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	345131	A. BUILDING ______ B. WING ______	C 11/05/2018

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F 000	INITIAL COMMENTS The survey team entered the facility on 10-31-18 to conduct a complaint and revisit survey. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/01/18 and was removed on 11/05/18. A Partial extended survey was conducted. The survey team exited the facility on 11/2/18 to allow the facility to complete their inservices on the abuse policy. The survey team returned to the facility on 11-5-18 to validate the creditable allegation of removal.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		11/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/15/2018

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

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This REQUIREMENT is not met as evidenced by:

Based on record review, staff interviews, resident interview, family interview and review of the facility's video footage the facility failed to protect 2 of 3 residents (Resident #1 and Resident #2) from staff physical abuse. This resulted in Resident #1 being hit and pushed into a glass door by an employee. In addition, Resident #2 was hit in the head with a cookie which was thrown at him by an employee.

Immediate Jeopardy began on 10-13-18 when Resident #1 was in the dining room and Nursing Assistant (NA) #1 hit the resident in the face then pushed him into a glass door. No physical injuries were assessed. Immediate Jeopardy was removed on 11-3-18 when the facility provided and implemented acceptable creditable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put in place are effective. Example #2 (Resident #2) was cited at a scope and severity of a D where a plan of correction is required.

Findings included:

1. Resident #1 was admitted to the facility on 11-9-17 with multiple diagnoses that included psychosis, dementia with behaviors, Alzheimer's, adult failure to thrive and weakness.

The quarterly Minimum Data Set (MDS) dated 8-23-18 revealed Resident #1 was severely cognitively impaired and rejected care 1 to 3 days a week. Resident #1 was also coded as needing

F 600

The plan for correcting the specific deficiency (the individual):
The alleged deficiency occurred on 10/13/18 at approximately 6:00PM certified nursing assistant (CNA) #2 walked into the dining hall on unit 1 and saw resident #1 slap CNA #1 in the face. CNA #1 then "grabbed" at Resident#1 hand (wrist) and "pushed him away" towards the door possibly making contact with his face at that time. CNA#2 states she caught Resident #1 to keep him from falling, then told CNA#1 "you can't do that" and redirected CNA #1 away from the resident and assuring another CNA was present between them. CNA #2 then went to get the assistance of the nurse. Licensed nurse #1 came into the dining room to assess the resident and remove CNA #1. Resident #1 did not appear in distress or upset. CNA #2 and Nurse #1 assessed Resident #1 for injuries and emotional impact and found neither. Resident #1 continued to be observed by the nursing staff for change in affect through the night and following day, no changes were reported. CNA #1 was removed from the facility and sent home. Nurse #1 notified the Director of Nursing who then notified the administrator. Resident #1 continued to ambulate throughout the unit without being upset and his assessment was unremarkable. The son of resident #1 was notified of the incident on 10/13/18 as was the medical doctor.

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supervision with one person for bed mobility, transfers and locomotion, extensive assistance with one person for dressing, toileting and personal hygiene and supervision with set up help for eating. He was also coded as being on Hospice Care.

Resident #1's care plan dated 9-11-18 revealed a goal that he would demonstrate effective coping skills and verbalize understanding for the need to control physically aggressive behavior. The interventions for that goal were as followed; administer medication as ordered, approach resident with question instead of a demand, provide physical and verbal cues to alleviate anxiety, give positive feedback, staff to approach resident in a calm manner, staff will allow resident down time in the evenings to help resident cope with sundowners.

A review of the incident report dated 10-13-18 at 6:01pm with a revision date of 10-17-18 at 1:08pm revealed "that during dinner Resident #1 was trying to eat another resident's dinner and when she tried to redirect resident he swung at her. The NA stated she put her arm up to deflect the resident from hitting her in the face and the resident fell back into the glass door. Another NA who was in the room and saw the altercation stated that the NA involved pushed the resident. The NA involved was sent home and it will be investigated. Resident unable to give description." The report also revealed there were no injuries to Resident #1 and the Director of Nursing (DON) was notified as well as the resident's family member.

