STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	R-C 07/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORESVILLE CENTER	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation for the removal of the immediate jeopardy on 06/28/18. A revisit survey was conducted on 07/02/18 for verification of the facility's allegation for removal of the immediate jeopardy and to determine the status of the ongoing immediate jeopardy. The facility provided evidence the immediate jeopardy was removed on 06/26/18. At the time of the exit on 07/02/18 the facility remained out of compliance for F 600, F 607, and F 835 at a lower scope and severity (D) isolated, no actual harm with potential for more then minimal harm that is not immediate jeopardy while the facility continues the process of monitoring the implementation of their corrective actions.	{F 000}		
{F 600} SS=D	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	{F 600}		7/2/18

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

Electronically Signed | 07/06/2018

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{F 600}	Continued From page 1 by: Based on observation, record review, family, hospital Medical Doctor, Detective and staff interviews the facility failed to protect a resident from a significant injury of unknown origin for 1 of 3 residents sampled (Resident #1). Resident #1 was discovered to have a bruise to his right arm and chest and was sent to the Emergency Room where it was discovered he also had a right chest wall hematoma (a collection of blood outside the blood vessels), right lung contusion (a type of hematoma in which blood has escaped from ruptured capillaries usually due to trauma), and a mild superior endplate compression fracture of T12 (thoracic spine). This deficiency was cited as an ongoing immediate jeopardy on the complaint survey of 06/20/18. The facility provided a credible allegation on 06/26/18 and it was accepted on 06/28/18. A revisit was conducted on 07/02/18 and found the facility had removed the immediate jeopardy effective 06/26/18. The scope and severity of this deficiency was lowered to a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy). The text from the original survey of 06/20/18 had been brought forward to reflect the removal of the immediate jeopardy, and ensure all staff members were inserviced, interventions were put in place, and monitoring was effective. The findings included: Resident #1 was readmitted to the facility on 10/27/15 with diagnoses that included: dementia without behavioral disturbances, history of transient ischemic attach (mini stroke), and weakness.	{F 600}	F 600 Free from Abuse and Neglect 1. Facility failed to protect resident # 1 from a significant injury of unknown origin. Resident #1 no longer resides at this facility. Facility staff failed to safely provide care for resident # 1, resulting in injuries. Investigation was not able to validate or substantiate abuse. Though there is no evidence of an improper transfer, the facility has concluded that the most likely cause of Resident #1□s injuries was related to an improper transfer technique. This conclusion is drawn from the review of the hospital records and the Medical Directors evaluation of injuries. This conclusion was made 6/26/18. 2. All resident have potential to be effected. Unit Managers and Regional Nurse reviewed all incident reports and interviewed alert and oriented residents to determine if any subsequent injuries of unknown origin had occurred, no significant issues were identified. Non-interviewable Residents on Resident # 1 unit were assessed during investigation, to determine if any injuries were present. No significant issues noted. The above was initiated on 6/8/18 and completed on 6/14/18. " Charge nurses were educated by the Nurse Practice Educator related to completion of Risk Management System Electronic Incident Reports for all injuries/bruises that are noted. This	

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{F 600}	Continued From page 2 Review of the most recent quarterly Minimum Data Set (MDS) dated 05/16/18 revealed that Resident #1 was severely cognitively impaired and required extensive assistance of 2 staff members with bed mobility, transfers, and dressing. Further review of the MDS revealed that Resident #1 received no anticoagulants (blood thinners) during the assessment period. Review of a care plan revised on 05/22/18 read in part, Resident #1 required limited to extensive assistance for activities of daily living due to cognitive loss/dementia. The goal of the care plan read in part, Resident #1's care needs would be anticipated and met to maintain highest practicable level of functioning. The interventions included: geri sleeves to bilateral arms and transfers require extensive assistance utilizing a gait belt and 1 to 2 person assistance. May use sit to stand lift if needed. Review of an Initial Allegation Report dated 05/25/18 at 6:30 PM revealed that Resident #1 had an injury of unknown source that included a bruise to right side rib area and right upper/inner arm. The report indicated that injury had been reported to the local law enforcement agency on 05/25/18. The accused employees were listed as Nursing Assistant (NA) #1, #2, and #3. Review of a 5-working day report dated 06/01/18 read in part, Resident #1 had been investigated for resident abuse for purple bruising to right upper extremity and medial side with purple bruising to right lateral chest. The report indicated that the incident had been reported to local law enforcement. The 5-working day report included brief statements from NA #1, #2, and #3. The	{F 600}	education was initiated on 6/8/18 and completed on 6/25/18. " On 6/08/18 Education on Safe Resident Transfers/Handling was initiated with all nursing staff and completed 6/25/18. This education was completed by Nurse Practice Educator and Unit Managers. " Education was completed with all facility staff related to abuse & neglect/ injuries of unknown origin. Included in this education were the definitions of injuries (bruising, fractures, skin tears), and residents right to be free from these injuries. During this education the staff were made aware that the facility had had a major injury of unknown origin. This education was initiated on 6/08/18 and completed on 6/25/18. This education was completed for all staff by the Nurse Practice Educator and Unit Manager. 3. All future injuries will be investigated according to regulation to ensure resident safety and prompt investigations are completed. " PCC Clinical Dashboard (which shows all patients who have a change in condition note) will be reviewed in clinical morning meeting. Incident reports (which are maintained electronically in the Risk Management System) will also be reviewed in the Clinical Morning Meeting by the Nursing Leadership team to determine if there have been any new injuries. " The Unit Managers and/or their designees will do random walking rounds three times a week to monitor resident	

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{F 600}	Continued From page 3	{F 600}		

conclusion read in part, "other residents on the unit were interviewed and none had issues with the staff. Skin assessments completed on the unit with no further injuries observed. All staff assigned to Resident #1 on 05/25/18 were interviewed and none of the staff were aware that Resident #1 had bruising to right inner arm and chest region. Resident #1 was a 1-2 person assist with pivot transfers. His skin was frail and he wore thickened arm protectors to decrease the risk of bruising. The incident was reported to the family and to the Medical Doctor (MD). There was no indication of abuse in this case" No cause of the bruise/injury was identified.

An interview was conducted with Resident #1's family member on 06/06/18 at 9:48 AM. The family member stated that she had visited him on 05/24/18 up until 6:30 PM and witnessed him getting ready for bed. The family member stated that at that time Resident #1 had no bruising and was his usual self. She stated that on 05/25/18 at approximately 6:30 PM she received a phone call from the facility telling her that they had found some bruising to Resident #1's right arm and chest area. The family member stated she immediately went over to the facility to see the bruising for herself. She added that when she saw the bruising which she described as dark purple around his right arm extending over to his right side and rib cage and she also noted a large protrusion to Resident #1's right chest area. She stated that she asked the facility what had happened and they replied, "we don't know what happened." The family member stated she contacted the local law enforcement at around 6:45 PM and they responded to the facility and they asked what had happened to Resident #1. The family member stated she directed the law

handling (care being provided, transfers being conducted properly) and to ensure residents are free from abuse/serious injuries. These rounds are under the direction of the Administrator, and any discrepancies will be reported to him for review. If the Administrator is not available, the Interim/Replacement Director of Nursing will be responsible for oversight. Interim DON started 6/25/18.
" The Administrator and Regional Nurse will also randomly review the PCC Clinical Dashboard and electronic incident reports weekly to determine if there are any injuries that require an investigation and if so, ensure that an investigation is completed accordingly. This process will be followed until the Quality Assurance and Performance Improvement Committee determines otherwise.
" All investigations will be reviewed by the Administrator and the Regional Nurse to ensure that injuries are investigated thoroughly to determine cause.
" The Interim/Replacement Director of Nursing or Regional Nurse will also randomly audit (with a minimum frequency of 5x/month) Safe Resident Handling for care being provided and transfers conducted to ensure residents are free from serious injuries. This education was started on 6/08/18 and concluded on 6/25/18.
" The Interim/Replacement Director of Nursing and Administrator will randomly question 10 staff members weekly to determine their knowledge of the definitions of resident injuries, how to report them, and the residents right to be

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{F 600}	Continued From page 4 enforcement questions to the facility and again they replied, "we don't know what happened." The interview further revealed local law enforcement then called Emergency Medical Services (EMS) and Resident #1 was transferred to the local hospital. Review of a Chest scan obtained in the hospital on 06/05/18 revealed the following: right anterior chest wall pectoralis hematoma (bleeding under the skin), ill-defined left upper lobe opacity may represent lung contusion (a type of hematoma in which blood has escaped from ruptured capillaries usually due to trauma), and mild superior endplate compression fracture of T12 (thoracic spine). An interview was conducted with the local law enforcement Detective on 06/07/18 1:30 PM. The Detective who was assigned to the case stated that on 05/25/18 one of his officers responded to the call made from Resident #1's family member from the facility. He responded to the facility and was made aware from the family something had happened to her family member. The Detective stated that when the officer saw the bruises and the staff was unable to tell him what happen to Resident #1 he called EMS to transport him to the hospital. The Detective stated he responded to the ER and observed the bruises and was surprised by the appearance of the dark bruises and the extent of the bruises. He added that he briefly spoke to the ER doctor and obtained some pictures but that was all that he had time to do. He added that he would be going back over to the facility to talk to the staff at some point but had not had time to do so. Review of the facility's daily assignment sheet	{F 600}	free from these injuries. These audits will begin on 6/26/18 4. The results of these audits and monitoring will be reviewed monthly in The Quality Assurance and Performance Improvement Committee, to ensure compliance with the plan. Regional Nurse to review and/or attend QAPI Meeting monthly. The Administrator is responsible for compliance with this plan of correction, with oversight provided by the Regional Vice President of Operations and/or the Regional Nurse. 5. Alleged date of compliance July 2, 2018	

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dated 05/25/18 revealed that NA #4 cared for Resident #1 from 11:00 PM on 05/24/18 to 7:00 AM on 05/25/18. The assignment sheet also revealed that NA#2 cared for Resident #1 on 05/25/18 from 7:00 AM to 11:00 AM, NA #3 cared for Resident #1 from 11:00 AM to 3:00 PM, NA #1 care for Resident #1 from 3:00 PM to 5:00 PM and NA #5 cared for Resident #1 from 5:00 PM until he was sent to the Emergency Room (ER) for evaluation.

