at the facility. He said she works about 8 hours per week. He said he hired the dietary manager and that he is not certified.	F 801	competencies and skills sets to carry out the functions of the food and nutrition services, however he does not have professional qualification required per regulatory requirements. The Executive Director stated that he understood that since the facility was employing mentioned Dietary Manager as the second Manager to lead the dietary department, he considered that the first designated manager who has worked in the facility for six years as dietary manager, (who was reassigned as the food service Director to manage the department as the second the manager & head cook), would have still counted as a qualified personnel per regulation. Chief Clinical Officer from the Consulting and Management Company contracted by the facility re-educated the Center Executive director and the Facility Human Resources Director on 7/2/2018 on the regulatory requirements related to qualified nutrition professional. IMMEDIATE ACTION On 7/3/2018, the center Executive Director change the Dietary Manager's duties. The second Dietary Manger #1 who was in charge of the dietary department for six years before 5/8/2018 will oversee all dietary food services effective 7/3/2018. IDENTIFICATION OF OTHERS 100% of all current employees in the facility who hold any position that requires professional qualification per regulation audited by the facility Human Resources Director and/or facility Executive Director to ensure each employee possess	

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F 801	Continued From page 102	F 801	required qualification per regulatory requirements. No other employee identified without appropriate qualification. This audit was completed on 7/2/2018 and 7/3/2018. Findings of this audit is documented in the employees' qualification audit tool maintained in the facility compliance binder SYSTEMIC CHANGES Effective 7/10/2018, the facility will only employ individuals with proper qualification as required by regulation to provide services in the facility. On 7/3/2018, Chief Clinical officer developed a spreadsheet with all professional positions at the facility with required qualification as required by regulation. The spreadsheet is provided to the facility Human Resources and Facility Executive Director. Effective 7/10/2018, the facility will utilize the developed spreadsheet with all professional positions at the facility as the reference guide before offering employment to any potential new hire to ensure that the required qualification per regulation are met. Chief Clinical Officer from the Consulting and Management Company contracted by the facility re-educated the Center Executive director and the Facility Human Resources Director on 7/3/2018 on necessary steps to be taken to verify each candidate professional qualification before offering employment. This education will also be added to the new hire process for any new Executive Director and/or Human	

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F 801	Continued From page 103	F 801	resources Director effective 07/10/2018 and will be provided annually. MONITORING PROCESS Chief Clinical officer from the Management and Consulting company or designated consultant will review all new hires qualification before hiring for the next 3 months to ensure facility only employ qualified employees per regulation. Executive Director will sign off on any new hire as an approval after verification of qualification take place, for every new hire for the next 6 months or until the pattern of compliance is maintained. RESPONSIBLE PARTY Effective 7/10/2018, the center Executive Director, and the Director of Human Resources will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 802		7/10/18

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F 802	Continued From page 104 §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the kitchen's dish machine service report, the dietary support personnel were not effectively carrying out the functions of dishwashing. Dietary staff were not properly trained on how to use the kitchen's dish machine to ensure that it properly cleaned and sanitized dishes. This problem had the potential to effect 93 of 104 residents who received meals at the nursing home. Findings included: An observation of staff washing dishes in the kitchen's dish machine was initially conducted on 06/07/18 at 9:33 AM. Staff was observed using a name brand single tank hot water sanitizing dish machine to wash the dishes. The machine's specifications listed on the front of the dish machine indicated the final rinse should operate at a minimum temperature of 180 degrees Fahrenheit. Dietary Aide (DA) #1 was observed pushing racks into the machine. The machine's tank was observed overflowing with suds. The Dietary Manager (DM) instructed DA #1 to drain the machine and start again. Observations were made in the kitchen on 6/7/18	F 802	F802 ROOT CAUSE Director of Nursing, Dietary Manager, Registered Dietitian, and the facility Executive Director discussed on 6/07/18 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from inadequate training/understanding of dietary staff, concluding that the facility failed to provide dietary support personnel training necessary to effectively carry out the functions of the food and nutrition service, specifically related to cleaning and sanitizing dishes using a high temperature machine. IMMEDIATE ACTION On 6/7/2018, food crumbs observed on the table where clean dishes come out on racks from the dish machine and dead ants on top of the dish machine were cleaned by the Dietary Manager. On 6/7/2018; Dietary Manager re-educated dietary aide #1 on the minimum acceptable temperature	

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

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F 802	Continued From page 105 from 9:58 AM until 10:59 AM. Food crumbs were observed on the table where clean dishes came out on racks from the dish machine. Dead ants were on top of the dish machine tank. The dish machine's readout displayed P1 and a wrench icon. The DM said the P1 meant phase 1. The cook said this was the first time she had ever seen the wrench on the dish machine's display and added, she was not familiar with that. Observations of staff washing several racks of dishes in the dish machine revealed the machine's final rinse temperatures viewed on the readout display only reached temperatures of 150, 147, 153, 160 degrees Fahrenheit. Diet Aide #1 continued to feed dishes into the machine even though the machine's final rinse cycle was not operating at a temperature of 180 degrees Fahrenheit. The DM was present during these observations and said it was DA #1's third day of employment and her first day working in the dish room. DA#1 was observed to pull dishes out of the dish machine without allowing the machine's final rinse cycle to finish. DA #1 removed one rack from the dish machine and inserted another rack. DA #1 was also observed to open the dish machine's door with the machine's final rinse cycle temperature at only 152 degrees Fahrenheit. DA #1 said, "It's on the right cycle now, because it is not taking forever." During this observation on 6/7/18 from 9:58 AM until 10:59 AM, the DM called the Maintenance Director (MD). The MD said he had a little familiarity with the dish machine. He called the service company to find out what the P1 and wrench icon on the readout meant. On 6/7/18 at 10:20 AM, DA#2 confirmed the sanitizing temperature for the kitchen's dish	F 802	required for a rinsing cycle. On 6/7/2018 Maintenance director educated the Dietary Manager, the cook, Dietary aide #3 of the meaning of a wrench sign and P1 after being advised by the service company of the meaning On 6/7/2018; Dietary Manager discontinued the use of the dish machine once notified by the Maintenance Director that the dish machine was not functioning properly, and the rinsing cycle did not reach 180 degree. On 6/7/2018; Dietary Manager spoke with Resident Council President and received approval to utilize paper products until machine is fixed and functioning properly. On 6/07/18 Dietary Manager prepared and utilized the 3 sink compartment for manual wash to ensure that dishes were getting clean, rinsed and sanitized appropriately using appropriate chemical sanitization chemicals. On 6/7/2018 the service company identified a burned wire that caused the machine to dysfunction. The company repaired the problem and the machine was verified to function properly with final rinsing circle reading 184 on 6/8/2018 IDENTIFICATION OF OTHERS No resident named in this alleged noncompliance. Any residents who receives meals from the facility kitchen has a potential to be affected by this alleged non- compliance.	

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F 802	Continued From page 106 machine's final rinse cycle should be 180 degrees Fahrenheit. The temperature of the machine's final rinse cycle was noted to only be reaching 160 degrees Fahrenheit and DA#1 continued to insert and remove dishes from the dish machine. Interview on 6/7/18 at 10:20 AM with DA #3 who was scrapping food from the dirty dishes said she did not know what the wrench symbol displayed on the machine's read out meant. On 06/07/18 at 10:59 AM, the Maintenance Director was observed with another maintenance person working on the dish machine. He said the service people could not come out, but told them to clean the probes. He said, "P1 means call for service." The DM decided to use paper products to serve lunch and he confirmed the decision was acceptable with the President of the Resident's Council. The DM added that no dish machine temperatures were recorded by staff during the morning of 6/7/18. The service company's report was reviewed. The report specified a repair was made to the dish washer on 6/7/18 around 5:30 PM. The report indicated a wire was burned. It was repaired and the machine functioned correctly when they left. On 6/8/18 at 9:21 AM, dishwashing was observed. There was no wrench icon on the dish machine's readout. The final rinse temperature of the machine was observed to reach a temperature of 184 degrees Fahrenheit. The DM said he had been trained to work with high temperature dish machines, but not this specific machine. Interview with the Registered Dietitian on 6/8/18	F 802	SYSTEMATIC CHANGES Effective 7/10/2018, dietary staff will check dish washing machine temperature for both washing and rinsing cycle at least three times daily. Findings from this process will be documented on “dish machine temperature log maintained at the dietary department. Any negative findings to include temperature less below 180 for the final rinsing cycle will be reported to the dietary manager and remove from being used immediately, until resolved. Three compartment sink will be utilized to clean dishes at that time. On 7/2/2018 Dietary manager revised a cleaning schedule to ensure the kitchen remains clean and sanitized at all times. This schedule incorporated cleaning on top of the dish machine and surfaces used for food preparation. Effective 7/10/2018; dietary staff will utilize revised cleaning schedule. Effective 7/10/2018, Dish machine is added on preventative maintenance schedule to be checked once monthly to ensure proper functionality per manufacturer guidelines Effective 07/10/2018, the facility establish a continuous education program called “safe food handling training” for all facility dietary staff that will cover all necessary information required to safely and effectively carry out the functions of the food and nutrition services. This cause will cover all aspects food handling to include	

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F 802	Continued From page 107 between 11:40 AM and 12:02 PM revealed the dishwasher was a high temperature machine and needed to reach a minimum final rinse temperature of 180 degrees Fahrenheit to sanitize the dishes and equipment being washed in the machine. She said she was responsible for the clinical documentation and not responsible for staff in the kitchen.	F 802	dish washing, kitchen sanitation, and equipment's functionalities and defects. Any new dietary support personnel will be checked off by the dietary manager and/or Registered Dietician before assuming duties in the facility. 100% education of all current dietary staff, to include full time, part time and as needed dietary staff, will complete "Safe food handling training" that will cover all necessary information required to safely and effectively carry out the functions of the food and nutrition services. This education will be provided and validated by the dietary manager and/or Registered dietician and will also cover all aspects food handling to include dish washing, kitchen sanitation, and equipment's functionalities and defects. This education will be completed by 07/10/2018, any dietary staff not educated by 07/10/2018 will not be allowed to work until educated. This education will also be added to the new hire process for all new dietary employees effective 07/10/2018 and will be provided annually. Registered Dietician and/or the Dietary Manager will complete in-servicing education on proper cleaning of dietary equipment and overall kitchen. This education will be completed by 07/10/2018, any dietary staff not educated by 07/10/2018 will not be allowed to work until educated. This education will also be added to the new hire process for all new dietary employees effective 07/10/2018 and will be provided annually.	