An observation and interview with Resident #1 occurred on 10-31-18 at 5:27pm. The resident

F 600

Procedure for implementing the plan (protecting other residents):
1. CNA #1 was suspended immediately and terminated on 10/15/18.
2.On 11/2/18 Current residents with a brief interview for mental status (BIMS)of 8 or higher were interviewed by the social worker using the critical element pathway resident interview for abuse to guide to determine if any other resident has experienced any incidences of possible abuse. No other incidences of possible abuse were identified
3. On 11/2/18 Residents with a BIMS of lower than 8 the licensed nurses and social worker were ask about residents changes in demeanor or mood that would assist in identification of any possible abuse. No other incidences of possible abuse were identified with residents with a BIMS lower than 8.
4.On 10/16/18 Re-education was started with staff at the facility regarding the Abuse and neglect protocol, this re-education continued until 11/5/2018 to include current staff. No staff will be allowed to work until re-education on abuse and neglect policy has been completed and this is also included in the new orientation of employees.
5.On 11/2/18 the Social worker was in serviced by the Vice President of Clinical services to provide support to staff who are caring for residents and encouraging them to debrief regarding their challenges and to strategize solutions for managing difficult situations.

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was noted to be sitting at a table with 3 other male residents eating his supper quietly with no agitation noted. Resident #1 was unable to recall the physical altercation with the NA but stated he did remember the NA being "rude" and "verbally abusive". He was unable to remember what the NA said to him but stated "I know it wasn't very nice."

A review of the facility's video footage from 10-13-18 occurred on 10-31-18 at 6:10pm. The video was reviewed by the surveyor, Administrator and the DON at that time. The video footage revealed Resident #1 leaning over a table in the dining room and beginning to lift the lid off one of the dinner plates when NA #1 came over and removed the tray from Resident #1. NA #1 was seen putting the tray on another table and returning to Resident #1 who was still standing at the table and engaging in a conversation. Resident #1 was seen turning towards NA #1 with his arm raised and NA #1 hitting the resident in his face and then pushing him into a glass door. The video also revealed a witness, NA #2 who caught Resident #1 from falling to the floor and NA #1 walking away from the situation.

During an interview with NA #2 on 10-31-18 at 6:23pm she stated she had walked into the dining room and witnessed NA #1 and the resident discussing "something" and Resident #1 became angry and went to hit NA #1. She stated the resident's finger tips brushed NA #1's face and NA #1 "grabbed" the residents arm and pushed him into the glass door. NA #2 denied seeing NA #1 hit the resident. She also stated Resident #1 had been agitated that evening but had not been aggressive towards anyone till the altercation.

Provider's Plan of Correction (F 600):

Monitoring Procedure:(measures)
1.Staff will be re-educated monthly starting in December 2018 by the staff development coordinator for the next 6 months then quarterly for 12 months on the abuse and neglect policy to include reporting procedures and resident/staff conflict management. Also to include identification of employee burnout.
2.On 11/2/18 the Social worker was in serviced by the Vice President of Clinical services to provide support to staff who are caring for residents and encouraging them to debrief regarding their challenges and to strategize solutions for managing difficult situations.
3.Statistics about the topics and situations discussed during the debriefing encounters will be submitted to the Quality Assurance Performance Improvement Committee (QAPI) by the social worker monthly for 6 months. These statistics will be reviewed by the committee to determine if further interventions need to be put into place to assist staff with handling dementia residents
4. The administrator or Director of nursing must notify either the vice president of clinical services or the regional clinical nurse consultant of any allegation of abuse, neglect or misappropriation immediately upon their notification.
5.All reportable incidences will be reviewed in QAPI to validate that reporting criteria was met and any trends that may be identified monthly for 6 months.
6.5 Residents with a BIMS of lower than 8 will be reviewed and observed weekly for 4 weeks and monthly for 5 months by the

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NA #1 was interviewed on 10-31-18 at 6:45pm. She stated she was trying to keep Resident #1 from eating food off of another resident's tray and the resident threatened to hit her and then swung at her but NA #1 denied Resident #1 ever made contact with her. She also stated when Resident #1 swung at her she "grabbed" his arm to stop him but denied ever pushing him or hitting him. NA #1 stated the resident had been agitated all evening but that she was able to redirect him with food and activities. She denied having contact with the resident after the altercation.