An interview was conducted with NA #4 on 06/06/18 at 11:33 AM. NA #4 confirmed that she cared for Resident #1 from 11:00 PM on 05/24/18 to 7:00 AM on 05/25/18 and that she routinely cared for him and was familiar with his needs. She stated that night Resident #1 was his usual self and sometime in the morning hours she bathed Resident #1 and got him dressed for the day. NA #4 stated that when she bathed Resident #1 on the morning on 05/25/18 he had no bruises at all on his right arm or chest area. She added that he had a small bruise to his left-hand area but the nurse was already aware of that area. NA #4 did not recall any protrusion from Resident #1's right chest area but confirmed that there was no bruising to his right arm or chest area. She stated if she would have seen any new bruising she would have reported it to the nurse and had no knowledge of how the bruises occurred.

An interview was conducted with NA #2 on 06/06/18 at 11:26 AM. NA #2 confirmed that she cared for Resident #1 on 05/25/18 from 7:00 AM until 11:00 AM. She also added that was the first time she had ever taken care of Resident #1 and she clearly remembered the morning of 05/25/18, stating "it was crazy that morning, there was only 2 of us on the hall and I did not know any of the

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residents and I knew I had to get 4 people up for breakfast." NA #2 stated that she grabbed NA #6 and asked her to help get Resident #1 up to his wheel-chair. NA #2 stated that in report NA #4 had reported that Resident #1 required 2 person assist with transfers and that he had already been bathed and dressed and just needed to be transferred to his chair. NA #2 stated that she entered Resident #1's room that morning and made sure his brief was dry by just sliding the top of his pants down and he was dry so she stated she pulled his pants up and her and NA #6 used a gait belt and pivoted Resident #1 to his chair. She stated that she did not see any bruising to his right arm or chest but added he was already bathed and dressed when she arrived for duty and he had a shirt on and his geri sleeve was on his right arm so the arm and chest were not visible to her. She added it was one quick movement to his chair and was very easy to transfer. NA #2 stated that after they placed Resident #1 in his chair she did not render anymore care to him because she left at 11:00 AM and NA #3 took over her assignment. She added she had no knowledge of how the bruises occurred.

An interview was conducted with NA #6 on 06/08/18 at 9:50 AM. NA #6 stated that she rarely worked with Resident #1 but vaguely recalled assisting NA #2 on 05/25/18 with sitting him on the side of the bed and then pivoting Resident #1 to his chair. NA #6 stated shortly after she assisted NA #2 with transferring Resident #1 to his chair she was moved to different assignment and was not in Resident #1 ' s room anymore that day. She added that she did not see any bruising to Resident #1's right arm or chest but he was dressed and had on a geri sleeve so she did not

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visualize his skin, she was just assisting with a transfer. She added she had no knowledge of how the bruises occurred.

An interview was conducted with NA #3 on 06/06/18 at 11:45 AM. NA #3 confirmed that he came to work on 05/25/18 at 11:00 AM and was responsible for Resident #1. He stated that when he arrived at 11:00 AM Resident #1 was already up in his chair and was taken to the dining room for lunch. NA #3 stated that after lunch someone returned Resident #1 to his room and he and NA #7 began their last round to change everyone and lay them down for the afternoon. He added that after he and NA #7 had laid down another resident and exited the room he entered Resident #1's room to lay him down and change him. However, NA #3 stated that when he entered Resident #1's room the curtain was pulled and he could see Resident #1's feet in the bed and his chair was empty beside the bed. NA #3 also stated that he saw NA #2 and who he believed to be NA #6 behind the curtain changing Resident #1. He added that when he saw the 2 other staff members in the room tending to Resident #1 he exited the room and again met up with NA #7 to continue their round. NA #3 stated that he was in Resident #1's room less than 30 seconds and never visualized his skin and had no knowledge of how the bruises occurred.

An interview was conducted with NA #7 on 06/06/18 at 12:00 PM. NA #7 confirmed that she was working on the unit where Resident #1 resided on 05/25/18. She stated that after lunch she and NA #3 started the last round on the unit and had just exited another residents room and NA #3 stated he was going to go and lay down Resident #1. She stated that very shortly after he

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went to Resident #1's room he returned and stated Resident #1 was already in the bed. NA #7 stated she does not know who placed Resident #1 in the bed that afternoon and when NA #3 returned to her and stated that Resident #1 was already in the bed they continued with providing care to the other residents. She added that she had no knowledge of how the bruises occurred.

An interview was conducted with NA #1 on 06/08/18 at 11:13 AM. NA #1 confirmed that on 05/25/18 she had worked on a different unit from 7:00 AM to 3:00 PM and at 3:00 PM she transferred to the unit where Resident #1 resided. She stated that when she arrived at the unit at 3:00 PM there was no staff present to give her report and so she started her round to change people and get them ready for supper. NA #1 stated that at approximately 3:40 PM she went to Resident #1's room to provide incontinent care to him and he was resting in the bed, with no pants on and his brief was soaked. She stated she provided incontinent care to Resident #1 and placed pants on him and then transferred him to the wheel-chair by herself with no gait belt. NA #1 stated she did not notice any bruises to his arms or chest area but stated she only had to change his brief and apply cloths to his lower half. She stated she had no knowledge of the how the bruises occurred. She added that when she left her shift at 5:00 PM Resident #1 was sitting in his wheelchair beside his bed waiting for supper.

An interview was conducted with NA #5 on 06/06/18 at 3:50 PM. NA #5 confirmed that she arrived for her shift on 05/25/18 at 5:00 PM and relieved NA #1. She added that Resident #1 was pushed in his wheelchair to the dining room for supper and she fed him. NA #5 stated that

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Resident #1 was his usual self and had no signs of pain or discomfort. She added that Resident #1 had on a short sleeve shirt and geri sleeve that came up to his elbow with jogging pants. She stated that he ate 100% of the meal and he was taken back to his room and at approximately 5:30-6:00 PM she began to undress Resident #1 for bed and noticed the dark purple bruise to his arm and chest area. NA #5 stated that he also had a large protrusion to his right chest area that had light purple bruising surrounding it. NA #5 stated that she had cared for Resident #1 on the evening of 05/24/18 as well and when she dressed him for bed there was no bruising to his right arm or chest area and the large protrusion was not there. She stated she had no knowledge of what happened to Resident #1. NA #5 stated that when she discovered the bruises she immediately reported it to Nurse #1.

An interview was conducted with Nurse #1 on 06/06/18 at 3:22 PM. Nurse #1 confirmed that she worked with Resident #1 on 05/25/18. She stated that after supper NA #5 had taken Resident #1 to his room to get him ready for bed and when she removed his shirt noted some purple bruising to his right arm and chest area and came and reported it. Nurse #1 stated she went to look at the bruises and when she saw them she went and got the Nursing Supervisor (NS) and the Director of Nursing (DON) and they came to the room and looked at the bruises. Nurse #1 stated that she asked NA #5 to remove the geri sleeve from his right arm and noticed a lot of facial grimacing from Resident #1 when his right arm was touched. Nurse #1 stated that the bruises were not present the night before when she had worked and she could tell by the color of the bruises that they were new bruises. Nurse #1

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added that he had a knot on his right chest area and she stated, "I thought something was broken in there." Nurse #1 stated she has no knowledge of how the bruises occurred.

An interview was conducted with NA #8 on 06/07/18 at 5:38 PM. NA #8 stated that on 05/25/18 she reported for her shift between 10:30 AM and 11:00 AM and was working on the same unit Resident #1 resided. She added that between 4:00 PM and 5:00 PM she was in the break room having a snack and NA #3 and NA #1 were in there talking. NA #8 stated she heard NA #3 state, "man we dropped Resident #1" and I asked them "did you not use the lift" and NA #3 replied "no we used top and bottom." NA #8 further stated that she asked them did you tell the nurse and NA #3 stated "no we did not say anything" we just picked him up and put him back in the bed. She stated later there was commotion outside of Resident #1's room and she heard them talking about bruises and she stated to the NS that "maybe you should talk to" NA #3 and NA #1 and NS told NA #8 "to mind your own business." NA #8 stated after that she returned to her assignment and did not say anything else about what she had heard and been told.

An interview was conducted with the NS on 06/06/18 at 4:12 PM. The NS stated that on 05/25/18 sometime after dinner Nurse #1 came to me and stated she needed to me to come and look at Resident #1. The NS stated that when she entered his room and Nurse #1 pointed to the right mid arm and a knot on his right chest and there was bruising below his right breast over to his side. She added the bruise to his mid arm looked bluish and looked like a new bruise and when his right arm was moved you could see

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changes in his facial expression so the staff were instructed to be very careful with him when they were moving him. The NS stated that Resident #1's family was notified and they came to the facility and they called the local law enforcement and they called EMS to take Resident #1 to the ER. She stated that before the local law enforcement arrived at the facility the Medical Doctor (MD) was notified of the new bruising and STAT (now) orders were given for x-rays. When the local law enforcement decided to call EMS the MD was again notified that Resident #1 was going to the ER. The NS stated she honestly had no idea how the bruises occurred and stated Resident #1 did not move enough to cause those injuries to himself but added "it was very well possible that he was dropped." The NS also stated that NA #8 was asking questions about what happened and trying to get involved in the situation and I told her she needed to mind her business and get back to work but she never reported to me that she had heard NA #3 and NA #1 talking about dropping Resident #1.