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F 802	Continued From page 108	F 802	MONITORING PROCESS Effective 7/10/2018, Dietary Manager and/or Registered Dietician will evaluate 3 randomly selected dietary staff to determine their competence level related to food handling including operating the dish washing machine and kitchen sanitation tasks. This evaluation will be conducted via interviews and return demonstration for the randomly selected dietary staff. Findings from this monitoring process will be documented on “Dietary Staff competence audit tool” maintained in the facility compliance binder. This monitoring process will take place daily Monday through Friday for two weeks, weekly for two more weeks then monthly for three months or until the pattern of compliance is maintained. Effective 07/10/2018, the Maintenance Director will inspect the dish machine to ensure it works properly per manufacturer recommendation. Findings from this monitoring process will be documented on “Dish Machine Inspection tool” maintained in the facility compliance binder. This monitoring process will take place daily Monday through Friday for two weeks, weekly for two more weeks then monthly for three months or until the pattern of compliance is maintained. Effective 7/10/2018, The Executive Director will conduct Sanitation inspection for the main kitchen to ensure all equipment are clean, sanitized and functioning per manufacturer	

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F 802	Continued From page 109	F 802	recommendation. Findings from this monitoring process will be documented on “Kitchen sanitation Audit” maintained in the facility compliance binder. This monitoring process will take place twice a week for 8 weeks, then monthly for three months or until the pattern of compliance is maintained. Effective 7/10/2018, Registered dietician will also complete sanitation inspection once a week on opposite days with the administrator for the main kitchen. Findings from this monitoring process will be documented on “Kitchen sanitation Audit” maintained in the facility compliance binder. This monitoring process will take place weekly for 8 weeks, then monthly for three months or until the pattern of compliance is maintained. Effective 7/10/2018, Dietary Manager and/or Executive director 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 7/10/2018, the center Executive Director, Dietary Manager and the Director of Nursing will be ultimately responsible to ensure implementation of	

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F 802	Continued From page 110	F 802	this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on menu review, recipe review, observation, staff and consulting registered dietitian interviews, the facility failed to follow the facility menus for 2 of 3 meals observed.	F 803	ROOT CAUSE Director of Nursing, Dietary Manager, Registered Dietitian, and the facility Executive Director discussed on 6/08/18	7/10/18

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F 803	Continued From page 111 Findings included: 1. Resident #90 was admitted to the nursing home on 5/8/18. Review of Resident #90's medical record revealed his current diet order was a renal regular. Review of the facility's supper menu for 6/6/18 revealed, a resident on a renal diet was planned to receive baked chicken, rice or noodles, green beans, dinner roll, margarine, white cake, fruit punch, beverage of choice. On 6/6/18 at 4:43 PM, Resident #90 was observed to receive baked chicken, potatoes, succotash (corn and lima beans), dinner roll, margarine, white cake, tea and 2 pepper packets on his supper meal tray. Resident #90 did not receive the rice or noodles and green beans as planned on the facility menu for this meal. Interview with the cook on 6/8/18 at 10:59 AM revealed she did not recall whether she was involved with the preparation of the supper meal for 6/6/18. A telephone interview with the registered dietitian on 6/8/18 from 11:40 AM- 12:02 PM revealed she would have expected rice to be served instead of potatoes to residents on a renal diet during the supper meal on 6/6/18. She did not comment on succotash being served instead for green beans. Interview with the Director of Nurses on 06/08/18 between 02:09 - 2:21 PM revealed he would not expect potatoes and succotash to be served on the renal diet. 2. Review of the facility's lunch menu for 6/8/18 revealed, parsilied potatoes were on the planned	F 803	to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from inadequate training/understanding of dietary staff, as the result the facility failed to provide a therapeutic diet consistent with renal diet restrictions for resident #90, and failed to follow the lunch menu during a Lunch meal on 6/8/2018. The root cause analysis also concluded that the lack of effective communication in the tray-line caused the error for a resident therapeutic diet to be served with items that resident #90 should have not received based on physician order. IMMEDIATE ACTION Resident #90 was assessed by the Director of Nursing on 6/8/2018 to determine if resident had any complication resulted from receiving items on the meal trays on 6/6/2018 and 6/7/2018 that were not compatible with the ordered therapeutic diet. Resident #90 shown no signs or symptoms of any complication. Resident #90□s attending physician was notified that resident #90 received food items on the meal tray for both dinner and breakfast on 6/6/2018 and 6/7/2018 consecutively that were not compatible with resident□s ordered therapeutic diet. No new orders were received. The notification took place on 6/9/2018. The facility's lunch menu for 6/8/18, that revealed, parsilied potatoes on the	

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F 803	Continued From page 112 menus. The recipe for parsilied potatoes called for frozen skin on diced potatoes or fresh potatoes cut into cubes. Margarine, salt, paprika and parsley completed the recipe. Observation of the kitchen's lunch tray line on 6/8/18 at 10:59 AM mashed potatoes were prepared instead of parsilied potatoes. Interview with the cook on 6/8/18 at 10:59 AM revealed parsilied potatoes were creamed potatoes. She said, "They don't like parsley. We've always done creamed potatoes." A telephone interview with the registered dietitian on 6/8/18 from 11:40 AM- 12:02 PM revealed she would expect parsley on potatoes and for staff to serve the planned menu. The registered dietitian further stated the form of the potatoes would be mashed or oven roasted.	F 803	planned menus was reviewed by the dietary manager on 6/8/2018 who concur with the findings that mashed potatoes should have not be prepared instead of parsilied potatoes without Registered dietician approval. No resident named to this alleged non-compliance. IDENTIFICATION OF OTHERS All residents on therapeutic diet have the potential to be affected by this alleged deficient practice. On 6/27/2018 & 6/28/2018 Dietary Managers, Completed facility audit on residents with therapeutic diets to ensure that diets ordered matches the tray cards system 5 other residents identified with diet orders not matching the tray card. Dietary Manager corrected all identified diet orders in the tray card system on 7/2/2018. Findings of this audit is documented on the Dietary Roster Report and maintained in the facility compliance binder. On 6/28/2018 Dietary Managers, Completed facility audit on residents all menu for meals scheduled for two weeks from 6/28/2018 to ensure the facility has all items necessary to prepare the meal per menu. Facility food storage indicate to have all necessary items to follow the menu. to ensure that diets ordered matches the tray cards system 5 other residents identified with diet orders not matching the	

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F 803	Continued From page 113	F 803		

tray card. Dietary Manager corrected all identified diet orders in the tray card system on 7/2/2018. Findings of this audit is documented on the Dietary Roster Report and maintained in the facility compliance binder.

On 6/27/2017 dietary manager observed the tray card process during the lunch meal to identify if any other resident with therapeutic diet received items in the try not compatible with their specific physician ordered diet. No other resident was identified as receiving items on the tray not compatible with the ordered diet.

SYSTEMATIC CHANGES

Effective 7/10/2018 the facility will provide therapeutic diet as ordered by the physician and will not include items not compatible with each resident□s diet. This will be accomplished through systemic modification of dietary meal preparation on tray line. This modification will include changes from the point of calling a diet order, plating food and receiving the tray at the end of the line as outlined below.

Effective 7/10/2018 the tray line will consist of the minimum of three dietary employees. The first employee will be responsible to call the diet order from a tray card. This employee will read the needed information from both individual resident□s tray card and from the menu spreadsheet. Information such as; diet

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F 803	Continued From page 114	F 803	texture, therapeutic restriction, food allergies, resident dislikes, and/or items not allowed on the try based on the therapeutic restriction will be verbally read and mentioned by the first dietary employee at the beginning of the tray line. The second dietary employee will be responsible to plate the food based on information read by the first employee. The third employee will be responsible to receive and verify the accuracy of the tray based on information on the tray card. Effective 7/10/2018, dietary Manager will complete 100% audit of all residents in the facility once every month by comparing physician orders and each resident□s diet on tray card to ensure no discrepancies are noted on the diet. Any identified discrepancy will be corrected promptly by the Dietary manager. Effective 7/10/2018 the facility will prepare meals based on posted menu and consult a dietician if a menu item has to be changed to ensure the substitution contain same nutritive value. Employed 100% education of all current dietary staff, to include full time, part time and as needed nursing staff, will be completed by Dietary Managers and/or Registered Dietitian. This education will provide an emphasis on proper diets. This education will be completed by 06/29/2018, any staff not educated by 06/29/2018 will not be allowed to work until educated. This education was also added to new hire process for all new	

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employees effective 06/29/2018 and will be provided annually.

Dietary Manager and/or Registered Dietician will complete 100% re-education to all current dietary staff, to include full time, part time and as needed dietary staffs. This education will focus on the new tray line process to include the three employees on the line duties and responsibilities and will also provide an emphasis on ensuring any resident with a therapeutic diet receive accurate meal items on the tray card comparable with resident□s diet orders. The education will also focus on common items not included in each commonly ordered therapeutic diets in the facility.
This education will be completed by 07/10/2018, any dietary staff not educated by 07/10/2018 will not be allowed to work until educated. This education will also be added to the new hire process for all new dietary employees effective 07/10/2018 and will be provided annually.

MONITORING PROCESS

Effective 07/10/2018, the Dietary Managers and Registered Dietitian will complete audit of one meal a day to assure dietary staff preparing, serving, and/or calling tray line, to ensure all trays match the diet requested per tray ticket, and to ensure meals prepared and served matched the facility Menu. Findings from this monitoring process will be documented on Tray/Dietary Monitoring Tool maintained in the facility compliance

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F 803	Continued From page 116	F 803	binder. This monitoring process will take place daily for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Effective 7/10/2018, Dietary Manager and/or Executive director 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 7/10/2018, the center Executive Director, Dietary Manager 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.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		7/10/18

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F 812	Continued From page 117 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and the service company's record, the facility failed to clean and sanitize dishes according to manufacturer's instructions. This problem had the potential to effect 93 of 104 residents who received meals at the nursing home. Findings included: An observation of staff washing dishes in the kitchen's dish machine was initially conducted on 06/07/18 at 9:33 AM. A name brand single tank hot water sanitizing dish machine was used. The front of the machine indicated the final rinse should operate at a minimum temperature of 180 degrees Fahrenheit. Dietary Aide (DA) #1 was observed pushing racks into the machine. The tank was overflowing with suds. The Dietary Manager (DM) instructed DA #1 to drain the machine and start again. Observations were made on 6/7/18 from 9:58 AM until 10:59 AM. Food crumbs were observed on the table where clean dishes came out on racks from the dish machine. Dead ants were on top of the dish machine tank. The dish machine's readout displayed P1 and a wrench icon. The	F 812	F802 ROOT CAUSE Director of Nursing, Dietary Manager, Registered Dietitian, and the facility Executive Director discussed on 6/07/18 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from inadequate training/understanding of dietary staff, concluding that the facility failed to provide dietary support personnel training necessary to effectively carry out the functions of the food and nutrition service, specifically related to cleaning and sanitizing dishes using a high temperature machine. IMMEDIATE ACTION On 6/7/2018, food crumbs observed on the table where clean dishes come out on racks from the dish machine and dead ants on top of the dish machine were cleaned by the Dietary Manager. On 6/7/2018; Dietary Manager re-educated dietary aide #1 on the minimum acceptable temperature	

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F 812	Continued From page 118 DM said the P1 meant phase 1. The cook said this was the first time she had ever seen the wrench on the dish machine's display and added, she was not familiar with that. Observations of staff washing several racks of dishes in the dish machine revealed the machine's final rinse temperatures viewed on the readout display only reached temperatures of 150, 147, 153, 160 degrees Fahrenheit. Diet Aide #1 continued to feed dishes into the machine even though the machine's final rinse cycle was not operating at a temperature of 180 degrees Fahrenheit. The DM was present during these observations and said it was DA #1's third day of employment and her first day working in the dish room. DA#1 was observed to pull dishes out of the dish machine without allowing the machine's final rinse cycle to finish. She removed one rack from the dish machine and inserted another rack. DA #1 was also observed to open the dish machine's door with the machine's final rinse cycle temperature at only 152 degrees Fahrenheit. DA #1 said, "It's on the right cycle now, because it is not taking forever." During this observation on 6/7/18 from 9:58 AM until 10:59 AM, the DM called the Maintenance Director (MD). The MD said he had a little familiarity with the dish machine. He called the service company to find out what the P1 and wrench icon on the readout meant. On 6/7/18 at 10:20 AM, DA#2 confirmed the sanitizing temperature for the kitchen's dish machine's final rinse cycle should be 180 degrees Fahrenheit. The temperature of the machine's final rinse cycle was noted to only be reaching 160 degrees Fahrenheit and DA#1 continued to insert and remove dishes from the dish machine.	F 812	required for a rinsing cycle. On 6/7/2018 Maintenance director educated the Dietary Manager, the cook, Dietary aide #3 of the meaning of a wrench sign and P1 after being advised by the service company of the meaning On 6/7/2018; Dietary Manager discontinued the use of the dish machine once notified by the Maintenance Director that the dish machine was not functioning properly, and the rinsing cycle did not reach 180 degree. On 6/7/2018; Dietary Manager spoke with Resident Council President and received approval to utilize paper products until machine is fixed and functioning properly. On 6/07/18 Dietary Manager prepared and utilized the 3 sink compartment for manual wash to ensure that dishes were getting clean, rinsed and sanitized appropriately using appropriate chemical sanitization chemicals. On 6/7/2018 the service company identified a burned wire that caused the machine to dysfunction. The company repaired the problem and the machine was verified to function properly with final rinsing circle reading 184 on 6/8/2018 IDENTIFICATION OF OTHERS No resident named in this alleged noncompliance. Any residents who receives meals from the facility kitchen has a potential to be affected by this alleged non- compliance.	