A review of NA #1's training record revealed she received abuse training on 6-28-18.

An interview was conducted on 10-31-18 at 7:31pm with nurse #3 who stated she was informed of the altercation by NA #2 around 6:00pm and she immediately went and assessed Resident #1 for any injuries. She denied seeing any marks or bruises on the resident, so she then called the DON who told nurse #3 to send NA #1 home immediately until an investigation could be done. Nurse #3 stated she removed NA #1 from another resident's room where she was providing care with another NA and informed her she would need to leave the building. The nurse denied NA #1 had any further contact with Resident #1 and denied any conversation with the DON about calling law enforcement.

During an interview with Resident #1's family member on 11-1-18 at 8:19am he stated he was informed of an incident "where my father was trying to eat food off another tray and the nurse confronted him and he swung at the nurse and when she put her arm up to protect herself my father pushed her arm into her face bruising it."

licensed nurses and social worker for changes in demeanor or mood that would assist in identification of any possible abuse.
7.5 residents a week for 4 weeks then monthly for 5 months with a brief interview for mental status (BIMS)of 8 or higher will be interviewed by the social worker using the critical element pathway resident interview for abuse to guide to determine if any other resident has experienced any incidences of possible abuse.
8.The social worker will report the findings of the interviews and observations to the QAPI meeting for any additional monitoring or modification of this plan monthly for 6 months

Title of person implementing the plan
The administrator is in charge of the implementation of this plan

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The family member denied being told of Resident #1 being hit or pushed into a glass door.

An interview with NA #4 occurred on 11-1-18 at 8:52am who stated she could not help the surveyor because she did not know anything. NA #4 stated she did not work on hall 100 and if she was in the dining room it was because she was waiting on trays for the hall she was working.

During an interview with the DON on 11-1-18 at 9:05am she stated she was contacted by nurse #3 around 6:00pm on 10-13-18 about the incident between NA #1 and Resident #1. The DON stated Nurse #3 told her NA #1 pushed Resident #1 into the glass door and that she informed Nurse #3 to have NA #1 "punch out and go home till an investigation can be completed." She also stated she told the nurse to assess the resident for injuries and notify the resident's power of attorney. The DON stated she then called the Administrator and informed her of the incident and that they did discuss calling law enforcement but since the NA had left the building they did not think it was necessary.

An interview with the Administrator occurred on 11-1-18 at 9:32am. The Administrator stated she was informed of the incident by the DON on 10-13-18 and that they discussed calling law enforcement but felt since the NA left the building there was not a need to call them. She stated she came to the facility the next day and reviewed the video "sometime before 2:00pm."

During an interview with the Corporate Compliance Officer on 11-2-18 at 8:50am she stated the facility had been using the wrong Abuse Policy. She stated there was an updated

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policy distributed at the end of August 2018 explaining the federal requirements for reporting abuse and did not know why the Administrator had not in serviced staff on the correct policy. The Compliance Officer stated the process when there was an incident was that the DON or the Administrator would call the regional or corporate compliance office and email risk management who would respond within 30 minutes of the email and guide the DON or Administrator through the process of filing a report with the state.

The Administrator and the Corporate Compliance Officer were notified of the immediate jeopardy on 11-1-18 at 5:25pm. On 11-2-18 at 3:50pm the facility provided the following credible allegation of Immediate Jeopardy removal:

1. "On 10-13-2018 at approximately 6:00pm NA #2 walked into the dining hall on Unit 1 and saw Resident #1 slap NA #1 in the face. NA #1 then "grabbed" at Resident #1's hand (wrist) and "pushed him away into the door" possibly making contact with his face at the same time. NA #2 states that she caught Resident #1 to keep him from falling, then told NA #1 "you can't do that" and redirected NA #1 away from the resident and assuring another NA was present between them. NA #2 then went to get the assistance of the nurse. Nurse #1 came to the dining room, noting NA #1 was no longer in the room. Nurse #1 then assessed Resident #1 who was uninjured and did not appear to be in distress or upset. Nurse #1 then called the DON who instructed her to assess and observe the resident, immediately suspend the NA forcing her to leave the facility, contact the family and contact the physician. Nurse #1 then suspended NA #1 pending an investigation. The DON then contacted the Administrator reaching