An interview was conducted with the DON on 06/08/18 at 1:09 PM. The DON stated that on 05/25/18 Nurse #1 called me to come and look at Resident #1. She stated that when she entered his room his shirt had been removed and I witnessed dark purple bruising to his right inner arm and light bruising to right lateral chest. NA #5 reported to me that the bruises had not been present the evening before. The DON stated she advised Nurse #1 to call the MD and request an X-ray to rule out any fracture due to how frail Resident #1 was. She added that she then left the facility but had to return shortly after that because the family was there and was upset. When she returned to the facility the family was at

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bedside and EMS was preparing to take Resident #1 to the local hospital and she updated the Administrator that the family was upset and that Resident #1 was going to the hospital. The DON stated that she had no knowledge of how the bruises occurred and no one that she had spoken to had any knowledge of how the bruises occurred. She added that Resident #1 was not able to move enough to harm himself and that believed something happened but the staff was not being forth coming.

An observation of Resident #1 was made in the local hospital on 06/07/18 at 3:50 PM. Resident #1 was resting in bed with eyes open, he was alert and incoherently verbal. There was extensive dark purple bruising noted from the right upper chest area down to his right hip area, the bruising extended across the abdomen but had turned to a yellow color across the abdomen. The right upper arm also contained purple bruising that extended approximately 3 inches around the upper arm. Resident #1 was turned on his left side and dark purple bruising was visible to the right side extending to the back of Resident #1. He was observed to have a large protrusion to the right chest area. Resident #1 was noted to have facial grimacing while being assisted with turning and repositioned but was unable to voice his pain level.

An interview was conducted with the hospital Medical Doctor (HMD) on 06/08/18 at 10:42 AM. The HMD stated that another MD admitted Resident #1 to the hospital on 05/25/18 and he took over his case on 05/30/18. The HMD stated that when he first met and examined Resident #1 he believed that moving Resident #1 in the bed could not have caused his injuries but stated a

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transfer may have caused the bruising. The HMD further explained that after they performed a chest scan that revealed a chest wall hematoma (a collection of blood outside the blood vessels) and lung contusion (a type of hematoma in which blood has escaped from ruptured capillaries usually due to trauma) he determined that bumping into something could not have caused the lung contusion. The HMD stated it would take a pretty strong force to cause the lung contusion and he believed from his injuries it appeared that Resident #1 may have been dropped. He added that he sees lung contusions a lot in motor vehicle accidents or in the elderly who have fallen out of bed and are not cognitively aware to put their hands down to break the fall. The HMD also stated that the protrusion on Resident #1's right chest was suspected to be a pectoral muscle tear but to confirm that he would need to perform a more extensive test and Resident #1 was not physically appropriate for that test. The HMD stated that the dark purple bruises indicated that his injuries were new or acute and that when the bruises start to turn yellow that indicates that they were beginning to heal. He added that it would be hard to say if his injuries were life threatening due to Resident #1's age and over-all health but initially he would say no.

An interview was conducted with the Administrator on 06/08/18 at 11:36 AM. The Administrator stated that he was notified on 05/25/18 that Resident #1 was discovered to have bruises around his right arm and chest area and by the time he arrived back at the facility Resident #1 had been transported to the ER. The Administrator obtained a copy of the police report but it contained no photographs so his knowledge of the bruises was reported to him by the DON.

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He added that by the reports of the bruises he would assume that Resident #1 was either dropped or someone "man handled" him but our investigation did not conclude what happened to Resident #1 or how he acquired the injuries in the facility. The Administrator stated that someone in the facility knew what happened and they needed to come forward and report it, he added that he had an open-door policy and he always encouraged the staff to come to him.

The acting Administrator was notified of the immediate jeopardy on 06/20/18 at 10:22 AM.

The facility provided an acceptable allegation of compliance to remove the jeopardy on 06/28/18 which is described below:

June 26, 2018

Facility respectfully submits the below allegation of compliance for F-600:
Abuse & Neglect/Failure to Protect and Prevent Injuries of Unknown Origin.

1. Timeline:
" May 25, 2018 -Resident # 1 noted to have bruising on his right chest, right upper arm, and right lower back.
o Director of Nursing notified and came into the Center, assessed resident, spoke with several staff members (#1, #2, and #3) on duty and ensured notification of the physician.
o Physician ordered x-rays of the ribs, right humerus and right shoulder which were completed and all were negative for fractures.
o Administrator completed and sent in the 24-hour report to the State.
o Resident's daughter in facility and asked to

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have resident sent to the hospital. Local law enforcement was notified and responded to the facility and filed a report.
o Resident was sent to the hospital. According to discharge summary from hospital, his admitting diagnosis included, Aspiration Pneumonia, Altered Mental Status, Chronic Respiratory Failure and tachycardia. According to discharge summary he also had diagnosis of Hematoma to right chest wall and a Pectoralis Muscle Strain. ER documentation states that resident "did not appear to be in any distress, and was going to be discharged home until he had a run of ventricular tachycardia". This information was obtained and reviewed 6/26/18.
" Resident # 1 has not returned to the facility.
" May 28th-June 1st: Investigation included interviews of staff and agency staff, as well as alert and oriented residents. This investigation was conducted by the Director of Nursing. Staff interviewed included Staff Members # 1, #2 and # 3. Director of Nursing stated that she had interviewed alert and oriented residents.
" June 1, 2018 - Initial investigation concluded by the Director of Nursing.
" Facility unable to determine the cause of injuries or name a perpetrator.
" June 7, 2018, staff member # 8 (agency nurse aid) was removed from schedule permanently due to performance issues.
" June 8, 2018
o Administrator re-opened the investigation post survey, due to issues with how initial investigation was handled by the Director of Nursing, in particular that no staff were suspended, and the investigation was not thorough and delayed in its completion.
o No concrete evidence of which staff members were responsible for this injury

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o The Nurse Aides assigned to Resident # 1 on the date of injury (4 agency nurse aides: # 1, #2, #3, and # 6) were removed from the schedule on 6/08/18.

" June 14, 2018 - Second investigation concluded

o Facility still unable to substantiate abuse for Resident # 1

o Not able to determine any staff member directly involved.

o Administrator decided to permanently remove three of the agency staff members (#1, #2, and #6) from the schedule due to inconsistencies in their statements, and reports of them being untruthful from other aide staff.

o The Nursing Agency was notified by the Administrator on June 8, 2018 that the facility did not want those three specific nurse aides to return to the facility under any circumstances.

o Fourth nurse aide (#3) was placed back on the schedule at the conclusion of the investigation by the Administrator and had worked six shifts from 6/14/18 to 6/20/18. Investigation showed that this nurse aid had not provided any care for this resident on 5/25 and corroborating statement from another staff member validates this nurse aids noninvolvement.

" Emergency Room Physician Documentation from 5/25/18 includes the following: This information was obtained and reviewed 6/26/18.

o Mild to moderate ecchymosis over anterior surface of right upper arm. No notable bruising over the right upper back, which is contrary to the initial report by the daughter

o Normal ROM (range of motion)

o Daughter asked physician to speak to police on the phone, physician states that he told the officer " I expressed my opinion that the patient has a tear to his right pectoralis muscle with

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subsequent hematoma. I do believe that this could have occurred during transfers from bed to wheel chair and is not necessarily an indication of abuse, neglect or gross negligence"
o The patient continues to rest peacefully
o I have done my best to explain to her (the daughter) that we do not see any condition that needs treatment in the hospital and ongoing nursing care, which should be provided in the nursing home, is appropriate. I let the daughter know that even if patient were admitted, he would likely be discharged the next day, the daughter agreed that we may return him to the nursing home.
" The Hospital Discharge summary from 6/17/18 , when resident was discharged to another SNF, states the following:
o Resident not in any distress.
o He is stable for discharge to SNF
o Discharge Diagnosis: Hematoma of right chest wall, improving. Tachycardia resolved, and Pectoralis muscle strain stable. This information was obtained and reviewed 6/26/18.
" Facility Medical Director, reviewed the ER Physician documentation as well as the Discharge Summary for Resident # 1, on 6/26/18 (had previously been on vacation) and provided a statement in which he indicates that the injury likely occurred during a transfer.
" June 20, 2018 -
o Regional Nurse and HR removed 4th aide (#3) from schedule permanently and the staffing agency was notified, due to his being named as a staff member involved in initial investigation, and no documentation as to why Administrator had returned him to schedule (Administrator not available this date).
" Administrator has left Police Investigator multiple messages to discuss the outcome of his

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{F 600}	Continued From page 18 investigation, the Investigator has not returned calls. Friday 6/15 and Tuesday 6/26/18. " Facility staff failed to safely provide care for resident # 1, resulting in injuries. Facility failed to protect and prevent injuries for resident #1. Investigation was not able to validate or substantiate abuse. Though there is no evidence of an improper transfer, the facility has concluded that the most likely cause of Resident #1's injuries was related to an improper transfer technique. This conclusion is drawn from the review of the hospital records and the Medical Directors evaluation of injuries. This conclusion was made 6/26/18. 2. Actions Taken: " The Administrator will ensure all future allegations of Abuse & Neglect/Injuries of unknown origin are promptly investigated. An investigation was re-opened by the Administrator on 6/08/18, and current employees who had had contact with Resident # 1 were interviewed by the Administrator to verify reporting of all allegations of abuse. " Unit Managers and Regional Nurse reviewed all incident reports and interviewed alert and oriented residents to determine if any subsequent injuries of unknown origin had occurred, no significant issues were identified. Non-interviewable Residents on Resident # 1 unit were assessed during investigation, to determine if any injuries were present. No significant issues noted. The above was initiated on 6/8/18 and completed on 6/14/18. " Charge nurses were educated by the Nurse Practice Educator related to completion of Risk Management System Electronic Incident Reports for all injuries/bruises that are noted. This education was initiated on 6/8/18 and completed	{F 600}		

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{F 600}	Continued From page 19 on 6/25/18. " On 6/08/18 Education on Safe Resident Transfers/Handling was initiated with all nursing staff and completed 6/25/18. This education was completed by Nurse Practice Educator and Unit Managers. " Education was completed with all facility staff related to abuse & neglect/ injuries of unknown origin. Included in this education were the definitions of injuries (bruising, fractures, skin tears), and residents' right to be free from these injuries. During this education the staff were made aware that the facility had had a major injury of unknown origin. This education was initiated on 6/08/18 and completed on 6/25/18. This education was completed for all staff by the Nurse Practice Educator and Unit Manager. 3. Action Items: " All future injuries will be investigated according to regulation to ensure resident safety and prompt investigations are completed. " PCC Clinical Dashboard (which shows all patients who have a change in condition note) will be reviewed in clinical morning meeting. Incident reports (which are maintained electronically in the Risk Management System) will also be reviewed in the Clinical Morning Meeting by the Nursing Leadership team to determine if there have been any new injuries. " The Unit Managers and/or their designees will do random walking rounds three times a week to monitor resident handling (care being provided, transfers being conducted properly) and to ensure residents are free from abuse/serious injuries. These rounds are under the direction of the Administrator, and any discrepancies will be reported to him for review. If the Administrator is not available, the Interim/Replacement Director of	{F 600}		

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Nursing will be responsible for oversight. Interim DON started 6/25/18.