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F 812	Continued From page 119 Interview on 6/7/18 at 10:20 AM with DA #3 who was scrapping food from the dirty dishes said she did not know what the wrench symbol displayed on the machine's read out meant. On 06/07/18 at 10:59 AM, the Maintenance Director was observed with another maintenance person working on the dish machine. He said the service people could not come out, but told them to clean the probes. He said, "P1 means call for service." The DM decided to use paper products to serve lunch and he confirmed the decision was acceptable with the President of the Resident's Council. The DM added that no dish machine temperatures were recorded by staff during the morning of 6/7/18. The dish machine's service company's report was reviewed. The report specified a repair was made to the dish washer on 6/7/18 around 5:30 PM. The report indicated a wire was burned. It was repaired and the machine functioned correctly when they left. On 6/8/18 at 9:21 AM, dishwashing was observed. There was no wrench icon on the dish machine's readout. The final rinse temperature of the machine was observed to reach a temperature of 184 degrees Fahrenheit. The DM said he had been trained to work with high temperature dish machines, but not this specific machine. Interview with the Registered Dietitian on 6/8/18 between 11:40 AM and 12:02 PM revealed the dishwasher was a high temperature machine and needed to reach a minimum final rinse temperature of 180 degrees Fahrenheit to	F 812	SYSTEMATIC CHANGES Effective 7/10/2018, dietary staff will check dish washing machine temperature for both washing and rinsing cycle at least three times daily. Findings from this process will be documented on “dish machine temperature log maintained at the dietary department. Any negative findings to include temperature less below 180 for the final rinsing cycle will be reported to the dietary manager and remove from being used immediately, until resolved. Three compartment sink will be utilized to clean dishes at that time. On 7/2/2018 Dietary manager revised a cleaning schedule to ensure the kitchen remains clean and sanitized at all times. This schedule incorporated cleaning on top of the dish machine and surfaces used for food preparation. Effective 7/10/2018; dietary staff will utilize revised cleaning schedule. Effective 7/10/2018, Dish machine is added on preventative maintenance schedule to be checked once monthly to ensure proper functionality per manufacturer guidelines Effective 07/10/2018, the facility establish a continuous education program called “safe food handling training” for all facility dietary staff that will cover all necessary information required to safely and effectively carry out the functions of the food and nutrition services. This cause will cover all aspects food handling to include	

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F 812	Continued From page 120 sanitize the dishes and equipment being washed in the machine. She said she was responsible for the clinical documentation and not responsible for staff in the kitchen.	F 812	dish washing, kitchen sanitation, and equipment's functionalities and defects. Any new dietary support personnel will be checked off by the dietary manager and/or Registered Dietician before assuming duties in the facility. 100% education of all current dietary staff, to include full time, part time and as needed dietary staff, will complete "Safe food handling training" that will cover all necessary information required to safely and effectively carry out the functions of the food and nutrition services. This education will be provided and validated by the dietary manager and/or Registered dietician and will also cover all aspects food handling to include dish washing, kitchen sanitation, and equipment's functionalities and defects. This education will be completed by 07/10/2018, any dietary staff not educated by 07/10/2018 will not be allowed to work until educated. This education will also be added to the new hire process for all new dietary employees effective 07/10/2018 and will be provided annually. Registered Dietician and/or the Dietary Manager will complete in-servicing education on proper cleaning of dietary equipment and overall kitchen. This education will be completed by 07/10/2018, any dietary staff not educated by 07/10/2018 will not be allowed to work until educated. This education will also be added to the new hire process for all new dietary employees effective 07/10/2018 and will be provided annually.	

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F 812	Continued From page 121	F 812	MONITORING PROCESS Effective 7/10/2018, Dietary Manager and/or Registered Dietician will evaluate 3 randomly selected dietary staff to determine their competence level related to food handling including operating the dish washing machine and kitchen sanitation tasks. This evaluation will be conducted via interviews and return demonstration for the randomly selected dietary staff. Findings from this monitoring process will be documented on “Dietary Staff competence audit tool” maintained in the facility compliance binder. This monitoring process will take place daily Monday through Friday for two weeks, weekly for two more weeks then monthly for three months or until the pattern of compliance is maintained. Effective 07/10/2018, the Maintenance Director will inspect the dish machine to ensure it works properly per manufacturer recommendation. Findings from this monitoring process will be documented on “Dish Machine Inspection tool” maintained in the facility compliance binder. This monitoring process will take place daily Monday through Friday for two weeks, weekly for two more weeks then monthly for three months or until the pattern of compliance is maintained. Effective 7/10/2018, The Executive Director will conduct Sanitation inspection for the main kitchen to ensure all equipment are clean, sanitized and functioning per manufacturer	

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F 812	Continued From page 122	F 812	recommendation. Findings from this monitoring process will be documented on "Kitchen sanitation Audit" maintained in the facility compliance binder. This monitoring process will take place twice a week for 8 weeks, then monthly for three months or until the pattern of compliance is maintained. Effective 7/10/2018, Registered dietician will also complete sanitation inspection once a week on opposite days with the administrator for the main kitchen. Findings from this monitoring process will be documented on "Kitchen sanitation Audit" maintained in the facility compliance binder. This monitoring process will take place weekly for 8 weeks, then monthly for three months or until the pattern of compliance is maintained. Effective 7/10/2018, Dietary Manager and/or Executive director 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 7/10/2018, the center Executive Director, Dietary Manager and the Director of Nursing will be ultimately responsible to ensure implementation of	

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F 812	Continued From page 123	F 812	this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 835 SS=J	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician and Department of Social Services interviews, and observations, the facility failed to provide oversight and leadership to the staff to ensure the facility was free from abuse and to prevent and protect 1 of 3 residents (Resident #84) from being physical abused by a visitor. Resident #84 was witnessed being physically abused by his spouse in the facility. The facility failed to implement measures specified by the Department of Social Services Adult Protective Services Social Worker prior to Resident #84's admission to the facility to protect him from being physically abused. Immediate jeopardy began on 6/4/18 when the facility administration failed to provide oversight and management to ensure the facility was free from abuse when 2 witnesses observed Resident #84 seated in his room in a wheelchair and a female visitor, identified as his wife, was observed hitting, kicking and stomping on Resident #84. Immediate jeopardy was removed 6/7/18 when the facility provided and implemented an acceptable allegation of	F 835	F835 ROOT CAUSE This alleged noncompliance resulted from the center's failure to be administered in a manner that use the resources effectively, efficiently, and consistently to ensure the facility implemented the abuse prohibition policies and procedures to protect residents from abuse and/or neglect and ensure the facility attain and maintain regulatory compliance consistently to avoid repeated deficient practices. The analysis conducted also indicated that the facility failure is resulted from the high turnover in administrative staff that cause inconsistences on processes as the result quality outcome is diminished. The high turnover rate is concluded to be due to the poor work place culture. This alleged noncompliance resulted from the center's failure to follow the abuse policy and procedures that led to not protecting one resident with prior history	7/10/18

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F 835	Continued From page 124 Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. Findings included: Cross Refer Tag -600: Based on record review, staff, resident, physician, and Department of Social Services staff interviews, the facility failed to protect 1 of 3 residents (Resident #84) from physical abuse when Resident #84 was witnessed by facility staff being hit and kicked by his spouse in his facility room. Cross Refer Tag F-607: Based on record review and staff interviews, the facility failed implement the policy to screen the resident, prevent abuse and protect 1 of 3 residents (Resident #84) from visitor to resident physical abuse. The facility failed to implement measures specified by the Department of Social Services Adult Protective Services Social Worker prior to Resident #84's admission on 4/25/18 to protect him from being physically abused. Following the physical assault Resident #84 was assessed and did not have any physical injuries and did not require medical treatment. The Administrator, DON and Corporate Consultant were notified of the immediate jeopardy on 6/6/18 at 2:55 PM. On 6/7/18 at 10:48 PM the facility provided the following credible allegation of immediate jeopardy removal: "This alleged noncompliance resulted from the	F 835	of suspected domestic abuse from a spouse. On 4/25/2018 the facility admitted resident #84 for rehabilitation and long term care placement. Resident #84 had a protective order named "Ex parte order" filed in Harnett County Clerk of Superior Court on 4/24/2018. The protective order was presented to the facility at the time of admission on 4/25/2018 by the assigned Social worker from the Department of Social Services. The protective order included information that the "department of Social services is concerned with the possibility of physical abuse and neglect", it also added that "Without a protective order department of Social Services is concerned the wife will remove respondent from the hospital/rehab." This alleged noncompliance resulted from the facility failure to implement abuse policies and procedures on the area of proper screening, identification, protection and reporting that resulted from the broken communication process from resident's admission to the facility for necessary information to include protective orders for resident #84. As the result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions to protect resident #84. Root cause analysis also concluded that the facility misinterpreted regulatory requirements that requires the facility to protect each resident while in the facility, and reporting any allegation of abuse immediately but no later than two hours	

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F 835	Continued From page 125	F 835		

center's failure to be administered in a manner that use the resources effectively, efficiently, and consistently to ensure the facility implemented the abuse prohibition policies and procedures to protect residents from abuse and/or neglect and ensure the facility attain and maintain regulatory compliance consistently to avoid repeated deficient practices.
The analysis conducted also indicated that the facility failure is resulted from the high turnover in administrative staff that cause inconsistences on processes as the result quality outcome is diminished. The high turnover rate is concluded to be due to the poor work place culture.

This alleged noncompliance resulted from the center's failure to follow the abuse policy and procedures that led to not protecting one resident with prior history of suspected domestic abuse from a spouse. On 4/25/2018 the facility admitted resident #84 for rehabilitation and long term care placement. Resident #84 had a protective order named "Ex parte order" filed in Harnett County Clerk of Superior Court on 4/24/2018. The protective order was presented to the facility at the time of admission on 4/25/2018 by the assigned Social worker from the Department of Social Services. The protective order included information that the "department of Social services is concerned with the possibility of physical abuse and neglect", it also added that "Without a protective order department of Social Services is concerned the wife will remove respondent from the hospital/rehab."

This alleged noncompliance resulted from the facility failure to implement abuse policies and procedures on the area of proper screening, identification, protection and reporting that after the allegation is made. The facility also failed to follow the policies and procedures to put measures in place to protect residents while in the facility even when they are under the custody of DSS.

The root cause analysis, concluded that, the systemic failure that resulted onto resident #84 incident on 6/4/2018 includes, broken communication process from admission for necessary information to include protective orders for resident #84. As a result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions to protect resident #84. The broken communication process resulted from a lack of a systemic process set forth on how protective orders was to be communicated by the Admission Director to the rest of the IDT.

Although the facility received the documentation on admission on 4/25/2018, and was notified by the DSS social worker of the protective orders of this resident, there is no indication that the facility put forth measures to protect Resident #84 from his wife. Admission Director failed to communicate the pertinent information to the interdisciplinary team necessary to insure resident #84 was protected while in the facility from his wife.

