STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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F 000	INITIAL COMMENTS A complaint investigation was conducted on 1/18/19 and a Statement of Deficiencies was posted on 1/23/19. Additional information was obtained on 2/12/19. Immediate Jeopardy was identified at: CFR 483.12(a)(1) at Tag F600 at a scope and severity of J The tag F600 constitutes Substandard Quality of Care. The immediate jeopardy began on 1/7/19. The immediate jeopardy was removed on 2/13/19. An partial extended survey was conducted on 2/19/19. The 2567 was amended on 2/19/19. The exit date of the survey was changed to 2/19/19.	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; This REQUIREMENT is not met as evidenced	F 600		3/3/19

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

Electronically Signed | 01/24/2019

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F 600	Continued From page 1 by: Based on record review, radiology interview, emergency medical services interview, nurse practitioner interview, family interview, and staff interview, the facility failed to prevent femur fractures for 1 (Resident #1) of 3 sampled residents reviewed for injuries of unknown origin. Resident #1 sustained femur fractures in both her legs without a plausible reason for this occurrence. Immediate Jeopardy began on 1/7/19 when Resident #1 had an acute fracture of the proximal left femur and an acute fracture of the distal right femur. The Immediate Jeopardy was removed on 2/13/19 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level grid position D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced. Findings included: Resident #1 was admitted to the facility with diagnoses of multiple cerebral vascular accidents, dysphagia, seizure disorder, and placement of a gastrostomy feeding tube. Documentation in the most recent quarterly minimum data set (MDS) assessment dated 10/2/18 coded Resident #1 as cognitively intact and requiring extensive assistance of one person with bed mobility, locomotion, dressing and personal hygiene. Documentation on the MDS assessment also revealed the resident did not walk and only transferred out of bed once or twice with the assistance of two people during the	F 600	This plan of correction constitutes a written Allegation of Compliance with federal and state requirements. Preparation and submission of this Allegation of Compliance does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Corrective action the resident found to have been affected by the deficient practice: Resident #1 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice: On 2/13/2109, skin and pain assessments for all residents in the facility were initiated and completed the same day by the Director of Health Services (DHS), Unit Coordinators and, charge nurses. None of the residents assessed exhibited any signs or symptoms of possible fractures. The Senior Clinical Nurse Consultant was present to ensure skin and pain assessments were initiated and completed appropriately. For residents who were out of the facility on 2/13/2019, skin and pain assessments were conducted upon return/readmission to the	

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F 600	Continued From page 2 assessment period. Resident #1 was coded on the MDS assessment as always incontinent of bowel and bladder as well as having range of motion impairment on both sides of upper and lower extremities. The documentation in the care plan, last updated on 10/16/18, for Resident #1 revealed a focus area for the potential for injury from falls relative to a history of multiple cerebral vascular accidents with impaired mobility, mechanical lift transfer, and some cognitive impairment. Interventions on the care plan included a reminder to call for assist with transfers and/or ambulation, bed in low position, call light within reach, and maintaining safety with transfers via mechanical lift with the assistance of two people. The documentation in the care plan also addressed the need for Resident #1 to have assistance of one to two staff members with activities of daily living and incontinent care needs due to impaired mobility, tube feeding, deconditioning, and general weakness. There was no documentation in the facility nursing progress notes on 1/7/19. Documentation on a skin assessment dated 1/7/19 and signed by the third floor 7:00 AM to 3:00 PM Nurse (Nurse #1) revealed the resident had edema on her left lower extremity and her upper right thigh was swollen. Bruising was not documented on this skin assessment. Documentation on a mobile x-ray report dated 1/7/19 revealed Resident #1 had an acute	F 600	facility. For new admissions, skin and pain assessments will be conducted by the charge nurse and/or the Unit Coordinator upon admission. Any residents who exhibit any signs of pain for possible fractures, a charge nurse and/or the Unit Coordinator will immediately notify the for further treatment recommendations to include but not limited to X-rays as needed for possible fractures. Therapy referrals will be made as needed based on the assessments for recommendations on resident transfers in accordance with their diagnoses to minimize any injuries during resident transfers. On 2/13/2019, MDS Coordinators printed out a diagnoses sequence for all residents with diagnoses including but not limited to Osteopenia, Osteoporosis, Osteoarthritis, Osteomyelitis, and Cerebro-Vascular Accident (CVA) to be used by the nursing team to conduct weekly assessments for possible fractures for residents at high risk. Interviews on abuse and neglect for alert and oriented residents were conducted by the Director of Social Services and completed by 2/13/2019. For alert and oriented residents admitted to the hospital, interviews for abuse and neglect will be conducted by the Director of Social Services upon readmission to the facility. There is no concern of abuse identified during the interviews. Systemic changes made to ensure that the deficient practice will not recur:	