" The Administrator and Regional Nurse will also randomly review the PCC Clinical Dashboard and electronic incident reports weekly to determine if there are any injuries that require an investigation and if so, ensure that an investigation is completed accordingly. This process will be followed until the Quality Assurance and Performance Improvement Committee determines otherwise.

" All investigations will be reviewed by the Administrator and the Regional Nurse to ensure that injuries are investigated thoroughly to determine cause.

" The Interim/Replacement Director of Nursing or Regional Nurse will also randomly audit (with a minimum frequency of 5x/month) Safe Resident Handling for care being provided and transfers conducted to ensure residents are free from serious injuries. This education was started on 6/08/18 and concluded on 6/25/18.

" The Interim/Replacement Director of Nursing and Administrator will randomly question 10 staff members weekly to determine their knowledge of the definitions of resident injuries, how to report them, and the residents right to be free from these injuries. These audits will begin on 6/26/18.

The Quality Assurance and Performance Improvement Committee met on 6/22/18 to discuss the findings identified during survey and to review this Action plan. The Quality Assurance and Performance Improvement Committee will review monthly to ensure compliance with the plan.

The Administrator is responsible for compliance with this plan of correction, with oversight

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{F 600}	Continued From page 21 provided by the Regional Vice President of Operations and/or the Regional Nurse. Alleged date of removal of the Immediate Jeopardy: June 26, 2018 The allegation of immediate jeopardy removal was verified on 07/02/18 as evidenced by: Interviews with nursing staff and non nursing staff revealed that they had been educated on protecting residents from harm and significant injury. The interviews also revealed that staff would immediately report any injuries including bruises to their immediate supervisor once they verified the resident was safe. Interviews with nursing staff revealed that they had been educated on safe transfers, using gait belt, mechnical lift, and sit to stand lift with the correct number of staff. They were educated on where each residents transfer status was located and how to access the information and were instructed to report any changes in a residents transfer status to the nurse immediately. Interviews with nursing administration including the unit managers revealed that they would conduct walking rounds 3 times a week to make sure staff was safely handling/transferring residents. The interviews also revealed that they would review the 24 hour nursing report each morning along with the clinical dashboard located in the electronic medical record to identify any reportable injury to ensure that it was promptly and thoroughly investigated. Interview with the Administrator revealed that he	{F 600}		

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{F 600}	Continued From page 22 had been educated on conducting a thorough investigation that included talking to residents, staff, any involved person, reaching out to the Medical Doctor, reaching out to the appropriate agency, and timely reporting. The Administartor interview also revealed the oversight that would be provided by the facility's corporate managment team to ensure compliance. Review of the educational material used to educate staff between 06/08/18 and 06/25/18 was made which included the facility's abuse policy and procedure, review of the residents care plan, and assignment sheets. Each staff member interviewed had attended the education and indicated that on a facility sign in sheet.	{F 600}		
{F 607} SS=D	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 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 observation, record review, family, hospital Medical Doctor, Detective, and staff interviews the facility failed to implement their abuse policy and procedures to protect residents from abuse during and after the investigation,	{F 607}	F 607 Develop/ Implement Abuse/Neglect Policies 1. Facility failed to follow policy to protect resident(s) by not suspending staff	7/2/18

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{F 607}	Continued From page 23 failed to thoroughly investigate an injury of unknown origin, and failed to report the injury to the State Survey Agency within 2 hours for 1 of 3 residents sampled (Resident #1). Resident #1 was discovered to have a significant bruising with injury to his right chest area and right upper/inner arm and the facility was not able to determine the cause of the injuries. The resident was admitted to the hospital for evaluation and treatment of his injuries which included; a right chest wall hematoma (a collection of blood outside the blood vessels), left lung contusion (a type of hematoma in which blood has escaped from ruptured capillaries usually due to trauma), and a mild superior endplate compression fracture of T12 (thoracic spine). This deficiency was cited as an ongoing immediate jeopardy on the complaint survey of 06/20/18. The facility provided a credible allegation on 06/26/18 and it was accepted on 06/28/18. A revisit was conducted on 07/02/18 and found the facility had removed the immediate jeopardy effective 06/26/18. The scope and severity of this deficiency was lowered to a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy). The text from the original survey of 06/20/18 had been brought forward to reflect the removal of the immediate jeopardy, and ensure all staff members were inserviced, interventions were put in place, and monitoring was effective. The findings included: A review of the facility's Abuse Prohibition policy revised on 03/01/18 read in part, upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect the	{F 607}	involved during investigation and failed to adequately and thoroughly investigate the cause of injuries, putting other residents at risk, and delayed in obtaining information from the ER and delay in medical director involvement. Resident # 1 no longer resides at this facility. 2. All residents have potential to be effected. Unit Managers and Regional Nurse reviewed all incident reports and interviewed alert and oriented residents to determine if any subsequent injuries of unknown origin had occurred, on 6/08/18, none were identified. Non-interviewable Residents on Resident # 1 unit were assessed during investigation, to determine if any injuries were present, by the Director of Nursing and Unit Managers, with no significant findings. " The Director of Nursing Services was placed on administrative leave on 6/8/2018 due to failure to complete a thorough investigation, failure to suspend staff members and protect resident/other residents and failure to complete a timely investigation. The Director of Nursing was terminated effective June 25, 2018. Interim Director of Nursing in place and has been educated by the Regional Nurse on the Policy and Procedure for investigations. Education included how to complete a thorough (includes interviewing staff, residents, assessing residents) investigation according to policy and regulations. Also included was abuse prevention and	

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{F 607}	Continued From page 24 Center Executive Director (CED/Administrator) or designee will perform the following: initiate an investigation within 24 hours of an allegation of abuse that focuses on: whether abuse or neglect occurred and to what extent, clinical examination for signs of injuries if indicated, causative factors, and interventions to prevent further injury. The CED will also report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property not later than 2 hours after the allegation is made if the event results in serious bodily injury. The policy further read, the center will protect patients from further harm during an investigation. Further review of the policy read, the employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. Resident #1 was readmitted to the facility on 10/27/15 with diagnoses that included: dementia without behavioral disturbances, history of transient ischemic attach (mini stroke), and weakness. Review of the most recent quarterly Minimum Data Set (MDS) dated 05/16/18 revealed that Resident #1 was severely cognitively impaired and required extensive assistance of 2 staff members with bed mobility, transfers, and dressing. Review of an Initial Allegation Report dated 05/25/18 at 6:30 PM, completed by the Administrator revealed that Resident #1 had an injury of unknown source that included bruises to right side ribs and right upper/inner arm. The report indicated that the injury had been reported to the local law enforcement agency on 05/25/18	{F 607}	protecting residents from injury. Administrator was also educated on the above by the Regional Nurse. " Staff were re□educated, Beginning on 6/08/18 and completed on 6/25/18 by the Nurse Practice Educator on the Facility Policy for Abuse and Neglect and mandated reporting of allegations of abuse to include injuries of unknown origin to the Administrator, Director of Nursing or the employees immediate supervisor. This re-education also included removing suspected employees from duty pending investigations to protect resident(s) while the investigation is completed. 3. " The Administrator will ensure all future allegations of Abuse & Neglect/Injuries of unknown origin are thoroughly investigated following policy and regulation to include suspension of any suspected employees. The Administrator will achieve this by reviewing the incident reports that may include abuse/neglect and injuries of unknown origin, and subsequent investigations, meeting with staffing coordinator and/or responsible department head to ensure staff involved/suspected have been suspended. This process will begin 6/25/18 and will continue until the Quality Assurance and Performance Improvement Committee determine otherwise. " PCC Clinical Dashboard (which shows all patients who have a change in	

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{F 607}	Continued From page 25 at 6:45 PM. The accused employees were listed as Nursing Assistant (NA) #1, #2, and #3. The form further indicated that it had been faxed to the State Survey Agency on 05/25/18 at 9:46 PM. Review of a 5-working day report dated 06/01/18 read in part, Resident #1 had been investigated for resident abuse for purple bruising to right upper extremity and medial side with purple bruising to right lateral chest. The report indicated that the incident had been reported to local law enforcement. The 5-working day report included brief statements from NA #1, #2, and #3. The conclusion read in part, "other residents on the unit were interviewed and none had issues with the staff. Skin assessments completed on the unit with no further injuries observed. All staff assigned to Resident #1 on 05/25/18 were interviewed and none of the staff were aware that Resident #1 had bruising to right inner arm and chest region. Resident #1 was a 1-2 person assist with pivot transfers. His skin was frail and he wore thickened arm protectors to decrease the risk of bruising. The incident was reported to the family and to the Medical Doctor (MD). There was no indication of abuse in this case." No cause of the bruise/injury was identified. The 5-working day report was faxed to the State Survey agency on 06/01/18 at 1:49 PM. Review of the daily assignment schedule for 05/25/18 revealed that NA #4 cared for Resident #1 from 11:00 PM on 05/24/18 to 7:00 AM on 05/25/18, NA #2 cared for Resident #1 from 7:00 AM to 11:00 AM on 05/25/18, NA #3 cared for Resident #1 from 11:00 AM to 3:00 PM on 05/25/18, NA #1 cared for Resident #1 from 3:00 PM to 5:00 PM on 05/25/18, and NA #5 cared for Resident #1 from 5:00 PM until he discharged to	{F 607}	condition note) will be reviewed in the clinical morning meeting. Incident reports (which are maintained electronically in the Risk Management System) in the Clinical Morning Meeting by the Nursing Leadership team to determine if there have been any new injuries. " The Unit Managers will do random walking rounds three times a week to monitor resident handling (care being provided, transfers being conducted properly) to ensure residents are free from abuse/serious injuries. These rounds are under the direction of the Administrator, and any discrepancies will be reported to him for review. If the Administrator is not available, the Interim/Replacement Director of Nursing will be responsible for oversight. " The Administrator and Regional Nurse will also randomly review the PCC Clinical Dashboard and electronic incident reports weekly to determine if there are any injuries that require an investigation and if so, ensure that an investigation is completed accordingly. This process will be followed until the Quality Assurance and Performance Improvement Committee determines otherwise. " All investigations will be reviewed by the Administrator and the Regional Nurse to ensure that policy and regulations were carried out to include the protection of residents and prompt, thorough investigations. A thorough investigation will include interviews of staff and residents, assessments of residents, and as indicated appropriate notification to enforcement and Adult Protective	