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her about 6:15pm. According to Nurse #1, Resident #1 continued to walk through the unit without apparent effect, uninjured and seemingly unaffected. The Administrator arrived at the facility on 10-14-18 at approximately 12:00 noon, viewed the video footage, interviewed NA #2 and determined that the event had occurred as reported. The 24-hour report was submitted by facsimile at 2:19pm on 10-14-18. Along with the DON, Administrator contacted NA #1 and terminated her on 10-15-18 at approximately 2:00pm."

2. "The facility is responsible for providing all residents with a consistently safe and nurturing environment. In servicing on the Abuse Prevention Program and the Abuse and Neglect: Clinical Protocol began on 10-16-18 with all of Unit 1 nursing staff who were present, then continued with all available nursing staff in the building on days and afternoons through 10-19-18. The staff development coordinator met with night shift staff early in the morning and addressed staff who had been unavailable on a face to face basis by telephone. In servicing resumed on 10-22-18 and has continued and expanded to all individuals who have contact with residents from every department and will include volunteers and contract staff. Employee, volunteer and contract staff lists are being used to validate attendance and in servicing will continue until all are checked off with this process completed no later than 11-2-18. In addition, on 11-2-18 all interview able residents are being interviewed by the Social Worker or her designee using the critical element pathway resident interview for abuse as a guide to determine this was an isolated incident. In accordance with CMS non-interview able abuse critical pathway, staff

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interviews regarding non-interview able residents will focus on changes in demeanor or mood to be completed on 11-2-18. Data from these interviews will be reviewed by the Regional Director of Clinical Services. On 11-2-18 all data collected through these interviews will be provided to QAPI for review by the committee and evaluation of opportunities to improve care during the upcoming November meeting."

3. "All staff receives the Abuse policy training at the time of orientation. Effective immediately, all staff will be in serviced on a monthly basis for the next 6 months then quarterly for one year to ensure staff has internalized the standards of care to which residents are entitled. All staff retraining began on 11-1-2018 and will continue through 11-2-18 with no staff being permitted to work with residents until they have completed training. Training includes the definitions of/understanding abuse, neglect, misappropriation, exploitation; the required response to any observed or reported occurrences focused on assuring the safety of any and all involved residents and providing medical and psychological intervention to residents involved and importantly, the importance of a hands-off response to any resident situation. In addition, the staff on the low stimulation unit will receive "Hand in Hand" training on dementia and managing difficult behavior, beginning on 11-2-18 which will become part of orientation for staff working on that unit assignment as well as having a module shown each month to reinforce training throughout the year. Modules one through six will be presented to current unit staff over the next week. The Social Worker was in serviced on 11-2-18 by the Vice President of Clinical Services to provide

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F 600	Continued From page 9 support to staff who are caring for residents and encouraging them to express and debrief regarding their challenges and to strategize solutions for managing difficult situations along with the staff person beginning on 11-2-18. While debriefing sessions will remain individually confidential, Social Worker will collect statistics about the number and kind of sessions held and bring these to QAPI to evaluate opportunities to improve care and communication beginning with the November QAPI session. This will include any incidences of verbal or physical contact between residents, staff and residents or other situations for the purpose of recognizing situations that suggest risk and require intervention as well as results from trainings and debriefing will be submitted to QAPI for review on a monthly basis for 6 months then quarterly for an additional 6 months. The QAPI team will establish this plan during an ad-hoc QAPI meeting held on 11-2-18. Beginning with the November 2018 meeting. At that time, the QAPI team will review all data and findings and determine the frequency of reporting for the upcoming year. The first session is being held on 11-2-18." 4. "The Regional Director of Clinical Services is responsible for assuring compliance with this plan of corrective action, which will be fully implemented beginning on 11-3-2018." The credible allegation for Immediate Jeopardy removal was validated on 11-5-18 at 10:55am which removed the Immediate Jeopardy on 11-3-18 as evidenced by staff interviews, in service record reviews and observations. The in service included information on the definition of abuse, who needed to be notified, keeping the resident safe and making sure the incident is reported to the state within 2 hours.	F 600		