On 6/4/2018 the resident's spouse was witnessed by the facility Activity Aide, & Central Supply Aide #1 in the room with the Resident #84. Activity Aide and

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F 835	Continued From page 126 resulted from the broken communication process from resident's admission to the facility for necessary information to include protective orders for resident #84. As the result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions to protect resident #84. Root cause analysis also concluded that the facility misinterpreted regulatory requirements that requires the facility to protect each resident while in the facility, and reporting any allegation of abuse immediately but no later than two hours after the allegation is made. The facility also failed to follow the policies and procedures to put measures in place to protect residents while in the facility even when they are under the custody of DSS. The root cause analysis, concluded that, the systemic failure that resulted onto resident #84 incident on 6/4/2018 includes, broken communication process from admission for necessary information to include protective orders for resident #84. As a result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions to protect resident #84. The broken communication process resulted from a lack of a systemic process set forth on how protective orders was to be communicated by the Admission Director to the rest of the IDT. Although the facility received the documentation on admission on 4/25/2018, and was notified by the DSS social worker of the protective orders of this resident, there is no indication that the facility put forth measures to protect Resident #84 from his wife. Admission Director failed to	F 835	Central Supply Aide stated they witnessed resident's spouse kicking resident's leg and stepping on his feet. Resident and the spouse were immediately separated by the Central Supply Aide. A Complete Head to toe body assessment was completed by the Registered nurse Supervisor #1. No injuries noted, resident denied any signs and symptoms of pain or discomforts. Initial report for the alleged abuse was completed and sent on 6/4/2018, DSS social worker and the attending Physician notified. IMMEDIATE ACTION TAKEN The Executive Director counselled the facility Admission Director on 6/7/2018 to address the communication failure that caused the deficient practice. The New Executive director was hired on 2/15/2018 to manage and supervise the facility's operation. The Executive director is rebuilding the facility management staff by hiring qualified personnel to manage the departments in the facility to ensure and assure quality outcomes. The Executive Director has hired qualified Assistant Director of Nursing, Two Registered nurse Supervisors, Business Office Manager, and Director of Food Services. The Admistrator is leading the team towards systematically identifying and addressing quality deficits. He has put systems and processes in place to improve facility systems and processes. Chief Clinical officer from the Management and consulting company	

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F 835	Continued From page 127 communicate the pertinent information to the interdisciplinary team necessary to insure resident #84 was protected while in the facility from his wife. On 6/4/2018 the resident's spouse was witnessed by the facility Activity Aide, & Central Supply Aide #1 in the room with the Resident #84. Activity Aide and Central Supply Aide stated they witnessed resident's spouse kicking resident's leg and stepping on his feet. Resident and the spouse were immediately separated by the Central Supply Aide. A Complete Head to toe body assessment was completed by the Registered nurse Supervisor #1. No injuries noted, resident denied any signs and symptoms of pain or discomforts. Initial report for the alleged abuse was completed and sent on 6/4/2018, DSS social worker and the attending Physician notified. IMMEDIATE ACTION TAKEN The Executive Director counselled the facility Admission Director on 6/7/2018 to address the communication failure that caused the deficient practice. The New Executive director was hired on 2/15/2018 to manage and supervise the facility's operation. The Executive director is rebuilding the facility management staff by hiring qualified personnel to manage the departments in the facility to ensure and assure quality outcomes. The Executive Director has hired qualified Assistant Director of Nursing, Two Registered nurse Supervisors, Business Office Manager, and Director of Food Services. The Admistrator is leading the team towards systematically identifying and addressing quality deficits. He has	F 835	that manages the center, re-educated the Center Executive Director and the Director of Nursing 6/7/2018 on the center Abuse Prohibition and Investigation policies and procedures, and emphasized the importance of screening, identification, protecting and reporting to the regulatory required agencies immediately but no later than two hours from the time the allegation is made. The education also emphasized on the importance of ensuring residents are screened for potential abuse and measures are put forth to protect them while residing in the facility. The Chief Clinical officer from the Management and consulting company that manages the center, re-educated facility management team that consist of the department supervisors on the center's Abuse Prohibition and Investigation policies and procedures, and emphasized on the importance of screening patients and employees before hire, protecting resident(s), and reporting any allegation of abuse or Neglect to their Direct supervisor and the Executive Director in a timely manner as well as to the Regulatory required agencies immediately but no later than 2 hours after forming suspicion, witness the abuse and/or after a resident, another staff and/or family member alleged abuse. On 6/04/2018 at approximately 5:00PM the Central Supplies aide separated resident #84 from his wife by pushing him out of the room to the hallway. The central	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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F 835	Continued From page 128 put systems and processes in place to improve facility systems and processes. Chief Clinical officer from the Management and consulting company that manages the center, re-educated the Center Executive Director and the Director of Nursing 6/7/2018 on the center Abuse Prohibition and Investigation policies and procedures, and emphasized the importance of screening, identification, protecting and reporting to the regulatory required agencies immediately but no later than two hours from the time the allegation is made. The education also emphasized on the importance of ensuring residents are screened for potential abuse and measures are put forth to protect them while residing in the facility. The Chief Clinical officer from the Management and consulting company that manages the center, re-educated facility management team that consist of the department supervisors on the center's Abuse Prohibition and Investigation policies and procedures, and emphasized on the importance of screening patients and employees before hire, protecting resident(s), and reporting any allegation of abuse or Neglect to their Direct supervisor and the Executive Director in a timely manner as well as to the Regulatory required agencies immediately but no later than 2 hours after forming suspicion, witness the abuse and/or after a resident, another staff and/or family member alleged abuse. On 6/04/2018 at approximately 5:00PM the Central Supplies aide separated resident #84 from his wife by pushing him out of the room to the hallway. The central supplies aide remained with resident #84 on the hallway, and notified	F 835	supplies aide remained with resident #84 on the hallway, and notified Assistant Director of Nursing (DON) who was standing in the proximity at the nurse's station #2. ADON walked towards the resident accompanied by the Unit Manager #1 who relieved the Central Supplies aide and took over supervision and protection, per facility abuse prohibition process of resident #84, per the facility abuse policy and procedures. Unit Manager #1 completed a head to toe assessment of the resident and noted no injuries. Resident denied pain or discomforts. Central Supplies aide notified a Medical Records supervisor who was standing at the nurse station #1. Medical Records aide walked to the resident's room immediately and met Unit Manager #1 in the room. Medical Records aide assisted Unit manager #1 while the Unit manager was assessing the patient. Unit Manager #1 and Medical Records supervisor transferred resident #84 to the wheel chair and moved the resident to the dining area. Medical Records supervisor remained with resident #84 until the police arrived with a brief period when she was relieved by the transportation aide who stayed with the resident when Medical Records supervisor departed. Likewise, the ADON who left Unit Manager #1 with resident#84 walked to the Executive Director's office for notification. On 06/04/2018 the 24 hour initial report was sent to the Department	

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F 835	Continued From page 129 Assistant Director of Nursing (DON) who was standing in the proximity at the nurse's station #2. ADON walked towards the resident accompanied by the Unit Manager #1 who relieved the Central Supplies aide and took over supervision and protection, per facility abuse prohibition process of resident #84, per the facility abuse policy and procedures. Unit Manager #1 completed a head to toe assessment of the resident and noted no injuries. Resident denied pain or discomforts. Central Supplies aide notified a Medical Records supervisor who was standing at the nurse station #1. Medical Records aide walked to the resident's room immediately and met Unit Manager #1 in the room. Medical Records aide assisted Unit manager #1 while the Unit manager was assessing the patient. Unit Manager #1 and Medical Records supervisor transferred resident #84 to the wheel chair and moved the resident to the dining area. Medical Records supervisor remained with resident #84 until the police arrived with a brief period when she was relieved by the transportation aide who stayed with the resident when Medical Records supervisor departed. Likewise, the ADON who left Unit Manager #1 with resident#84 walked to the Executive Director's office for notification. On 06/04/2018 the 24 hour initial report was sent to the Department of Health and Human Services related to resident #84's witnessed abuse by the spouse. These reports were completed and submitted by the Director of Nursing. The Five day report was completed on 6/7/2018 after a detail investigation was conducted by the Center Executive Director, Director of Social Services and Director of Nursing. The incident on 6/4/2018 against resident #84 was substantiated based on	F 835	of Health and Human Services related to resident #84's witnessed abuse by the spouse. These reports were completed and submitted by the Director of Nursing. The Five day report was completed on 6/7/2018 after a detail investigation was conducted by the Center Executive Director, Director of Social Services and Director of Nursing. The incident on 6/4/2018 against resident #84 was substantiated based on findings of the investigation conducted by the Facility, Department of Social Services, and Harnett county Police Department. Resident #84's spouse is ordered by the court not to visit or be in contact with the resident effective 6/5/2018. Facility has yet to receive a confirmation of actions taken legally against the spouse. Facility will keep resident on 1 on 1 until confirmation is obtained of the spouse's inability to come to the facility. The photograph of the alleged perpetrator (resident#84 wife) is currently posted at the front desk, and at each nurse's station for easy identification and notification effective 6/6/18. The photograph is located on the pertinent location where all employees can identify resident #84's wife. Facility Executive Director, Director of Nursing, and Social Worker from Department of Social Services met briefly on 6/5/2018 to discuss the incident that happened on 6/4/2018. The team discussed the possible actions necessary	

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F 835	Continued From page 130 findings of the investigation conducted by the Facility, Department of Social Services, and Harnett county Police Department. Resident #84's spouse is ordered by the court not to visit or be in contact with the resident effective 6/5/2018. Facility has yet to receive a confirmation of actions taken legally against the spouse. Facility will keep resident on 1 on 1 until confirmation is obtained of the spouse's inability to come to the facility. The photograph of the alleged perpetrator (resident#84 wife) is currently posted at the front desk, and at each nurse's station for easy identification and notification effective 6/6/18. The photograph is located on the pertinent location where all employees can identify resident #84's wife. Facility Executive Director, Director of Nursing, and Social Worker from Department of Social Services met briefly on 6/5/2018 to discuss the incident that happened on 6/4/2018. The team discussed the possible actions necessary to protect the resident from the spouse. Multiple ideas were discussed, such as room change, identify the resident with a different name, or transfer resident #84 to another location that the spouse will not be aware of. On 6/5/2018, the facility as well as the DSS social worker reached a conclusion that, the best course of action that will protect resident #84 from his spouse, while maintaining his dignity, self-determination, and reduce risk for deterioration from this event is to relocate resident #84 to another part of the facility. Resident #84's name was changed on 6/5/2018 to an alias to ensure his protection, per facility abuse prohibition process by the facility	F 835	to protect the resident from the spouse. Multiple ideas were discussed, such as room change, identify the resident with a different name, or transfer resident #84 to another location that the spouse will not be aware of. On 6/5/2018, the facility as well as the DSS social worker reached a conclusion that, the best course of action that will protect resident #84 from his spouse, while maintaining his dignity, self-determination, and reduce risk for deterioration from this event is to relocate resident #84 to another part of the facility. Resident #84's name was changed on 6/5/2018 to an alias to ensure his protection, per facility abuse prohibition process by the facility Director of Nursing, Executive Director and Admission Director. This measure is in alignment with the facility abuse policy and procedure. Resident #84 was relocated to another room in the facility on 6/5/2018 and the posted name in the facility was changed. Resident #84 was placed on every 15 minutes watch from 7pm on 6/4/2018 to 9am. One on one supervision was initiated on 6/5/2018 in which an employee observes the resident at all times while in the facility. One on one supervision was discontinued on 6/27/2018, after the facility Quality Assurance and Improvement Committee determine that resident #84 is safe and protected from his wife with the other measures in place such as locking the means of egress, resident relocation to another room and change resident□s	