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{F 607}	Continued From page 26 the Emergency Room (ER) on 05/25/18. An interview was conducted with NA #1 on 06/08/18 at 11:13 AM. NA #1 confirmed that she had cared for Resident #1 on 05/25/18. She stated that on 05/30/18 the Director of Nursing (DON) had asked her for a written statement about what had occurred with Resident #1 on 05/25/18 and she had done so. She added that she continued to work her regularly scheduled assignment with no change to her scheduled duties and had no knowledge of how Resident #1 acquired the bruise/injury of unknown origin. An interview was conducted with NA #2 on 06/06/18 at 11:26 AM. NA #2 confirmed that she cared for Resident #1 on 05/25/18. She stated that on 05/28/18 the DON had asked her for a written statement about what had occurred with Resident #1 on 05/25/18 and she had done so. She added that she continued to work her regularly scheduled assignment with no change to her scheduled duties and had no knowledge of how Resident #1 acquired the bruise/injury of unknown origin. An interview was conducted with NA #3 on 06/06/18 at 11:45 AM. NA #3 confirmed that he cared for Resident #1 on 05/25/18. He stated that on 05/31/18 the DON had asked him for a written statement about what had occurred with Resident #1 on 05/25/18 and he had done so. He added that he continued to work his regularly scheduled assignment with no change to his scheduled duties and had no knowledge of how Resident #1 acquired the bruise/injury of unknown origin. An interview was conducted with NA #4 on 06/06/18 at 11:33 AM. NA #4 confirmed that she	{F 607}	Services, and timely reporting to the state agency (DHHS). 4. The results of the above audits and monitoring will be brought before the Quality Assurance and Performance Improvement Committee monthly to ensure compliance with plan. The Regional Nurse will review and/or attend QAPI Meeting monthly. " The Administrator is responsible for compliance with this plan of correction, with oversight provided by the Regional Vice President of Operations and/or the Regional Nurse. " Alleged date of compliance: July 2, 2018	

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cared for Resident #1 from 11:00 PM on 05/24/18 to 7:00 AM on 05/25/18 and that she routinely cared for him and was familiar with his needs. NA #4 stated that the DON did not speak to her about the bruises discovered on Resident #1 and she was not asked to write a statement. She added that she continued to work her regularly scheduled assignment with no change to her scheduled duties and had no knowledge of how Resident #1 acquired the bruise/injury of unknown origin.

An interview was conducted with NA #5 on 06/06/18 at 3:50 PM. NA #5 confirmed that she cared for Resident #1 on 05/25/18 from 5:00 PM until his was discharged to the hospital. She stated that after she discovered the dark purple bruises to Resident #1 and reported it to Nurse #1 the DON had asked her what happened but she was not asked to write a statement. She added that she continued to work her regularly scheduled assignment with no change to her scheduled duties and had no knowledge of how Resident #1 acquired the bruise/injury of unknown origin.

An interview was conducted with NA #8 on 06/07/18 at 5:38 PM. NA #8 stated that on 05/25/18 she reported for her shift between 10:30 AM and 11:00 AM and was working on the same unit Resident #1 resided. She added that between 4:00 PM and 5:00 PM she was in the break room having a snack and NA #3 and NA #1 were in there talking about how they had dropped Resident #1 and they had not reported it they just picked him up and put him back to bed. She stated later there was commotion outside of Resident #1's room and she heard them talking about bruises and she stated to the Nursing

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Supervisor (NS) that "maybe you should talk to" NA #3 and NA #1 and the NS told NA #8 "to mind your own business." NA #8 stated after that she returned to her assignment and did not say anything else about what she had been told and heard and no one ever questioned her about the incident and she was not asked to give a statement. She added that she continued to work her regularly scheduled assignment with no change to her scheduled duties and had no knowledge of how Resident #1 acquired the bruise/injury of unknown origin.

An interview was conducted with the NS on 06/06/18 at 4:12 PM. The NS stated she honestly had no idea how the bruises occurred and stated Resident #1 did not move enough to cause those injuries to himself but added "it was very well possible that he was dropped." The NS also stated that NA #8 was asking questions about what happened and trying to get involved in the situation and I told her she needed to mind her business and get back to work but she never reported to me that she had heard NA #3 and NA #1 talking about dropping Resident #1.

An interview was conducted with Resident #1's family member on 06/06/18 at 9:48 AM. She stated that on 05/25/18 at approximately 6:30 PM she received a phone call from the facility telling her that they had found some bruising to Resident #1's right arm and chest area. The family member stated she immediately went over to the facility to see the bruising for herself. She added that when she saw the bruising which she described as dark purple around his right arm extending over to his right side and rib cage and she also noted a large protrusion to Resident #1's right chest area. She stated that she asked the

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facility what had happened and they replied, "we don't know what happened." The family member stated she contacted the local law enforcement at around 6:45 PM and they responded to the facility and they asked what had happened to Resident #1. The family member stated she directed the law enforcement questions to the facility and again they replied, "we don't know what happened." The interview further revealed local law enforcement then called Emergency Medical Services (EMS) and Resident #1 was transferred to the local hospital.

An observation of Resident #1 was made in the local hospital on 06/07/18 at 3:50 PM. Resident #1 was resting in bed with eyes open, he was alert and incoherently verbal. There was extensive dark purple bruising noted from the right upper chest area down to his right hip area, the bruising extended across the abdomen but had turned to a yellow color across the abdomen. The right upper arm also contained purple bruising that extended approximately 3 inches around the upper arm. Resident #1 was turned on his left side and dark purple bruising was visible to the right side extending to the back of Resident #1. He was observed to have a large protrusion to the right chest area. Resident #1 was noted to have facial grimacing while being assisted with turning and repositioned but was unable to voice his pain level.

An interview was conducted with the hospital Medical Doctor (HMD) on 06/08/18 at 10:42 AM. The HMD stated that another MD admitted Resident #1 to the hospital on 05/25/18 and he took over his case on 05/30/18. The HMD stated that when he first met and examined Resident #1 he believed that moving Resident #1 in the bed

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could not have caused his injuries but stated a transfer may have caused the bruising. The HMD further explained that after they performed a chest scan that revealed a chest wall hematoma (a collection of blood outside the blood vessels) and lung contusion (a type of hematoma in which blood has escaped from ruptured capillaries usually due to trauma) he determined that bumping into something could not have caused the lung contusion. The HMD stated it would take a pretty strong force to cause the lung contusion and he believed from his injuries it appeared that Resident #1 may have been dropped. He added that he sees lung contusion a lot in motor vehicle accidents or in the elderly who have fallen out of bed and are not cognitively aware to put their hands down to break the fall. The HMD also stated that the protrusion on Resident #1's right chest was suspected to be a pectoral muscle tear but to confirm that he would need to perform a more extensive test and Resident #1 was not physically appropriate for that test. The HMD stated that the dark purple bruises indicated that his injuries were new or acute and that when the bruises start to turn yellow that indicates that they were beginning to heal. He added that it would be hard to say if his injuries were life threatening due to Resident #'s age and over-all health but initially he would say no.

Review of a Chest scan obtained in the hospital on 06/05/18 revealed the following: right anterior chest wall pectoralis hematoma (bleeding under the skin), ill-defined left upper lobe opacity may represent lung contusion (a type of hematoma in which blood has escaped from ruptured capillaries usually due to trauma), and mild superior endplate compression fracture of T12 (thoracic spine).

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An interview was conducted with the local law enforcement Detective on 06/07/18 1:30 PM. The Detective who was assigned to the case stated that on 05/25/18 one of his officers responded to the call made from Resident #1's family member from the facility. He responded to the facility and was made aware from the family something had happened to her family member. The Detective stated that when the officer saw the bruises and the staff was unable to tell him what happen to Resident #1 he called EMS to transport him to the hospital. The Detective stated he responded to the ER and observed the bruises and was surprised by the appearance of the dark bruises and the extent of the bruises. He added that he briefly spoke to the ER doctor and obtained some pictures but that was all that he had time to do. He added that he would be going back over to the facility to talk to the staff at some point but had not had time to do so.

An interview was conducted with the DON on 06/08/18 at 1:09 PM. The DON confirmed that she conducted the investigation of Resident #1's bruise/injury of unknown origin. She indicated she started with the staff that cared for him on 05/25/18 and then proceeded from there with the full investigation. The DON confirmed that she listed NA #1, #2, and #3 on the initial and 5-working day report because they were on the schedule and cared for Resident #1 on 05/25/18. She confirmed that none of the accused individuals were suspended or reassigned on 05/25/18 or during the investigation. She further confirmed that all 3 accused staff members provided care to other residents in the days following the bruise/injury of unknown origin. The DON stated that she provided verbal reeducation

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for staff immediately on proper transfer and she believed that was protecting the residents. She added that she was unable to determine what caused Resident #1's bruise/injury but stated "something happened" and "someone knows" what happened and they need to come forward. The DON stated that she should have suspended the accused individuals until she could determine that no abuse had occurred to make sure all the residents were protected. She added that she had not reached out to the hospital to determine the extent of Resident #1's injuries and confirmed that she based her investigation on the 3 individuals that cared for Resident #1 on 05/25/18 but acknowledged that she did not talk to everyone that provided care to him that day and she should have.