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2. Resident #2 was initially admitted to the facility on 7-5-18 and then readmitted on 8-10-18 with multiple diagnoses that included Alzheimer's disease, irritability and anger disorder, unspecified mood disorder and cellulitis.

The 30-day Minimum Data Set (MDS) dated 9-11-18 revealed Resident #2 was moderately cognitively impaired and had physical behaviors towards others 1-3 days and verbal behaviors towards others 1-3 days. He was coded as needing extensive assistance with 2 people for bed mobility and transfers, total assistance with 2 people for dressing, extensive assistance with one person for eating, toileting and personal hygiene.

Resident #2's care plan dated 9-24-18 revealed a goal that he would have fewer episodes of problem behaviors. The interventions for that goal were as followed; offer snacks such as yogurt, applesauce and pudding, offer food before and after care, psych referral as needed, review medications,

A review of the incident report dated 10-10-18 with a revision date of 11-1-18 at 1:36pm revealed nursing assistant (NA) #5 was assisting NA #2 with providing activities of daily living (ADL) care to Resident #2. NA #2 gave the resident a cookie while he was facing her and handed NA #5 a cookie when they turned the resident towards NA #5 and when they turned the resident, the resident swung at NA #5 and in response NA #5 hit the resident in the head with the cookie. No injuries were reported.

An interview with NA #2 occurred on 11-1-18 at

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 600	Continued From page 11 1:12pm. During the interview NA #2 stated she was providing ADL care to Resident #2 with NA #5 and while the resident was facing her she had handed him a cookie to eat and that the resident was calm and cooperative but when NA #2 and NA #5 turned the resident towards NA #5 the resident swung at NA #5 and NA #1 then threw a cookie at Resident #2 hitting him in the head and left the room. NA #2 denied Resident #2 ever made physical contact with NA #5. The NA stated nurse #4 came into the room to assist in completing Resident #2's ADL care and NA #2 informed the nurse of the incident when they were finished with the resident's care. During an interview with nurse #4 on 11-1-18 at 4:05pm she stated on 10-10-18 she had come out of another residents room and had heard NA #5 say "nobody's gonna beat on me" but did not know what the NA was talking about and when nurse #4 was walking to her medication cart she saw NA #2 in Resident #2's room performing ADL care by herself so she went in to help. She stated once the care was completed, NA #2 told her that NA #5 had thrown a cookie and hit the resident in the head and when she assessed the resident he stated, NA #5 had hit him in the face with a cookie. NA #5 was interviewed on 11-1-18 at 4:35pm. NA #5 stated on 10-10-18 while she and another NA were providing ADL care to Resident #2, they had turned him towards her and he balled up his fist and hit her in the right breast. She also stated she put her arm up to protect herself from getting hit again and when she did the cookie flew out of her hand and landed on the resident's neck. NA #5 stated she left the room and was trying to find help for NA #2 but could not find anyone. During	F 600		

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F 600	Continued From page 12	F 600		

the interview NA #5 stated "he can be violent. I didn't sign up for all this. I just signed up to work the rehab."

During an interview with nurse #3 on 11-1-18 at 11:30am she stated Resident #2 could be combative and that he had dementia. The nurse stated she would offer the resident food or milkshakes to help decrease his agitation, so staff could provide care and if that did not work staff would leave and return later. She also stated most of the time Resident #2 is "sweet and friendly." Nurse #3 denied that Resident #2 ever tried to hit her.