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F 835	Continued From page 131 Director of Nursing, Executive Director and Admission Director. This measure is in alignment with the facility abuse policy and procedure. Resident #84 was relocated to another room in the facility on 6/5/2018 and the posted name in the facility was changed. Resident #84 was placed on every 15 minutes watch from 7pm on 6/4/2018 to 9am. One on one supervision was initiated on 6/5/2018 in which an employee observes the resident at all times while in the facility. One on one care will continue until the facility receives confirmation that resident #84's wife is arrested. 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 documentation in any resident medical records that indicate allegation of abuse, neglect, or injury of unknown sources, 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 two other documented allegation of abuse, and/or neglect documented in resident medical records. This audit was completed on 6/6/18 & 6/7/18. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. 100% audit was completed by the Center Executive Director for all allegation of abuse and/or neglect submitted in the last from 1/24/2018 to 6/7/2018 determine is the alleged perpetrator was suspended during investigation	F 835	name. 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 documentation in any resident medical records that indicate allegation of abuse, neglect, or injury of unknown sources, 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 two other documented allegation of abuse, and/or neglect documented in resident medical records. This audit was completed on 6/6/18 & 6/7/18. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. 100% audit was completed by the Center Executive Director for all allegation of abuse and/or neglect submitted in the last from 1/24/2018 to 6/7/2018 determine is the alleged perpetrator was suspended during investigation to protect the resident, 24 hours completed within 2 hours of the allegation, and 5 days completed and submitted to the state agency as required by regulation and Elder Justice Act in a timely manner. The audit revealed 5 of 5 completed abuse/neglect reports indicated the alleged perpetrator was suspended pending investigation per abuse	

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F 835	Continued From page 132 to protect the resident, 24 hours completed within 2 hours of the allegation, and 5 days completed and submitted to the state agency as required by regulation and Elder Justice Act in a timely manner. The audit revealed 5 of 5 completed abuse/neglect reports indicated the alleged perpetrator was suspended pending investigation per abuse prohibition policy and procedure, however all 5 of 5 initial 24 hour reports were not submitted within two hours of the allegation. Two months noted with detail investigation and the Alleged Perpetrator(s) were suspended. This audit was completed on 6/7/2018. On 06/06/2018, 100% interviews was completed by Director of Rehabilitation Center, Business Office Manager, Activity Director, Medical Records Supervisor and MDS for all current alert and oriented residents in the facility to identify any other resident with an allegation of Abuse and/or Neglect. Two other residents, Resident#2, and Resident #3 voiced allegation of abuse and/or neglect. Alleged perpetrators identified were suspended while the investigation is conducted by the facility Executive Director and/or Director of Nursing. 24 hour reports were submitted on 6/6/2018. A thorough investigation initiated. The resident's attending Physician and Responsible Party were notified of the allegation. Resident #2 and #3, 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. The Director of Social Services, Assistant Director of Nursing, Unit Manager, Admission Director and Director of Rehabilitation Services interviewed the responsible parties for residents who were not able to answer questions during	F 835	prohibition policy and procedure, however all 5 of 5 initial 24 hour reports were not submitted within two hours of the allegation. Two months noted with detail investigation and the Alleged Perpetrator(s) were suspended. This audit was completed on 6/7/2018. On 06/06/2018, 100% interviews was completed by Director of Rehabilitation Center, Business Office Manager, Activity Director, Medical Records Supervisor and MDS for all current alert and oriented residents in the facility to identify any other resident with an allegation of Abuse and/or Neglect. Two other residents, Resident#2, and Resident #3 voiced allegation of abuse and/or neglect. Alleged perpetrators identified were suspended while the investigation is conducted by the facility Executive Director and/or Director of Nursing. 24 hour reports were submitted on 6/6/2018. A thorough investigation initiated. The resident's attending Physician and Responsible Party were notified of the allegation. Resident #2 and #3, 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. The Director of Social Services, Assistant Director of Nursing, Unit Manager, Admission Director and Director of Rehabilitation Services interviewed the responsible parties for residents who were not able to answer questions during this interview due to mental capacity deficit on	

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F 835	Continued From page 133 this interview due to mental capacity deficit on 6/7/18. No family member voiced any allegation of abuse and/or neglect. SYSTEMIC CHANGES Effective 6/7/18 the facility will conduct an interdisciplinary weekly team building meeting that with the department supervisors to discuss culture change initiatives to be implemented in the facility. These meetings will be held without affecting resident care activities. Effective 6/7/2018 the facility established an Employee Appreciation Committee (EAC) chaired by the Director of Human Resources. Initial members of this committee were selected by the facility Executive Director and Director of Nursing Services. Members include the Activity Director, Director of Social Services, Nurse Aide #1, Dietary Aide #1 and Laundry aide #1. This committee will meet monthly to discuss ways to improve employees' morale in order to reduce staff turnover and improve work place culture effective 6/7/2018. Effective 6/7/2018, all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and, are reported immediately, but not later than 2 hours after the allegation is made to the Administrator of the facility and to other officials to include; the State Survey Agency, adult protective services, the state Ombudsmen in accordance with State law through established facilities policies and procedures. Effective 6/7/2018, The facility will report the results of all investigations to the Administrator or his or her designated representative and to other	F 835	6/7/18. No family member voiced any allegation of abuse and/or neglect. SYSTEMIC CHANGES Effective 6/7/18 the facility will conduct an interdisciplinary weekly team building meeting that with the department supervisors to discuss culture change initiatives to be implemented in the facility. These meetings will be held without affecting resident care activities. Effective 6/7/2018 the facility established an Employee Appreciation Committee (EAC) chaired by the Director of Human Resources. Initial members of this committee were selected by the facility Executive Director and Director of Nursing Services. Members include the Activity Director, Director of Social Services, Nurse Aide #1, Dietary Aide #1 and Laundry aide #1. This committee will meet monthly to discuss ways to improve employees' morale in order to reduce staff turnover and improve work place culture effective 6/7/2018. Effective 6/7/2018, all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and, are reported immediately, but not later than 2 hours after the allegation is made to the Administrator of the facility and to other officials to include; the State Survey Agency, adult protective services, the state Ombudsmen in accordance with State law through established facilities policies and procedures.	

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F 835	Continued From page 134 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 6/7/2018, the facility interdisciplinary team to include Executive Director, Director of Nursing, Director of Social services and at least three other department supervisors will attend a monthly mandatory training that will be conducted by contracted management and consulting company that oversees the facility. This training will put an emphasis on all seven components of abuse prohibition to include screening, training, prevention, identification, investigation, protection, reporting and responses. This training will take place monthly for next twelve months or until the pattern of compliance is maintained. Effective 6/7/2018, the Center Director of Human Services, and/or employee direct supervisor 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. The 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. Effective 6/7/2018, 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 month to identify any allegation of Abuse and/or Neglect. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse,	F 835	Effective 6/7/2018, The facility 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 6/7/2018, the facility interdisciplinary team to include Executive Director, Director of Nursing, Director of Social services and at least three other department supervisors will attend a monthly mandatory training that will be conducted by contracted management and consulting company that oversees the facility. This training will put an emphasis on all seven components of abuse prohibition to include screening, training, prevention, identification, investigation, protection, reporting and responses. This training will take place monthly for next twelve months or until the pattern of compliance is maintained. Effective 6/7/2018, the Center Director of Human Services, and/or employee direct supervisor 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. The interview process will be incorporated to the annual employee evaluating. Any staff member not	

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F 835	Continued From page 135 and/or neglect 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. The Director of Social services, Assistant Director of Nursing, Unit manager, Admission Director and Director of Rehabilitation Services will interview the responsible parties for residents who are not able to answer questions during the interview due to mental capacity deficit effective 6/7/18. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse, and/or neglect 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 6/7/2018 a copy of any resident's protective orders received on admission or readmission by the admission director or designated person during the admission process, will be placed in the medical file under the advance directive tab for easy identification and accessibility by the nursing staff. Effective 6/7/2018; received protective orders will be added to resident's care plan by the Admitting nurse and/or Nursing supervisor and nursing aide care guide for accessibility by both license nurses and nurse aides. If the protective order includes guidelines such as supervised visits, no visitation, or not allowed on the premises such measures will be added to resident's face sheet and appropriate information posted such as the perpetrator picture and/or description in a readily accessible location in the facility.	F 835	interviewed by the anniversary date will not be allowed to work until educated. Effective 6/7/2018, 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 month to identify any allegation of Abuse and/or Neglect. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse, and/or neglect 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. The Director of Social services, Assistant Director of Nursing, Unit manager, Admission Director and Director of Rehabilitation Services will interview the responsible parties for residents who are not able to answer questions during the interview due to mental capacity deficit effective 6/7/18. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse, and/or neglect 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 6/7/2018 a copy of any resident's protective orders received on admission or readmission by the admission director	

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F 835	Continued From page 136 Facility Director of Nursing (DON), Assistant Director of Nursing and/or Unit manager will complete 100% education on the location of protective orders in each resident's medical charts and the location of intervention necessary to protect the resident with protective orders. This education will also cover process to be taken if the protective order to include adding the protective order interventions to resident's care plan and to nursing aide care guide for accessibility by both license nurses and nurse aides. Guidelines such as supervised visits, no visitation, or not allowed on the premises will also be covered in this education. The education will also emphasize on the process that such information will be added to resident's face sheet and appropriate information posted such as the perpetrator picture and/or description to be a readily accessible location in the facility. This education will be provided for all licensed nurses, nursing assistant to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses and nursing aides effective 6/7/2018, and will also be provided annually. Effective 6/7/2018, the center nursing administrative team, which includes DON, Nurse supervisors, Unit Managers, and/or SDC, added reviewing of DSS protective orders to an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24	F 835	or designated person during the admission process, will be placed in the medical file under the advance directive tab for easy identification and accessibility by the nursing staff. Effective 6/7/2018; received protective orders will be added to resident's care plan by the Admitting nurse and/or Nursing supervisor and nursing aide care guide for accessibility by both license nurses and nurse aides. If the protective order includes guidelines such as supervised visits, no visitation, or not allowed on the premises such measures will be added to resident's face sheet and appropriate information posted such as the perpetrator picture and/or description in a readily accessible location in the facility. Facility Director of Nursing (DON), Assistant Director of Nursing and/or Unit manager will complete 100% education on the location of protective orders in each resident's medical charts and the location of intervention necessary to protect the resident with protective orders. This education will also cover process to be taken if the protective order to include adding the protective order interventions to resident's care plan and to nursing aide care guide for accessibility by both license nurses and nurse aides. Guidelines such as supervised visits, no visitation, or not allowed on the premises will also be covered in this education. The education will also emphasize on the process that such information will be added to	

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F 835	Continued From page 137 hours, and Physician orders written in the last 24 hours. By adding the review of DSS protective orders to this process, it will ensure that any resident with prior history of allegation of abuse, neglect, and/or injuries of unknown sources has appropriate measures in place to protect the resident from the alleged perpetrator, effective 6/7/2018. This process with take place daily Monday through Fridays effective 6/7/2018. The result of this systemic process will be documented on the clinical meeting form maintained in the "Daily Clinical meeting binder." Effective 6/7/2018, the 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 and/or injuries of unknown sources reported/documented is investigated thoroughly, the alleged perpetrator is suspended pending investigation, and ensure the event is reported to the facility Executive Director. This process will also incorporate reviewing of any DSS protective orders to ensure the facility put measures in place to address such orders. 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 6/7/2018. Effective 6/7/2018 the Admission Director (AD) will print any protective order for any referral to the facility before bed is offered. The AD will then provide copies of the protective order to the facility Executive Director, Director of Nursing, Director of social services and/or designated	F 835	resident's face sheet and appropriate information posted such as the perpetrator picture and/or description to be a readily accessible location in the facility. This education will be provided for all licensed nurses, nursing assistant to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses and nursing aides effective 6/7/2018, and will also be provided annually. Effective 6/7/2018, the center nursing administrative team, which includes DON, Nurse supervisors, Unit Managers, and/or SDC, added reviewing of DSS protective orders to an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours. By adding the review of DSS protective orders to this process, it will ensure that any resident with prior history of allegation of abuse, neglect, and/or injuries of unknown sources has appropriate measures in place to protect the resident from the alleged perpetrator, effective 6/7/2018. This process with take place daily Monday through Fridays effective 6/7/2018. The result of this systemic process will be documented on	