An interview was conducted with the Administrator on 06/08/08 at 11:36 AM. The Administrator stated that he was informed of Resident #1's bruising on 05/25/18 at approximately 6:45 PM and by the time he arrived back at the facility Resident #1 had been sent to the Emergency Room (ER) so he had not visualized Resident #1. He stated that when he returned to the facility he had to gather the needed information and at that point he faxed the initial allegation report to the State Survey Agency and confirmed that it was outside of the 2-hour window but stated he reported it as quickly as he could. He added that he also had not seen any pictures that had been taken by the family or the local law enforcement. The Administrator stated that he delegated the investigation to the DON but did not see or review the investigation until the DON had faxed the 5-working day report to the State Survey Agency on 06/01/18. The Administrator stated that when he reviewed the

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investigation after it had been reported to the State Survey Agency he believed that the investigation "was lacking in areas" and "could have been more through" but at that time the report had already been faxed to the agency so he signed off on the report. He further stated that to his knowledge no one that was caring for Resident #1 on 05/25/18 when the injury occurred were suspended or placed on leave pending the investigation. He acknowledged that they remained working in the facility on 05/25/18 and in the days, that followed. The Administrator stated that he expected the DON or anyone conducting investigations to follow the facility policy and thoroughly investigation each allegation of bruise/injury of unknown origin. He added that with the extent of Resident #1's injuries he would say he was "man-handled or dropped" but could not rule out abuse and the results of the facility's investigation left him with unanswered questions. He added that because he did not conduct the investigation he could not say how the residents were protected and would have to ask the DON. The Administrator stated that he expected the DON or anyone conducting investigations to follow the facility policy and protect the residents from further harm during the investigation period. The Administrator added that he planned to reopen the investigation and conduct the investigation himself to determine how Resident #1 acquired his injuries while in the facility.

A review of the reopened investigation was made on 06/20/18. The investigation contained statements from the DON, NA #1, NA #2, NA #3, NA #5, NA #7, NA #9, Nurse #1, NS, and Nurse #2 but contained no date of when the investigation was completed. The conclusion of

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the investigation read in part, "to the best of our ability we have obtained new statements from the interested parties involved and as of today we cannot isolate the cause of the bruises. We feel the individuals that were involved with the care of Resident #1 are not necessarily being forthcoming with events of the day in question. All of these individuals are agency staff and were suspended from duty on 06/08/18 and will not return to the building."

Review of a daily assignment sheet dated 06/20/18 indicated that NA #3 was scheduled to work from 7:00 AM to 3:00 PM. Review of NA #3's time card confirmed that he had worked on 06/20/18 from 7:15 AM to 3:01 PM, further review of his time card indicated that he had worked on 06/11/18, 06/12/18, 06/13/18, 06/14/18, and 06/15/18. Review of time card for NA #1 and #2 revealed that they had clocked out on 06/08/18 and had not returned to the facility to work.

An interview was conducted with the Clinical Quality Specialist (CQS) on 06/20/18 at 6:00 PM. The CQS stated that the Administrator had reopened the investigation on 06/08/18 and concluded the investigation on 06/14/18. The CQS confirmed that NA #3 had worked on 06/20/18 and provided care to the residents. She indicated that the Administrator was currently on vacation and unavailable for interview but had communicated to her that his investigation had revealed no definitive cause of the bruises but he had decided that NA #1 and NA #2 could not return to the facility to work for reasons other than the investigation. The CQS indicated that the Administrator had determined that NA #3 had not done anything wrong and allowed him to return to duty. She could not answer as to why the

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Administrator's conclusion of his investigation indicated that the involved parties would not be returning to the facility or what basis was made for allowing NA #3 to return to duty.

The acting Administrator was notified of the immediate jeopardy on 06/20/18 at 10:22 AM

The facility provided an acceptable allegation of compliance to remove the jeopardy on 06/28/18 which is described below:

June 26, 2018

Facility respectfully submits the below allegation of compliance for F 607:
Abuse & Neglect/Injury of Unknown Origin/Failure to Follow Policy to Protect Other Residents and Failure to Adequately Investigate.

1. Timeline:
" May 25, 2018 -Resident # 1 noted to have bruising on his right chest, right upper arm, and right lower back.
o Director of Nursing notified and came into the Center, assessed resident, spoke with several staff members on duty(#1, #2, and #3) and ensured notification of the physician.
o Physician ordered x-rays of the ribs, right humerus and right shoulder which were completed and all were negative for fractures.
o Administrator completed and sent in the 24-hour report to the State.
o Resident's daughter in facility and asked to have resident sent to the hospital. Local law enforcement was notified and responded to the facility and filed a report. (Daughter phoned the police upon her arrival at the facility)
o Resident was sent to the hospital. According

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to discharge summary from hospital, his admitting diagnosis included, Aspiration Pneumonia, Altered Mental Status, Chronic Respiratory Failure and tachycardia. According to discharge summary he also had diagnosis of Hematoma to right chest wall and a Pectoralis Muscle Strain. ER documentation states that resident "did not appear to be in any distress, and was going to be discharged home until he had a run of ventricular tachycardia". This information obtained and reviewed on 6/26/18.

" Resident # 1 has not returned to the facility.

" May 28th-June 1st: Investigation included interviews of staff and agency staff, as well as alert and oriented residents. This investigation was conducted by the Director of Nursing. Staff interviewed included Staff Members # 1, #2 and # 3. Director of Nursing stated that she had interviewed alert and oriented residents to ensure that they had not experienced abuse/injuries. Not reported. Director of nursing failed to send any staff home during the investigation.

" June 1, 2018 - Initial investigation concluded by the Director of Nursing. In her conclusion she noted that she was unable to identify a responsible party or isolate the cause of resident's injuries. She reported these conclusions to the state on the 5 day report and to the Administrator.

" Facility unable to determine the cause of injuries or name a perpetrator.

" June 8, 2018

o Administrator re-opened the investigation post survey, due to issues with how initial investigation was handled by the Director of Nursing, in particular that no staff were suspended, and the investigation was not thorough and delayed in its completion.

o No concrete evidence of which staff

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members were responsible for this injury
o The Nurse Aides assigned to Resident # 1 on the date of injury (4 agency nurse aides: # 1, #2, #3, and # 6) were removed from the schedule on 6/08/18. Staff member #4 was noted by the Regional HR to have also worked with Resident #1 on 5/25/18, this was noted on 6/25, at which time staff #4 was suspended and interviewed. Staff #4 statement did not provide any additional information to the investigation.
" June 14, 2018 - Second investigation concluded
o Facility still unable to substantiate abuse for Resident # 1
o Not able to determine any staff member directly involved.
o Administrator decided to permanently remove three of the agency staff members (#1, #2, and #6) from the schedule due to inconsistencies in their statements, and reports of them being untruthful from other aide staff.
o The Nursing Agency was notified by the Administrator on June 8, 2018 that the facility did not want those three specific nurse aides to return to the facility under any circumstances.
o Fourth nurse aide (#3) was placed back on the schedule at the conclusion of the investigation by the Administrator and had worked six shifts from 6/11/18 to 6/20/18. Investigation showed that this nurse aid had not provided any care for this resident on 5/25 and corroborating statement from another staff member validates this nurse aids noninvolvement.
" Emergency Room Physician Documentation from 5/25/18 includes the following:
o Mild to moderate ecchymosis over anterior surface of right upper arm. No notable bruising over the right upper back, which is contrary to the initial report by the daughter

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o Normal ROM (range of motion)
o Daughter asked physician to speak to police on the phone, physician states that he told the officer " I expressed my opinion that the patient has a tear to his right pectoralis muscle with subsequent hematoma. I do believe that this could have occurred during transfers from bed to wheel chair and is not necessarily an indication of abuse, neglect or gross negligence"
o The patient continues to rest peacefully
o I have done my best to explain to her (the daughter) that we do not see any condition that needs treatment in the hospital and ongoing nursing care, which should be provided in the nursing home, is appropriate. I let the daughter know that even if patient were admitted, he would likely be discharged the next day, the daughter agreed that we may return him to the nursing home.
o This information was obtained and reviewed 6/26/18.
" The Hospital Discharge summary from 6/17/18 , when resident was discharged to another SNF, states the following:
o Resident not in any distress.
o He is stable for discharge to SNF
o Discharge Diagnosis: Hematoma of right chest wall, improving. Tachycardia resolved, and Pectoralis muscle strain stable.
o This information was obtained and reviewed 6/26/18.
" Facility Medical Director, reviewed the ER Physician documentation as well as the Discharge Summary for Resident # 1, on 6/26/18 (had previously been on vacation) and provided a statement in which he indicates that the injury likely occurred during a transfer.
" June 20, 2018 -
o Regional Nurse and HR removed 4th aide

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{F 607}	Continued From page 39 (#3) from schedule permanently and the staffing agency was notified, due to his being named as a staff member involved in initial investigation, and no documentation as to why Administrator had returned him to schedule (Administrator not available this date). " Administrator has left Police Investigator multiple messages to discuss the outcome of his investigation, the Investigator has not returned calls. Friday 6/15 and Tuesday 6/26/18. " Facility failed to follow policy to protect resident(s) by not suspending staff involved and failed to adequately and thoroughly investigate the cause of injuries, putting other residents at risk, as evidenced by delay in obtaining information from the ER and delay in medical director involvement. This conclusion was made 6/26/18.The Administrator and Medical Director were on vacation from 6/15-6/24, and had not previously made contact with the hospital for this information. 2. Actions Taken " The Director of Nursing Services was placed on administrative leave on 6/8/2018 due to failure to complete a thorough investigation, failure to suspend staff members and protect resident/other residents and failure to complete a timely investigation. The Director of Nursing will not be returning to the facility and will be terminated effective June 25, 2018. " Staff were re-educated, beginning on 6/08/18 and completed 6/25/18 by Nurse Practice Educator and Unit Managers on mandated reporting of abuse and neglect/ injury of unknown origin, including protection of the resident(s) by suspending suspected employees and investigating injuries time.	{F 607}		