A review of the investigation revealed in part at approximately 10:00pm on 10-10-18 a call was received to the Administrator that there had been an incident on the hall. NA #5 and NA #2 were both in Resident #2's room to provide care. Resident #2 had swung at NA #5 while providing care and as a response NA #5 had thrown a cookie at the resident due to her frustration. Immediately NA #5 was asked to leave the unit and go home pending an investigation. During the investigation NA #5 was interviewed and stated she had "flung' the cookie at the resident but did not realize that it had hit him in the head. The resident was assessed for any signs of pain or discomfort by the nurse and care was completed by the nurse and NA #2. The resident was unhappy about the situation but was able to calm down. He did not show any lasting mental anguish due to this situation. NA #5 is no longer an employee for the facility.

An interview with the Administrator was conducted on 11-5-18 at 12:11pm. The Administrator stated she felt the new abuse policy

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F 600	Continued From page 13 was clearer and that she expected her staff to be trained sufficiently and follow the new policy. The Administrator also stated NA #5 was suspended immediately on 10-10-18 and subsequently terminated after the investigation was completed.	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 record review, staff interviews and review of the facility's video footage the facility failed to implement or follow the abuse policy by not reporting an incident of staff to resident physical abuse to the local police department and the State Survey Agency within 2 hours for 1 of 3 residents (Resident #1) who were reviewed for allegations of abuse. Findings included: A review of the facility's Abuse Prevention and policy revealed the following parts; "Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation." The policy also stated, "Investigate	F 607	The plan for correcting the specific deficiency: The alleged deficiency occurred on 10/13/18 at approximately 6pm resident #1 was pushed and possibly struck in the face when blocking his arm by the certified nursing assistant (CNA#1) In response to resident #1 slapping CNA#1 on the face. The facility failed to report the incident to law enforcement and state agency within 2 hours as required. Resident #1 was uninjured and seemingly unaffected. CNA #1 was relieved of her duties and escorted out of the building by licensed nurse #1 with no injuries. Police	11/23/18

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and report any allegations of abuse within the time frame required by Federal requirements."

A review of the revised abuse policy from 08-2018 and revised again 11-2018 revealed in part; "Immediate reporting requirements: any allegation of abuse, whether or not physical contact has been made, must be reported to the state within 2 hours of the incident or as soon as it becomes known. The local police department should be notified, and a police report made."

Resident #1 was admitted to the facility on 11-9-17 with multiple diagnoses that included psychosis, dementia with behaviors, Alzheimer's, adult failure to thrive and weakness.

The quarterly Minimum Data Set (MDS) dated 8-23-18 revealed Resident #1 was severely cognitively impaired.

A review of the incident report dated 10-13-18 at 6:01pm with a revision date of 10-17-18 at 1:08pm revealed "that during dinner Resident #1 was trying to eat another resident's dinner and when she tried to redirect resident he swung at her. The NA stated she put her arm up to deflect the resident from hitting her in the face and the resident fell back into the glass door. Another NA who was in the room and saw the altercation stated that the NA involved pushed the resident. The NA involved was sent home and it will be investigated. Resident unable to give description." The report also revealed there were no injuries to Resident #1 and the Director of Nursing (DON) was notified as well as the resident's family member.

A review of the facility's video footage from

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department was notified on 10/16/2018. The initial report was submitted to the state agency on 10/14/2018

The procedure for implementing the plan:

1.Interviewable residents were interviewed by the social worker on 11/2/18 using the critical element pathway for abuse as a guide to ask questions regarding abuse. No other residents have voiced concerns regarding abuse.
2.On 11/2/18 the Director of Nursing and unit managers reviewed all non interviewable residents for changes in behaviors or demeanor along with reviewing body audits to ensure no signs of abuse were indicated. No other residents were noted to be affected.
3. on 11/1/18 The vice president of clinical services re-educated the administrator on the facility policy regarding reporting allegations to the states agency and police department when indicated and the time frame required.
4. Starting on 11/1/2018 and ending on 11/5/18 the Staff development coordinator re-educated the current staff on facility policy regarding reporting allegations and the time frames required. No current employee will be allowed to work until re-education is completed. This education has been added to the new hire orientation.
5. The administrator or Director of Nursing must notify either the vice president of clinical services or the regional nurse consultant of any allegation of abuse, neglect or misappropriation immediately