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F 835	Continued From page 138 licensed nurse. The IDT team will then review all referrals with DSS protective orders prior to admitting resident to the facility to ensure measures are put in place to protect the resident when admitted to the facility. Effective 6/7/2018 the facility Executive Director, Director of Nursing, and/or Director of social services will discuss new admits and re-admits to the facility during their daily department head meeting to validate that any admitted or readmitted resident with protective orders has measures in place to protect the resident against the alleged perpetrators. Effective 6/7/2018 any alleged perpetrator with restraining orders for visitation will not be allowed to visit the facility. All the facility exit doors are locked and can only be accessed using an approved card. Visitors will utilize the facility main entrance to enter the premises, effective 6/7/18. All the facility exit doors are locked using a magnetized lock that releases in case of fire. In case of any other emergency, each locked facility exit door is equipped with an emergency release override switch located beside each exit door to allow the door to demagnetize and open from the inside. The magnetic lock system is also equipped with a master override switch located at each nurse's station. This is in compliance with North Carolina life safety code. Signs have been posted on all exit doors to direct visitors to the main entrance, effective 6/7/18. Facility Executive Director, Director of Nursing (DON), Assistant Director of Nursing and/or Director of Social Services will complete 100% re-education on the location of protective orders in each resident's medical charts and the	F 835	the clinical meeting form maintained in the "Daily Clinical meeting binder." Effective 6/7/2018, the 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 and/or injuries of unknown sources reported/documented is investigated thoroughly, the alleged perpetrator is suspended pending investigation, and ensure the event is reported to the facility Executive Director. This process will also incorporate reviewing of any DSS protective orders to ensure the facility put measures in place to address such orders. 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 6/7/2018. Effective 6/7/2018 the Admission Director (AD) will print any protective order for any referral to the facility before bed is offered. The AD will then provide copies of the protective order to the facility Executive Director, Director of Nursing, Director of social services and/or designated licensed nurse. The IDT team will then review all referrals with DSS protective orders prior to admitting resident to the facility to ensure measures are put in place to protect the resident when admitted to the	

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F 835	Continued From page 139 importance of implementing approaches to ensure the resident's protection, per facility abuse prohibition process. This education will be provided for all licensed nurses, to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses effective 6/7/2018, and will also be provided annually. MONITORING PROCESS Effective 6/7/2018 the facility will conduct a directed performance improvement plan with the direct oversees by the Contracted and management company, to assist the facility on making culture changes and reduce employee turnover. This will be accomplished through weekly visit by the 3 times a week visits by the member of the management and consulting company for 4 weeks, then once weekly for three or until the pattern of compliance is maintained. Effective 6/7/2018, the facility will conduct a quality assurance and performance improvement meeting monthly with an agent from the contracted management and consulting company to ensure that the facility systematically identify and address areas that needs performance improvement to assure the facility maintain and retain substantial compliance. This will take place for the next twelve months or until the facility shows the pattern of compliance. Effective 6/7/2018, Executive Director and or Director of Social Services will review all alleged violation to ensure a thorough investigation is	F 835	facility. Effective 6/7/2018 the facility Executive Director, Director of Nursing, and/or Director of social services will discuss new admits and re-admits to the facility during their daily department head meeting to validate that any admitted or readmitted resident with protective orders has measures in place to protect the resident against the alleged perpetrators. Effective 6/7/2018 any alleged perpetrator with restraining orders for visitation will not be allowed to visit the facility. All the facility exit doors are locked and can only be accessed using an approved card. Visitors will utilize the facility main entrance to enter the premises, effective 6/7/18. All the facility exit doors are locked using a magnetized lock that releases in case of fire. In case of any other emergency, each locked facility exit door is equipped with an emergency release override switch located beside each exit door to allow the door to demagnetize and open from the inside. The magnetic lock system is also equipped with a master override switch located at each nurse's station. This is in compliance with North Carolina life safety code. Signs have been posted on all exit doors to direct visitors to the main entrance, effective 6/7/18. Facility Executive Director, Director of Nursing (DON), Assistant Director of Nursing and/or Director of Social Services will complete 100% re-education on the location of protective orders in each	

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F 835	Continued From page 140 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 2 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 6/7/2018, the facility will conduct a quality assurance and performance improvement meeting monthly with an agent from the contracted management and consulting company that oversees the company to ensure that the facility systematically identify and address areas related to resident's abuse and neglect and ensuring the abuse policies and procedures is implemented. This will take place for the next twelve months or until the facility shows the pattern of compliance. Effective 6/7/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with resident protection, per facility abuse prohibition process, thorough investigation, injuries of unknown sources and resident neglect by conducting clinical meeting daily. This meeting will allow the team to review all allegation of abuse, incidents or accidents that occurred from the prior clinical meeting. Any DSS protective orders and any documented information that indicate suspicion of abuse will be reviewed to ensure measures are in place to protect the resident. Any issues identified during this monitoring process will be addressed	F 835	resident's medical charts and the importance of implementing approaches to ensure the resident's protection, per facility abuse prohibition process. This education will be provided for all licensed nurses, to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses effective 6/7/2018, and will also be provided annually. MONITORING PROCESS Effective 6/7/2018 the facility will conduct a directed performance improvement plan with the direct oversees by the Contracted and management company, to assist the facility on making culture changes and reduce employee turnover. This will be accomplished through weekly visit by the 3 times a week visits by the member of the management and consulting company for 4 weeks, then once weekly for three or until the pattern of compliance is maintained. Effective 6/7/2018, the facility will conduct a quality assurance and performance improvement meeting monthly with an agent from the contracted management and consulting company to ensure that the facility systematically identify and address areas that needs performance improvement to assure the facility maintain and retain substantial compliance. This will take place for the	

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F 835	Continued From page 141	F 835		

promptly. Findings from this meeting will be documented on a daily clinical report form and filed in the clinical meeting binder after proper follow up is done. This monitoring process will take place daily for 4weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.

Effective 6/7/2018, 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 6/7/2018, 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."

The credible allegation for immediate jeopardy removal was validated on 6/8/18, which removed the IJ on 06/07/18, as evidenced by staff interviews, in-service record reviews, and observations. The in service included information r/t Resident #84's new alias, new room number, and what action was to be taken if his wife was observed on the facility property. Other observations included one on one (1:1) staff with Resident #84, monitored entry and exits from the facility's main entrance, and a photograph of Resident #84's wife posted at every nursing station and ante room. A care plan was initiated next twelve months or until the facility shows the pattern of compliance.

Effective 6/7/2018, 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 2 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.

Effective 6/7/2018, the facility will conduct a quality assurance and performance improvement meeting monthly with an agent from the contracted management and consulting company that oversees the company to ensure that the facility systematically identify and address areas related to resident's abuse and neglect and ensuring the abuse policies and procedures is implemented. This will take place for the next twelve months or until the facility shows the pattern of compliance.

Effective 6/7/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with resident protection, per

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F 835	Continued From page 142 6/6/18 and focused on "Safety: At risk for injury and social isolation r/t spousal abuse." The stated goals included maintained safety from his wife. Interventions included, but were not limited to, relocation to another room, identify by a different name, 1:1 supervision, staff education on name change, room change, safety interventions, monitoring for changes in mood or behavior, and an approved visitor list.	F 835	facility abuse prohibition process, thorough investigation, injuries of unknown sources and resident neglect by conducting clinical meeting daily. This meeting will allow the team to review all allegation of abuse, incidents or accidents that occurred from the prior clinical meeting. Any DSS protective orders and any documented information that indicate suspicion of abuse will be reviewed to ensure measures are in place to protect the resident. 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 the clinical meeting binder after proper follow up is done. This monitoring process will take place daily for 4weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 6/7/2018, 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 6/7/2018, 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	

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F 835	Continued From page 143	F 835	the facility remains in substantial compliance."	
F 867 SS=E	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 action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility ' s Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and effective monitoring of the interventions that the facility put into place. This was for three federal deficiencies which were originally cited on the 11/16/2017 complaint survey and was recited on the current recertification survey. The deficiencies were cited in the area of 483.12 (freedom from abuse, neglect & exploitation). The continued failure of the facility to sustain compliance during 2 federal surveys of record demonstrates a pattern of the facility ' s inability to sustain an effective Quality Assurance program. The findings included: This tag is cross referenced to: 1a) CFR 483.12 - Freedom from abuse, neglect and exploitation: Based on record review, staff, resident, physician, and Department of Social Services staff interviews, the facility failed to protect 1 of 3 residents (Resident #84) from physical abuse when Resident #84 was witnessed by facility staff being hit and kicked by	F 867	F867 ROOT CAUSE This alleged noncompliance resulted from the center's failure to be administered in a manner that use the resources effectively, efficiently, and consistently to ensure the facility implemented the abuse prohibition policies and procedures to protect residents from abuse and/or neglect and ensure the facility attain and maintain regulatory compliance consistently to avoid repeated deficient practices. The analysis conducted also indicated that the facility failure is resulted from the high turnover in administrative staff that cause inconsistences on processes as the result quality outcome is diminished. The high turnover rate is concluded to be due to the poor work place culture. Repeated citation caused by the facility failure to follow through with plan of action set forth on the previous surveys. F600 & F607: This alleged noncompliance resulted from the center's failure to follow the abuse policy and	7/10/18

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F 867	Continued From page 144 his spouse in his facility room. During the complaint survey of 11/16/17 the facility was cited for 483.12(a)(1) failure to protect a resident from staff to resident physical abuse for 1 of 1 residents. 1b) CFR 483.12 - Develop/Implement Abuse/Neglect policies: Based on record review and staff interviews, the facility failed implement the policy to screen the resident, prevent abuse and protect 1 of 3 residents (Resident #84) from visitor to resident physical abuse. The facility failed to implement measures specified by the Department of Social Services Adult Protective Services Social Worker prior to Resident #84's admission on 4/25/18 to protect him from being physically abused. Following the physical assault Resident #84 was assessed and did not have any physical injuries and did not require medical treatment. During the complaint survey of 11/16/17 the facility was cited for failure to follow their policy in the areas of prevention, protection, investigation and reporting for staff to resident physical abuse. 1c) CFR 483.12 Investigate/Prevent/Correct Alleged Violation: Based on observation, record review, facility staff, Nurse Practitioner and Medical Director interviews, the facility failed to submit a 24-hour and 5-day report to the Sate Agency for 1 of 1 residents who was observed with a bruise of unknown origin to the left eye (Resident #19). During the complaint survey of 11/16/17 the facility was cited for failure to report staff to resident physical abuse within 24 hours to the	F 867	procedures that led to not protecting one resident with prior history of suspected domestic abuse from a spouse. On 4/25/2018 the facility admitted resident #84 for rehabilitation and long term care placement. Resident #84 had a protective order named "Ex parte order" filed in Harnett County Clerk of Superior Court on 4/24/2018. The protective order was presented to the facility at the time of admission on 4/25/2018 by the assigned Social worker from the Department of Social Services. The protective order included information that the "department of Social services is concerned with the possibility of physical abuse and neglect", it also added that "Without a protective order department of Social Services is concerned the wife will remove respondent from the hospital/rehab." This alleged noncompliance resulted from the facility failure to implement abuse policies and procedures on the area of proper screening, identification, protection and reporting that resulted from the broken communication process from resident's admission to the facility for necessary information to include protective orders for resident #84. As the result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions to protect resident #84. Root cause analysis also concluded that the facility misinterpreted regulatory requirements that requires the facility to protect each resident while in the facility, and reporting any allegation of abuse immediately but no later than two hours	