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{F 607}	Continued From page 40 " Investigation re-opened by the Administrator on 6/08/18: o Staff were interviewed by the Administrator to verify reporting of all allegations of abuse. o As of 6/14/18 the investigation was not able to conclude the cause of resident # 1's injuries. o Unit Managers and Regional Nurse reviewed all incident reports and interviewed alert and oriented residents to determine if any subsequent injuries of unknown origin had occurred, on 6/08/18, none were identified. o Non-interviewable Residents on Resident # 1 unit were assessed during investigation, to determine if any injuries were present, by the Director of Nursing and Unit Managers, with no significant findings. " Interim-Administrator and Unit Managers were educated on 6/20/18 by the Regional Nurse related to the regulations on Abuse Prevention and protection residents from injury. Education also included how to complete a thorough (includes interviewing staff, residents, assessing residents) investigation according to policy and regulations. Administrator is to return on 6/25/18 and at that time will be re-educated by the Regional Nurse Consultant on the above, along with Interim-Director of Nursing. " Beginning on 6/08/18 and completed on 6/25/18 facility employees were re-educated by the Nurse Practice Educator on the Facility Policy for Abuse and Neglect and mandated reporting of allegations of abuse to include injuries of unknown origin to the Administrator, Director of Nursing or the employees immediate supervisor. This re-education also included removing suspected employees from duty pending investigations to protect resident(s) while the investigation is completed. No facility employee shall work after 06/25/18 without receiving this	{F 607}		

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re-education. Education will include the definitions of abuse, and the facilities "no tolerance" policy.

3. Action Items:
" Beginning on 06/25/18, all newly hired facility staff will be educated prior to beginning work in the resident care area by the Nurse Practice Educator on the Facility Policy for Abuse and Neglect/ injuries of unknown origin and mandated reporting of allegations of resident abuse and neglect to the Administrator, Interim/Replacement Director of Nursing or the employee's immediate Supervisor. This education will also include removing suspected employees from duty pending investigation to protect resident(s) while the investigation is completed. Nurse Practice Educator or Unit Manager will educate all new Agency staff on the above. (All currently scheduled agency staff have received this education)
" Administrator and Interim/Replacement Director of Nursing were re-educated by the Regional Nurse Consultant related to the regulations on Abuse Prevention and protection residents from injury. Education will also include how to complete a thorough (includes interviewing staff, residents, assessing residents) and thorough investigation according to policy and regulations, prior to their returning to work. This education was completed on 6/25/18.
" The Administrator will ensure all future allegations of Abuse & Neglect/Injuries of unknown origin are thoroughly investigated following policy and regulation to include suspension of any suspected employees. The Administrator will achieve this by reviewing the incident reports that may include abuse/neglect and injuries of unknown origin, and subsequent

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investigations, meeting with staffing coordinator and/or responsible department head to ensure staff involved/suspected have been suspended. This process will begin 6/25/18 and will continue until the Quality Assurance and Performance Improvement Committee determine otherwise.

" PCC Clinical Dashboard (which shows all patients who have a change in condition note) will be reviewed in the clinical morning meeting. Incident reports (which are maintained electronically in the Risk Management System) in the Clinical Morning Meeting by the Nursing Leadership team to determine if there have been any new injuries.

" The Unit Managers will do random walking rounds three times a week to monitor resident handling (care being provided, transfers being conducted properly) to ensure residents are free from abuse/serious injuries. These rounds are under the direction of the Administrator, and any discrepancies will be reported to him for review. If the Administrator is not available, the Interim/Replacement Director of Nursing will be responsible for oversight.

" The Administrator and Regional Nurse will also randomly review the PCC Clinical Dashboard and electronic incident reports weekly to determine if there are any injuries that require an investigation and if so, ensure that an investigation is completed accordingly. This process will be followed until the Quality Assurance and Performance Improvement Committee determines otherwise.

" All investigations will be reviewed by the Administrator and the Regional Nurse to ensure that policy and regulations were carried out to include the protection of residents and prompt, thorough investigations. A thorough investigation will include interviews of staff and residents,

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assessments of residents, and as indicated appropriate notification to enforcement and Adult Protective Services, and timely reporting to the state agency (DHHS).

The Quality Assurance and Performance Improvement Committee met on 6/22/18 to discuss the findings identified by the survey and to review this action plan. The Quality Assurance and Performance Improvement Committee will review monthly to ensure compliance with this plan.

The Administrator is responsible for compliance with this plan of correction, with oversight provided by the Regional Vice President of Operations and/or the Regional Nurse.

Alleged date of removal of the Immediate Jeopardy: June 26, 2018

The allegation of immediate jeopardy removal was verified on 07/02/18 as evidenced by:

Interviews with nursing staff and non nursing staff revealed that they had been educated on the facility's abuse and neglect policy and procedures that including protecting residents from harm and significant injury. The interviews also revealed that staff would immediately report any injury including bruises to their immediate supervisor once they verified the resident was safe.

Interviews with nursing staff revealed that they had been educated on safe transfers using a gait belt, mechnical lift, and sit to stand lift with the correct number of staff. They were educated on where each residents transfer status was located and how to access the information and were

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{F 607}	Continued From page 44 instructed to report any changes in a residents transfer status to the nurse immediately. Interviews with nursing administration revealed that they would conduct walking rounds 3 times a week to make sure staff was safely handling/transferring residents. The interviews also revealed that they would review the 24 hour nursing report each morning along with the clinical dashboard located in the electronic medical record to identify any reportable injury to ensure that it was promptly and thoroughly investigated. Interview with the Administrator and Interim Director of Nursing revealed that they had been educated on conducting a thorough investigation that included talking to residents, staff, any involved person, reaching out to the Medical Doctor, reaching out to the appropraite agency, and timely reporting. The Administartor interview also revealed the oversight that would be provided by the facility's corporate managment team to ensure compliance. Review of the educational material used to educate staff between 06/08/18 and 06/25/18 was made which included the facility's abuse and neglect policy and procedure, review of the residents care plan, and assignment sheets. Each staff member interviewed had attended the education and indicated that on a facility sign in sheet.	{F 607}		
{F 835} SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that	{F 835}		7/2/18

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{F 835}	Continued From page 45 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 observation, record review, family, hospital Medical Doctor, Detective and staff interview the facility Administration failed to provide leadership and oversight to protect a resident from a significant injury of unknown origin and conduct a thorough investigation to determine the cause, failed to implement their abuse policies to protect the residents during and after the investigation, and failed to report the significant injury to the state survey agency within 2 hours for 1 of 3 residents sampled (Resident #1). Resident #1 was discovered by facility staff to have significant bruising to his upper torso which the origin was unknown. The resident was sent to the hospital for evaluation and treatment and was diagnosed with a compression fracture to the spine, chest wall hematoma, and left lung contusion. This deficiency was cited as an ongoing immediate jeopardy on the complaint survey of 06/20/18. The facility provided a credible allegation on 06/26/18 and it was accepted on 06/28/18. A revisit was conducted on 07/02/18 and found the facility had removed the immediate jeopardy effective 06/26/18. The scope and severity of this deficiency was lowered to a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy). The text from the original survey of 06/20/18 had been brought forward to reflect the removal of the immediate jeopardy, and ensure all staff members were inserviced, interventions	{F 835}	F 835 Administration 1. The facility Administration failed to provide leadership and oversight to protect a resident from a significant injury of unknown origin and conduct a thorough investigation to determine the cause, failed to implement their abuse policies to protect the residents during and after the investigation, and failed to report the significant injury to the state survey agency within 2 hours for Resident # 1. Resident # 1 no longer resides at this facility. Administrative staff (Administrator and Director of Nursing) both new to their roles in the last year. Administrative staff failed to involve Corporate Team in enough detail of this significant event, to allow for appropriate assistance and guidance on the process. 2. All residents have potential to be effected. Regional Nurse reviewed all incident reports to determine if any subsequent injuries of unknown origin had occurred, on 6/08/18, with none identified. During this review Regional Nurse also audited for any other significant event, none were noted. " The Director of Nursing Services was placed on administrative leave on 6/8/2018 due to failure to complete a	

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{F 835}	Continued From page 46 were put in place, and monitoring was effective. The findings included: 1. This tag is cross referred to F600: Based on observation, record review, family, hospital Medical Doctor, Detective and staff interviews the facility failed to protect a resident from a significant injury of unknown origin for 1 of 3 residents sampled (Resident #1). Resident #1 was discovered to have a bruise to his right arm and chest and was sent to the Emergency Room where it was discovered he also had a right chest wall hematoma (a collection of blood outside the blood vessels), right lung contusion (a type of hematoma in which blood has escaped from ruptured capillaries usually due to trauma), and a mild superior endplate compression fracture of T12 (thoracic spine). 2. This tag is cross referred to F607: Based on observation, record review, family, hospital Medical Doctor, Detective, and staff interviews the facility failed to implement their abuse policy and procedures to protect residents from abuse during and after the investigation, failed to thoroughly investigate an injury of unknown origin, and failed to report the injury to the State Survey Agency within 2 hours for 1 of 3 residents sampled (Resident #1). Resident #1 was discovered to have a significant bruising with injury to his right chest area and right upper/inner arm and the facility was not able to determine the cause of the injuries. The resident was admitted to the hospital for evaluation and treatment of his injuries which included; a right chest wall hematoma (a collection of blood outside the blood	{F 835}	thorough investigation, failure to suspend staff members and protect resident/other residents and failure to complete a timely investigation. The Director of Nursing will not be returning to the center. Director of Nursing has also been reported to the Board of Nursing by Regional Nurse Consultant on 6/22/18. " The Administrator and Director of Nursing were educated by the Regional Nurse related to the regulations on Abuse Prevention and protection residents from injury. Education also included how to complete a thorough investigation (includes interviewing staff, residents, assessing residents) according to policy and regulations. Education completed on 6/25/18. " Administrator and Interim Director of Nursing were also educated by the Regional Nurse on process for notification of Regional Team including Regional Nurse and Regional Vice President of Operations, of significant events in the center. This education included what is considered a significant event. This education was completed on 6/25/18. 3. " The Administrator will ensure all future allegations of Abuse & Neglect/Injuries of unknown origin are promptly investigated following policy and regulation to include suspension of any suspected employees. The Administrator will achieve this by reviewing the incident report and subsequent investigations, meeting with staffing coordinator and/or responsible department head to ensure staff	