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F 600	Continued From page 3 fracture of the proximal left femur and an acute fracture of the distal right femur. Proximal refers to closer to the center of the body while distal refers to away from the center of the body. Documentation on a nursing home to hospital transfer form dated 3:03 PM on 1/7/19 revealed Resident #1 was transferred to the hospital due to a fracture and pain in her legs. The nurse identified as the person at the nursing home to get questions answered was Nurse #1. Documentation in an emergency medical services (EMS) record dated 1/7/19 revealed, "Patient (Resident #1) found in her bed, alert and oriented to EMS arrival in significant distress. Facility staff state patient has bilateral femur fractures, which discovered following a bedside radiology consult. EMS was activated by facility upon receipt of the results. Facility staff reports that patient states that she fell out of bed overnight. Patient states she was pulled out of bed by a facility CNA (certified nursing assistant) in the evening. Facility staff at bedside is unaware of circumstances of fall as they had not been notified of fall or reasoning. Patient is in obvious pain, but fully alert and oriented. Patient endorses 10/10 pain in her R leg. Patient has L (left) sided hemiparesis due to previous CVA (cerebrovascular accident)." An interview was conducted on 2/18/19 at 1:22 PM with the paramedic who wrote the documentation in the EMS record dated 1/7/19. He stated he heard Resident #1 correct a staff member who stated that Resident #1 fell out of	F 600	Education was initiated on 2/13/2019 by the Administrator, Director Health Services, Clinical Competency Coordinator, Nursing Management team and Department managers for all staff on Prevention of Patient Abuse (mental, verbal, sexual, physical -including injuries of unknown origin), Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property. 100% education was completed on 2/19/2019. Staff members who have not completed the education will not be allowed to work until they are educated. All newly hired staff will be educated on Prevention of Patient Abuse (mental, verbal, sexual, physical -including injuries of unknown origin), Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property during new hire orientation by the Director of Health Services and/or the Clinical Competency Coordinator. Skin and pain assessments will be completed on admission/readmission and then weekly using the skin audit tool and the pain assessment tool. Care plans will be updated with observations from assessments as needed to ensure compliance. On 2/13/2019, Unit Managers/Coordinators and charge nurses were notified by the DHS of their responsibility to do skin and pain assessments and they will immediately notify the DHS and the physician of any concerns for appropriate recommendations. The Unit Coordinators/Managers and MDS Coordinators are responsible for updating	

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F 600	Continued From page 4 bed. The paramedic stated he heard Resident #1 say she was pulled out of bed by a nurse aide on the night shift. The paramedic stated he was told by the nurse who gave him report, Resident #1 was someone who could be believed. The paramedic also stated Resident #1 was in such extreme pain that she really was not talking or verbalizing much at the time of the emergency transport to the hospital. Documentation in Duke Orthopedic surgery consultation note dated 1/7/19 revealed an assessment of the resident. The resident was documented as presenting with "altered mental status" with "noted confusion and inability to follow directions." The exam portion of the documentation revealed the swelling in her distal right thigh but no "skin defect" as well as swelling in the left hip but "no skin defect." Documentation revealed the plan was to put the resident in traction due to bilateral femur fractures and surgical repair when the patient was medically capable. Nurse #1, assigned to care for Resident #1 from 7:00 AM to 3:00 PM on 1/7/19, was interviewed on 1/18/19 at 11:00 AM. Nurse #1 explained how the resident was identified as having a fracture. Nurse #1 stated that on Monday morning two nurse aides (NA #1 and NA #5) informed her Resident #1 was in pain and stated she had a fall. Nurse #1 stated she went into the room to assess Resident #1. Nurse #1 stated that Resident #1 indicated she was receiving incontinent care and she fell out of bed. Nurse #1 stated that Resident #1 told her the nurse aide, who was providing care when she fell, put her back in bed by herself.	F 600	care plans and were notified of the same on 2/13/2019 by the Administrator and the DHS. The Senior Clinical Nurse Consultant will conduct unannounced audits/checks for skin and pain assessments monthly for 3 months. Any areas of non-compliance will be reported to the QA committee for further recommendations. The Senior Clinical Nurse Consultant will attend Quality Assurance and Performance Improvement meetings to ensure compliance is maintained. Starting on 2/18/2019, a questionnaire on Abuse will be completed with 10% of all staff by the Administrator, Director of Health Services, Clinical Competency Coordinator and, Department Managers weekly for 4 weeks then monthly for 2 months and then quarterly for 3 quarters to ensure compliance is maintained. The results of the Abuse questionnaire will be collected by the Administrator and reported to the Quality Assurance / Performance Improvement Committee until 6 months of continued compliance has been sustained. Starting on 2/18/2019, a questionnaire on Abuse will be conducted and completed with 50% of alert and oriented residents by the Director of Social Services and/or the Activities Director weekly for 4 weeks, then monthly for 2 months and then quarterly for 3 quarters to ensure compliance is maintained. The results of the Abuse questionnaire will be collected by the Administrator and reported to the Quality Assurance / Performance	