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F 867	Continued From page 145 state agency and failed to thoroughly investigate the allegation of abuse. During an interview with the Administrator on 6/8/18 at 4:40 PM he stated the Quality Assurance committee met monthly and the medical director also attended monthly. He reported the facility was monitoring abuse and the reporting of abuse due to previous citations. He stated they had appointed one person so the reporting and investigation would be centralized to one person and the Administrator would provide oversite for guidance and review of any incidents to be sure the process will be followed through and completed in a timely manner. The Administrator added that the corporate consultant would also attend all QAPI meetings for the next 12 months until compliance is achieved and maintained.	F 867	after the allegation is made. The facility also failed to follow the policies and procedures to put measures in place to protect residents while in the facility even when they are under the custody of DSS. The root cause analysis, concluded that, the systemic failure that resulted onto resident #84 incident on 6/4/2018 includes, broken communication process from admission for necessary information to include protective orders for resident #84. As a result the resident's alleged perpetrator visited resident #84 multiple times with no appropriate interventions to protect resident #84. The broken communication process resulted from a lack of a systemic process set forth on how protective orders was to be communicated by the Admission Director to the rest of the IDT. Although the facility received the documentation on admission on 4/25/2018, and was notified by the DSS social worker of the protective orders of this resident, there is no indication that the facility put forth measures to protect Resident #84 from his wife. Admission Director failed to communicate the pertinent information to the interdisciplinary team necessary to insure resident #84 was protected while in the facility from his wife. On 6/4/2018 the resident's spouse was witnessed by the facility Activity Aide, & Central Supply Aide #1 in the room with the Resident #84. Activity Aide and Central Supply Aide stated they witnessed resident's spouse kicking resident's leg and stepping on his feet. Resident and the	

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F 867	Continued From page 146	F 867	spouse were immediately separated by the Central Supply Aide. A Complete Head to toe body assessment was completed by the Registered nurse Supervisor #1. No injuries noted, resident denied any signs and symptoms of pain or discomforts. Initial report for the alleged abuse was completed and sent on 6/4/2018, DSS social worker and the attending Physician notified. F610: This alleged noncompliance was resulted from the Center s Director of Nursing misinterpretation of regulatory requirements related to thoroughly investigation of an injury of unknown source. The DON stated that he noted the bruise on resident #19 and based on the location and the type of injury he concluded that the bruise was resulted from resident hitting her face against the bedside table. DON added that he did not consider the injury as unknown since he was able to conclude how the injury happen. Root cause analysis also concluded that the DON reached the conclusion without thoroughly investigating the causative factors as he did not interview other employees, a resident involved and/or any other staff member who noticed the injury to gain the perspective on how the injury might have happened. On the interview conducted on 6/8/2018 at 9:48am with the state survey agency staff while on site; The DON indicated there was a misunderstanding/miscommunication about the bedside table . DON also did not report the injury of unknown source before completing the investigation of	

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F 867	Continued From page 147	F 867	causative factors; something that should have been done after the reporting of injury of unknown source to the State Agency, Adult Protective Services and other officials as required by the state within two hours of the occurrence. Chief Clinical Officer from the Consulting and Management Company contracted by the facility re-educated the Center Executive director and the Director of Nursing on 7/2/2018 on reporting expectation if there is an injury of unknown origin noted for any resident in the facility. IMMEDIATE ACTION TAKEN The Executive Director counselled the facility Admission Director on 6/7/2018 to address the communication failure that caused the deficient practice. The New Executive director was hired on 2/15/2018 to manage and supervise the facility's operation. The Executive director is rebuilding the facility management staff by hiring qualified personnel to manage the departments in the facility to ensure and assure quality outcomes. The Executive Director has hired qualified Assistant Director of Nursing, Two Registered nurse Supervisors, Business Office Manager, and Director of Food Services. The Executive Director is leading the team towards systematically identifying and addressing quality deficits. He has put systems and processes in place to improve facility systems and processes. Chief Clinical officer from the Management and consulting company	

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

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F 867	Continued From page 148	F 867	that manages the center, re-educated the Center Executive Director and the Director of Nursing 6/7/2018 on the center Abuse Prohibition and Investigation policies and procedures, and emphasized the importance of screening, identification, protecting, investigating and reporting to the regulatory required agencies immediately but no later than two hours from the time the allegation is made. The education also emphasized on the importance of ensuring residents are screened for potential abuse and measures are put forth to protect them while residing in the facility. The Chief Clinical officer from the Management and consulting company that manages the center, re-educated facility management team that consist of the department supervisors on the center's Abuse Prohibition and Investigation policies and procedures, and emphasized on the importance of screening patients and employees before hire, protecting resident(s), and reporting any allegation of abuse or Neglect to their Direct supervisor and the Executive Director in a timely manner as well as to the Regulatory required agencies immediately but no later than 2 hours after forming suspicion, witness the abuse and/or after a resident, another staff and/or family member alleged abuse. On 6/04/2018 at approximately 5:00PM the Central Supplies aide separated resident #84 from his wife by pushing him out of the room to the hallway. The central supplies aide remained with resident #84 on the hallway, and notified Assistant	

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F 867	Continued From page 149	F 867	Director of Nursing (DON) who was standing in the proximity at the nurse's station #2. ADON walked towards the resident accompanied by the Unit Manager #1 who relieved the Central Supplies aide and took over supervision and protection, per facility abuse prohibition process of resident #84, per the facility abuse policy and procedures. Unit Manager #1 completed a head to toe assessment of the resident and noted no injuries. Resident denied pain or discomforts. Central Supplies aide notified a Medical Records supervisor who was standing at the nurse station #1. Medical Records aide walked to the resident's room immediately and met Unit Manager #1 in the room. Medical Records aide assisted Unit manager #1 while the Unit manager was assessing the patient. Unit Manager #1 and Medical Records supervisor transferred resident #84 to the wheel chair and moved the resident to the dining area. Medical Records supervisor remained with resident #84 until the police arrived with a brief period when she was relieved by the transportation aide who stayed with the resident when Medical Records supervisor departed. Likewise, the ADON who left Unit Manager #1 with resident#84 walked to the Executive Director's office for notification. On 06/04/2018 the 24 hour initial report was sent to the Department of Health and Human Services related to resident #84's witnessed abuse by the spouse. These reports were completed and submitted by the Director of Nursing.	

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F 867	Continued From page 150	F 867	The Five day report was completed on 6/7/2018 after a detail investigation was conducted by the Center Executive Director, Director of Social Services and Director of Nursing. The incident on 6/4/2018 against resident #84 was substantiated based on findings of the investigation conducted by the Facility, Department of Social Services, and Harnett county Police Department. Resident #84's spouse is ordered by the court not to visit or be in contact with the resident effective 6/5/2018. Facility has yet to receive a confirmation of actions taken legally against the spouse. Facility will keep resident on 1 on 1 until confirmation is obtained of the spouse's inability to come to the facility. The photograph of the alleged perpetrator (resident#84 wife) is currently posted at the front desk, and at each nurse's station for easy identification and notification effective 6/6/18. The photograph is located on the pertinent location where all employees can identify resident #84's wife. Facility Executive Director, Director of Nursing, and Social Worker from Department of Social Services met briefly on 6/5/2018 to discuss the incident that happened on 6/4/2018. The team discussed the possible actions necessary to protect the resident from the spouse. Multiple ideas were discussed, such as room change, identify the resident with a different name, or transfer resident #84 to another location that the spouse will not be aware of. On 6/5/2018, the facility as well as the DSS social worker reached a	

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F 867	Continued From page 151	F 867	conclusion that, the best course of action that will protect resident #84 from his spouse, while maintaining his dignity, self-determination, and reduce risk for deterioration from this event is to relocate resident #84 to another part of the facility. Resident #84's name was changed on 6/5/2018 to an alias to ensure his protection, per facility abuse prohibition process by the facility Director of Nursing, Executive Director and Admission Director. This measure is in alignment with the facility abuse policy and procedure. Resident #84 was relocated to another room in the facility on 6/5/2018 and the posted name in the facility was changed. Resident #84 was placed on every 15 minutes watch from 7pm on 6/4/2018 to 9am. One on one supervision was initiated on 6/5/2018 in which an employee observes the resident at all times while in the facility. One on one supervision was discontinued on 6/27/2018, after the facility Quality Assurance and Improvement Committee determine that resident #84 is safe and protected from his wife with the other measures in place such as locking the means of egress, resident relocation to another room and change resident s name. F610: On 6/4/2018, the 24 hour report and 5 day report were sent to the Department of Health and Human Services, for resident #19s injury of unknown source identified. These reports were completed and submitted by the Director of Nursing. No further actions	

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F 867	Continued From page 152	F 867	taken for resident #19. 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 documentation in any resident medical records that indicate allegation of abuse, neglect, or injury of unknown sources, 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 two other documented allegation of abuse, and/or neglect documented in resident medical records. This audit was completed on 6/6/18 & 6/7/18. Findings of this audit is documented on clinical records audit tool located at the facility compliance binder. 100% audit was completed by the Center Executive Director for all allegation of abuse and/or neglect submitted in the last from 1/24/2018 to 6/7/2018 determine is the alleged perpetrator was suspended during investigation to protect the resident, 24 hours completed within 2 hours of the allegation, and 5 days completed and submitted to the state agency as required by regulation and Elder Justice Act in a timely manner. The audit revealed 5 of 5 completed abuse/neglect reports indicated the alleged perpetrator was suspended pending investigation per abuse prohibition policy and procedure, however	

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F 867	Continued From page 153	F 867	all 5 of 5 initial 24 hour reports were not submitted within two hours of the allegation. Two months noted with detail investigation and the Alleged Perpetrator(s) were suspended. This audit was completed on 6/7/2018. On 06/06/2018, 100% interviews was completed by Director of Rehabilitation Center, Business Office Manager, Activity Director, Medical Records Supervisor and MDS for all current alert and oriented residents in the facility to identify any other resident with an allegation of Abuse and/or Neglect. Two other residents, Resident#2, and Resident #3 voiced allegation of abuse and/or neglect. Alleged perpetrators identified were suspended while the investigation is conducted by the facility Executive Director and/or Director of Nursing. 24 hour reports were submitted on 6/6/2018. A thorough investigation initiated. The resident's attending Physician and Responsible Party were notified of the allegation. Resident #2 and #3, 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. The Director of Social Services, Assistant Director of Nursing, Unit Manager, Admission Director and Director of Rehabilitation Services interviewed the responsible parties for residents who were not able to answer questions during this interview due to mental capacity deficit on 6/7/18. No family member voiced any allegation of abuse and/or neglect. F610: 100% audit was completed by the	

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F 867	Continued From page 154	F 867	Director of Nursing of all incidents reports completed within the last 30 days to identify any injuries of unknown source and ensure that a proper investigation was completed and a an initial report within two hours as well as 5 days reports are completed and submitted to the state agency as required by regulation and Elder Justice Act. The audit revealed no other incident of injury of unknown source noted. This audit was completed on 6/7/2018. Findings of this audit is documented on incident reports audit tool located at the facility compliance binder. F610: 100% skin assessments of all active residents completed by the Director of Nursing, Assistant Director of Nursing and/or Unit Manager to identify any other resident with an injury of unknown source. The audit revealed no other incidents of injury of unknown source noted. This audit was completed on 6/6/18. SYSTEMIC CHANGES On 6/7/2018, Chief Clinical Officer completed re-training with the facility Administrator and the Director of Nursing, regarding the quality assurance performance improvement program (QAPI) process. This education will include how to identify quality deficiencies as well as ways to establish a system that will ensure consistent and measurable outcomes. The education will also cover methods on how to track and trend data, as well as best practices on root cause analysis. Effective 07/10/2018, this plan of correction will be incorporated and	