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	345283	A. BUILDING _____ B. WING _____	R-C 07/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORESVILLE CENTER	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 835}	Continued From page 47 vessels), left lung contusion (a type of hematoma in which blood has escaped from ruptured capillaries usually due to trauma), and a mild superior endplate compression fracture of T12 (thoracic spine). A follow up interview was conducted with the Administrator on 06/08/18 at 7:01 PM. The Administrator again stated that he felt like the investigation that the Director of Nursing (DON) had conducted was not thorough and he had decided to reopen the investigation and had already conducted several interviews and obtained additional statements. He added that at the time the 5-working day report had already been sent to the State Survey Agency and "it was over and done with and we were moving on." The Administrator stated that once he learned of the significant injuries Resident #1 sustained he felt like he needed to try and figure out what happened but he certainly expected the DON or anyone he delegated to conduct the investigation would do a thorough investigation and determine a cause and protect the residents at the same time and clearly that was not done with this incident. The Administrator also stated he would expect the reporting of the incident to be completed within the 2-hour time frame. The acting Administrator was notified of the immediate jeopardy on 06/20/18 at 10:22 AM. The facility provided an acceptable allegation of complaince to remove the jeopardy on 06/28/18 which is described below: June 26, 2018 Facility respectfully submits the below allegation	{F 835}	involved/suspected have been suspended. The Regional Nurse will ensure this process of followed by conducting her own review of the Incident Reports weekly with follow up with the Administration as indicated. This process will begin 6/25/18 and will continue until the Quality Assurance and Performance Improvement Committee determine otherwise. " PCC Clinical Dashboard (which shows all patients who have a change in condition note) will be reviewed in the Clinical Morning Meeting. Incident reports (which are maintained electronically in the Risk Management System) in the Clinical Morning Meeting by the Nursing Leadership team to determine if there have been any new injuries. The Regional Nurse will ensure this process is followed by her own review of the Dashboard and RMS system (both electronic systems) weekly with appropriate follow up with the Administrative Staff. Regional Nurse will also attend the Clinical Morning Meeting on scheduled bi-monthly visits to monitor the process. " In the event of a serious injury or abuse allegation, the Administrator and Director of Nursing will be notified immediately, and will in turn notify the Regional Nurse and the Regional Vice President of Operations to ensure that a coordinated investigation is completed. " All investigations will be reviewed by the Administrator and the Regional Nurse to ensure that policy and regulations were carried out to include the protection of	

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{F 835}	Continued From page 48 of compliance for F 835: Administration-Failure to provide oversight to prevent a resident from sustaining injuries and to protect residents from future occurrences, as well as failure to investigate these injuries thoroughly. 1. Facility Administrative Staff failed to protect and failed to ensure a thorough investigation for Resident #1 with significant injuries of unknown origin. Administrative staff (Administrator and Director of Nursing) both new to their roles in the last year. Administrative staff failed to involve Corporate Team in enough detail of this significant event, to allow for appropriate assistance and guidance on the process. 2. Actions Taken: " The Director of Nursing Services was placed on administrative leave on 6/8/2018 due to failure to complete a thorough investigation, failure to suspend staff members and protect resident/other residents and failure to complete a timely investigation. The Director of Nursing will not be returning to the center. Director of Nursing has also been reported to the Board of Nursing by Regional Nurse Consultant on 6/22/18. " Interim-Administrator and Unit Managers were educated on 6/20/18 by the Regional Nurse related to the regulations on Abuse Prevention and protection residents from injury. Education will also include how to complete a thorough investigation (includes interviewing staff, residents, assessing residents) according to policy and regulations. Administrator return to work on 6/25/18 and was re-educated by the Regional Nurse Consultant on the above at that time with Interim-Director of Nursing.	{F 835}	residents and prompt, thorough investigations. 4. The above audits and monitoring will be reported to The Quality Assurance and Performance Improvement Committee monthly to ensure compliance with this plan. Regional Nurse will review Quality Assurance and Performance Improvement minutes monthly for 6 months to ensure compliance. Regional Nurse will attend Quality Assurance and Performance Improvement Committee randomly over next 6 months. The Regional Team (Regional Nurse and Regional Vice President) of Operation are responsible for compliance with this plan of correction. Alleged date of compliance: July 2, 2018	

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{F 835}	Continued From page 49 " Administrator and Interim Director of Nursing were educated by the Regional Nurse on process for notification of Regional Team including Regional Nurse and Regional Vice President of Operations, of significant events in the center. This education included what is considered a significant event. This education was completed on 6/25/18. " Regional Nurse reviewed all incident reports to determine if any subsequent injuries of unknown origin had occurred, on 6/08/18, with none identified. During this review Regional Nurse also audited for any other significant event, none were noted. 3. Action Items: " The Administrator will ensure all future allegations of Abuse & Neglect/Injuries of unknown origin are promptly investigated following policy and regulation to include suspension of any suspected employees. The Administrator will achieve this by reviewing the incident report and subsequent investigations, meeting with staffing coordinator and/or responsible department head to ensure staff involved/suspected have been suspended. The Regional Nurse will ensure this process of followed by conducting her own review of the Incident Reports weekly with follow up with the Administration as indicated. This process will begin 6/25/18 and will continue until the Quality Assurance and Performance Improvement Committee determine otherwise. " PCC Clinical Dashboard (which shows all patients who have a change in condition note) will be reviewed in the Clinical Morning Meeting. Incident reports (which are maintained electronically in the Risk Management System) in	{F 835}		

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{F 835}	Continued From page 50 the Clinical Morning Meeting by the Nursing Leadership team to determine if there have been any new injuries. The Regional Nurse will ensure this process is followed by her own review of the Dashboard and RMS system (both electronic systems) weekly with appropriate follow up with the Administrative Staff. Regional Nurse will also attend the Clinical Morning Meeting on scheduled bi-monthly visits to monitor the process. " In the event of a serious injury or abuse allegation, the Administrator and Director of Nursing will be notified immediately, and will in turn notify the Regional Nurse and the Regional Vice President of Operations to ensure that a coordinated investigation is completed. " All investigations will be reviewed by the Administrator and the Regional Nurse to ensure that policy and regulations were carried out to include the protection of residents and prompt, thorough investigations. " Administrator will complete his onboarding process with the Regional Team via visits and web based trainings. Program is entitled "Leadership Essential" and includes business and clinical aspects of Nursing Home Administration. " New Interim Director of Nursing will receive all of the above education by the Regional Nurse upon start with facility. The Quality Assurance and Performance Improvement Committee, with the Regional Nurse in attendance, met on 6/22/18 to discuss the findings identified by the survey and to review this action plan. The Regional Vice President of Operations visited facility on 6/25 to conduct a Quality Review of this Plan of Correction. The Quality Assurance and Performance Improvement Committee will review monthly to ensure compliance with this plan. Regional Nurse	{F 835}		

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{F 835}	Continued From page 51	{F 835}		

will review Quality Assurance and Performance Improvement minutes monthly for 6 months to ensure compliance. Regional Nurse will attend Quality Assurance and Performance Improvement Committee randomly over next 6 months.

The Regional Team (Regional Nurse and Regional Vice President of Operation are responsible for compliance with this plan of correction.

Alleged date of removal of the Immediate Jeopardy: June 26, 2018

The allegation of immediate jeopardy removal was verified on 07/02/18 as evidenced by:

Interviews with nursing staff and non nursing staff revealed that they had been educated on the facility's abuse and neglect policy and procedures that including protecting residents from harm and significant injury. The interviews also revealed that staff would immediately report any injury including bruises to their immeditate supervisor once they verified the resident was safe.

Interviews with nursing staff revealed that they had been educated on safe transfers, use of gait belt, mechnical lift, and sit to stand lift with the correct number of staff. They were educated on where each residents transfer status was located and how to access the information and were instructed to report any changes in a residents transfer status to the nurse immediately.

Interviews with nursing administration including the unit managers revealed that they would

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conduct walking rounds 3 times a week to make sure staff was safely handling/transfering residents. The interviews also revealed that they would review the 24 hour nursing report each morning along with the clinical dashboard located in the electronic medical record to identify any reportable injury to ensure that it was promptly and thoroughly investigated.

Interview with the Interim Director of Nursing (DON) revealed that she had been educated on the facility's abuse and neglect policy and the process for conducting a thorough investigation. The interview also revealed her responsibility of notifying the regional corporate team of significant events in the center.

Interview with the Administrator and DON revealed that they had been educated on conducting a thorough investigation that included talking to residents, staff, any involved person, reaching out to the Medical Doctor, reaching out to the appropriate agency, suspension of accused individuals, and timely reporting. The Administartor interview also revealed the oversight that would be provided by the facility's corporate managment team to ensure compliance.

Review of the educational material used to educate staff between 06/08/18 and 06/25/18 was made which included the facility's abuse and neglect policy and procedure, review of the residents care plan, assignment sheets, and the Quality Assurance and Performance Improvement Committees involvment. Each staff member interviewed had attended the education and indicated that on a facility sign in sheet.