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10-13-18 occurred on 10-31-18 at 6:10pm. The video was reviewed by the surveyor, Administrator and the DON at that time. The video footage revealed Resident #1 leaning over a table in the dining room and beginning to lift the lid off one of the dinner plates when NA #1 came over and removed the tray from Resident #1. NA #1 was seen putting the tray on another table and returning to Resident #1 who was still standing at the table and engaging in a conversation. Resident #1 was seen turning towards NA #1 with his arm raised and NA #1 hitting the resident in his face and then pushing him into a glass door. The video also revealed a witness, NA #2 who caught Resident #1 from falling to the floor and NA #1 walking away from the situation.

NA #1 was interviewed on 10-31-18 at 6:45pm. She stated she was trying to keep Resident #1 from eating food off of another resident's tray and the resident threatened to hit her and then swung at her but NA #1 denied Resident #1 ever made contact with her. She also stated when Resident #1 swung at her she "grabbed" his arm to stop him but denied ever pushing him or hitting him. NA #1 stated the resident had been agitated all evening but that she was able to redirect him with food and activities. She denied having contact with the resident after the altercation.

During an interview with NA #2 on 10-31-18 at 6:23pm she stated after she made sure Resident #1 was safe, she went and informed the nurse on duty of the altercation.

An interview was conducted on 10-31-18 at 7:31pm with nurse #3 who stated she was informed of the altercation by NA #2 and she immediately went and assessed Resident #1 for

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upon their notification
6. A log will be maintained by the administrator that documents all notifications to the state survey agency including residents name, fax cover sheet, confirmation page, allegation date, time of discovery and time of notification. Log will be placed in binder and maintained by administrator.
7. The log maintained by the administrator will be reviewed by the Vice President of Clinical services or regional nurse consultant monthly to ensure timely reporting

Monitoring procedure:
1. The vice president of clinical services or regional nurse consultant will audit all initial reporting allegations weekly for 4 weeks and monthly for 2 months ensure timely reporting.
2. The administrator will report the findings of audits and reviews to Quality Assurance and Performance improvement committee (QAPI) for any additional monitoring or modifications of this plan monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance.

The person responsible for implementing the plan:
The administrator is responsible for implementing this plan

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F 607	Continued From page 16 any injuries then called the DON who told nurse #3 to send NA #1 home immediately until an investigation could be done. The nurse denied any conversation with the DON regarding calling law enforcement. During an interview with the DON on 11-1-18 at 9:05am she stated she was contacted by nurse #3 around 6:00pm on 10-13-18 about the incident between NA #1 and Resident #1. The DON stated Nurse #3 told her NA #1 pushed Resident #1 into the glass door and that she informed Nurse #3 to have NA #1 "punch out and go home till an investigation can be completed." The DON stated she then called the Administrator and informed her of the incident and that they had discussed calling law enforcement but since the NA had left the building they did not think it was necessary. She stated a 24-hour report was completed, instead of contacting the State agency within 2 hours, because there was no injury to the resident. An interview with the Administrator occurred on 11-1-18 at 9:32am. The Administrator stated she was informed of the incident by the DON on 10-13-18 and that they discussed calling law enforcement but felt since the NA left the building there was not a need to call them. She stated she came to the facility the next day and reviewed the video "sometime before 2:00pm" and that she completed the 24-hour report after watching the video. The Administrator stated she felt the 24-hour report was appropriate, instead of reporting the abuse within 2 hours to the State Survey Agency, because there was no injury to the resident. During an interview with the Corporate	F 607		

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F 607	Continued From page 17 Compliance Officer on 11-2-18 at 8:50am she stated the facility had been using the wrong Abuse Policy. She stated there was an updated policy distributed at the end of August 2018 and did not know why the Administrator had not in serviced staff on the correct policy. She also stated she did not feel the old policy was clear on the need to contact law enforcement or report the physical abuse by NA #1 to Resident #1 to the State agency within 2 hours and that was why it was not done.	F 607		