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F 867	Continued From page 155	F 867	discussed in the QAPI committees meeting by the Executive Director monthly until the next annual inspection. Any repeated citation in the following year will necessitate modification of this plan and extension of discussion during monthly QAPI meetings. Effective 6/7/18 the facility will conduct an interdisciplinary weekly team building meeting that with the department supervisors to discuss culture change initiatives to be implemented in the facility. These meetings will be held without affecting resident care activities. Team building will play role on maintaining facility's regulatory compliance and prevent repeat citation Effective 6/7/2018 the facility established an Employee Appreciation Committee (EAC) chaired by the Director of Human Resources. Initial members of this committee were selected by the facility Executive Director and Director of Nursing Services. Members include the Activity Director, Director of Social Services, Nurse Aide #1, Dietary Aide #1 and Laundry aide #1. This committee will meet monthly to discuss ways to improve employees' morale in order to reduce staff turnover and improve work place culture effective 6/7/2018. Effective 6/7/2018, all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and, are reported immediately, but not later than 2 hours after the allegation is made to the Administrator of the facility and to other officials to include; the State Survey	

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F 867	Continued From page 156	F 867	Agency, adult protective services, the state Ombudsmen in accordance with State law through established facilities policies and procedures. Effective 6/7/2018, The facility 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 6/7/2018, the Center Director of Human Services, and/or employee direct supervisor 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. The 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. Effective 6/7/2018, 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 month to identify any allegation of Abuse and/or Neglect. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse, and/or neglect will be reported to the Center Executive Director promptly. Alleged perpetrators will be suspended pending investigation by the facility, and	

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F 867	Continued From page 157	F 867	reported according to the regulatory requirements. The Director of Social services, Assistant Director of Nursing, Unit manager, Admission Director and Director of Rehabilitation Services will interview the responsible parties for residents who are not able to answer questions during the interview due to mental capacity deficit effective 6/7/18. This interview will be documented on the psychosocial assessment tool. Any voiced allegation of abuse, and/or neglect 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 6/7/2018 a copy of any resident's protective orders received on admission or readmission by the admission director or designated person during the admission process, will be placed in the medical file under the advance directive tab for easy identification and accessibility by the nursing staff. Effective 6/7/2018; received protective orders will be added to resident's care plan by the Admitting nurse and/or Nursing supervisor and nursing aide care guide for accessibility by both license nurses and nurse aides. If the protective order includes guidelines such as supervised visits, no visitation, or not allowed on the premises such measures will be added to resident's face sheet and appropriate information posted such as the perpetrator picture and/or description in a readily accessible location in the	

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F 867	Continued From page 158	F 867	facility. Facility Director of Nursing (DON), Assistant Director of Nursing and/or Unit manager will complete 100% education on the location of protective orders in each resident's medical charts and the location of intervention necessary to protect the resident with protective orders. This education will also cover process to be taken if the protective order to include adding the protective order interventions to resident's care plan and to nursing aide care guide for accessibility by both license nurses and nurse aides. Guidelines such as supervised visits, no visitation, or not allowed on the premises will also be covered in this education. The education will also emphasize on the process that such information will be added to resident's face sheet and appropriate information posted such as the perpetrator picture and/or description to be a readily accessible location in the facility. This education will be provided for all licensed nurses, nursing assistant to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses and nursing aides effective 6/7/2018, and will also be provided annually. Effective 6/7/2018, the center nursing administrative team, which includes DON, Nurse supervisors, Unit Managers, and/or	

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F 867	Continued From page 159	F 867	SDC, added reviewing of DSS protective orders to an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours. By adding the review of DSS protective orders to this process, it will ensure that any resident with prior history of allegation of abuse, neglect, and/or injuries of unknown sources has appropriate measures in place to protect the resident from the alleged perpetrator, effective 6/7/2018. This process with take place daily Monday through Fridays effective 6/7/2018. The result of this systemic process will be documented on the clinical meeting form maintained in the "Daily Clinical meeting binder." Effective 6/7/2018, the 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 and/or injuries of unknown sources reported/documented is investigated thoroughly, the alleged perpetrator is suspended pending investigation, and ensure the event is reported to the facility Executive Director. This process will also incorporate reviewing of any DSS protective orders to ensure the facility put measures in place to address such orders. This systemic process will take place every Saturday and Sunday. Any negative findings will be	

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F 867	Continued From page 160	F 867	documented on the week end supervisor report form and maintained in the daily clinical meeting binder, effective 6/7/2018. Effective 6/7/2018 the Admission Director (AD) will print any protective order for any referral to the facility before bed is offered. The AD will then provide copies of the protective order to the facility Executive Director, Director of Nursing, Director of social services and/or designated licensed nurse. The IDT team will then review all referrals with DSS protective orders prior to admitting resident to the facility to ensure measures are put in place to protect the resident when admitted to the facility. Effective 6/7/2018 the facility Executive Director, Director of Nursing, and/or Director of social services will discuss new admits and re-admits to the facility during their daily department head meeting to validate that any admitted or readmitted resident with protective orders has measures in place to protect the resident against the alleged perpetrators. Effective 6/7/2018 any alleged perpetrator with restraining orders for visitation will not be allowed to visit the facility. All the facility exit doors are locked and can only be accessed using an approved card. Visitors will utilize the facility main entrance to enter the premises, effective 6/7/18. All the facility exit doors are locked using a magnetized lock that releases in case of fire. In case of any other emergency, each locked facility exit door is equipped with an emergency release override switch located beside each exit door to allow the door to demagnetize and	

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F 867	Continued From page 161	F 867	open from the inside. The magnetic lock system is also equipped with a master override switch located at each nurse's station. This is in compliance with North Carolina life safety code. Signs have been posted on all exit doors to direct visitors to the main entrance, effective 6/7/18. Facility Executive Director, Director of Nursing (DON), Assistant Director of Nursing and/or Director of Social Services will complete 100% re-education on the location of protective orders in each resident's medical charts and the importance of implementing approaches to ensure the resident's protection, per facility abuse prohibition process. This education will be provided for all licensed nurses, to include full time, part time and as needed licensed nursing staff. This education will be completed by 6/7/2018. Any employee not educated by 6/7/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses effective 6/7/2018, and will also be provided annually. F610: Effective 7/10/2018, Facility will thoroughly investigate any injury of unknown source immediately but not later than two hours after the injury being noted to the facility Executive Director and to other state officials including the State Survey Agency and to the Adult Protective Services in the accordance with State law. Effective 7/10/2018, the center nursing administrative team, which includes DON, ADON, Unit Manager, Nurse supervisors, Unit Managers, and/or SDC will review in	

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	345213	A. BUILDING _____ B. WING _____	C 06/08/2018

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F 867	Continued From page 162	F 867	details any noted injury on completed skin assessment reports and/or incident report to ensure that such injuries has a known source and if not, ensure the proper procedure for reporting and investigating is followed based on the facility Abuse Policy and Procedures. This process of thorough review will be added on an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours. This process will take place daily Monday through Fridays effective 7/10/2018. The result of this systemic process will be documented on the clinical meeting form maintained in the Daily Clinical meeting binder. Effective 7/10/2018, the week end Registered Nurse supervisor and/or designated licensed nurse will review in details any noted injury on completed skin assessment reports and/or incident report to ensure that such injuries has a known source and if not, ensure the proper procedure for reporting and investigating is followed based on the facility Abuse Policy and Procedures. This process of thorough review will be added on an existing process of reviewing clinical documentation for the last 24 hours, which includes completed skin assessments, incident reports for the last 24 hours, and Physician orders written in the last 24 hours. This systemic process will take place every Saturday and Sunday. Any negative findings will be documented on the week end supervisor	

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F 867	Continued From page 163	F 867	report form and maintained in the daily clinical meeting binder, effective 7/10/2018. Chief Clinical officer completed an education on through investigation of injury of unknown sources to the facility Executive Director, Director of Nursing and Director of Social Services on 7/2/2018. This re-education emphasized on the methodologies to thoroughly investigate an allegation of abuse, neglect or injury of unknown source per the facility s abuse/neglect policy and procedures. This education will also be added on new hires orientation process for all any new Executive Director, Director of Nursing and Social Services Director effective 7/10/2018, and will also be provided annually. Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% re-education on the facility s abuse/neglect policy and procedures including notification protocols, and investigation procedures. This education will emphasize on reporting any injury of unknown source immediately but not later than two hours to the facility Executive Director and to other state officials including the State Survey Agency and to the Adult Protective Services in the accordance with State law. This education will be provided for all employees, to include full time, part time and as needed staff. This education will be completed by 7/10/2018. Any employee not educated by 7/10/2018 will not be allowed to work until educated.	

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F 867	Continued From page 164	F 867	This education will also be added on new hires orientation process for all new employees effective 7/10/2018, and will also be provided semi-annually. MONITORING PROCESS Effective 6/7/2018 the facility will conduct a directed performance improvement plan with the direct oversees by the Contracted and management company, to assist the facility on making culture changes and reduce employee turnover. This will be accomplished through weekly visit by the 3 times a week visits by the member of the management and consulting company for 4 weeks, then once weekly for three or until the pattern of compliance is maintained. Effective 6/7/2018, the facility interdisciplinary team to include Executive Director, Director of Nursing, Director of Social services and at least three other department supervisors will attend a monthly mandatory training that will be conducted by contracted management and consulting company that oversees the facility. This training will put an emphasis on all seven components of abuse prohibition to include screening, training, prevention, identification, investigation, protection, reporting and responses. This training will take place monthly for next twelve months or until the pattern of compliance is maintained. Effective 6/7/2018, the facility will conduct a quality assurance and performance improvement meeting monthly with an agent from the contracted management and consulting company to ensure that	

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F 867	Continued From page 165	F 867	the facility systematically identify and address areas that needs performance improvement to assure the facility maintain and retain substantial compliance. This will take place for the next twelve months or until the facility shows the pattern of compliance. Effective 6/7/2018, 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 2 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 6/7/2018, the facility will conduct a quality assurance and performance improvement meeting monthly with an agent from the contracted management and consulting company that oversees the company to ensure that the facility systematically identify and address areas related to resident's abuse and neglect and ensuring the abuse policies and procedures is implemented. This will take place for the next twelve months or until the facility shows the pattern of compliance. Effective 6/7/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff	

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F 867	Continued From page 166	F 867	Development Coordinator, will monitor compliance with resident protection, per facility abuse prohibition process, thorough investigation, injuries of unknown sources and resident neglect by conducting clinical meeting daily. This meeting will allow the team to review all allegation of abuse, incidents or accidents that occurred from the prior clinical meeting. Any DSS protective orders and any documented information that indicate suspicion of abuse will be reviewed to ensure measures are in place to protect the resident. 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 the clinical meeting binder after proper follow up is done. This monitoring process will take place daily for 4weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 6/7/2018, 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. F610: Effective 7/10/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with investigation and reporting of injuries of unknown sources by conducting clinical meeting daily (M-F).	

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F 867	Continued From page 167	F 867	This meeting will allow the team to review the daily clinical meeting checklist to ensure completion and proper follow through, incidents or accidents occurred from the prior clinical meeting to ensure any injury of unknown source was noted 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 weeks, then monthly x 3 months or until the pattern of compliance is maintained. RESPONSIBLE PARTY Effective 7/10/2018, 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 substantial compliance, and prevent repeat deficiencies.	