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F 600	Continued From page 5 Nurse #1 revealed she questioned Resident #1 if a mechanical lift was used to put her back in the bed after the fall and Resident #1 denied a mechanical lift was used. Nurse #1 said she did a skin assessment and noticed the right upper thigh had swelling but no bruising. Nurse #1 revealed that she also noted the left lower leg had swelling but that this was not unusual for this resident. Nurse #1 stated that the edema to the Resident's left lower leg was being treated with compression hose. Nurse #1 stated that she did not note any bruising on any part of the body of Resident #1. Nurse #1 said she gave Resident #1 Tylenol via her gastrostomy tube and then called the Director of Nursing (DON) and the Administrator. Nurse #1 stated she then contacted the doctor who ordered x-rays to be done as soon as possible. Nurse #1 noted that the resident's vital signs were normal. Nurse #1 stated she received no report from the previous shift of any fall that occurred for Resident #1. The nurse aide (NA #1) assigned to care for Resident #1 for the 7:00 AM to 3:00 PM shift on 1/7/19 was interviewed on 1/18/19 at 11:20 AM. NA #1 stated that at the beginning of the 7:00 AM to 3:00 PM shift, Resident #1 was asleep. NA #1 stated Resident #1 was awakened by NA #5 who began to raise the head of the bed for Resident #1 in preparation for being served a meal tray. NA #1 stated NA #5 came to get her because Resident #1 cried out in pain when the head of the bed was raised. NA #1 stated she went to the room of Resident #1 and asked her what was wrong. NA #1 stated that Resident #1 told her both her legs were hurting and that a girl was trying to change her and she fell on the floor. The NA #1 stated she went to get the nurse who came	F 600	Improvement Committee until 6 months of continued compliance has been sustained. Plans to monitor its performance to make sure that solutions are sustained; A skin audit tool and a pain assessment tool will be utilized by Unit Coordinators/Managers starting on 2/13/2019 and reviewed by the Director of Health Services and/or the Clinical Nurse Consultant daily for 1 week, then 2x weekly for 3 weeks, then weekly for 4 weeks and, monthly for 1 month and then quarterly thereafter. The results of audits and assessments will be collected and presented to the Quality Assurance / Performance Improvement Committee by the Director of Health Services until 6 months of continued compliance has been sustained. Starting on 2/18/2019, a questionnaire on Abuse was initiated with 10% of all staff by the Administrator, Director of Health Services, Clinical Competency Coordinator and, Department Managers weekly for 4 weeks then monthly for 2 months and then quarterly for 3 quarters to ensure compliance is maintained. The results of the Abuse questionnaire will be collected by the Administrator and reported to the Quality Assurance / Performance Improvement Committee until 6 months of continued compliance has been sustained. Starting on 2/18/2019, a questionnaire on Abuse was initiated and will be completed	

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F 600	Continued From page 6 immediately. NA #1 said she considered Resident #1 to be reliable and that she recognized her by name. NA #1 stated that Resident #1 was able to communicate her needs and it was very unlike her to not want to sit up. The nurse practitioner (NP #1) who assessed Resident #1 before she was sent to the hospital on 1/7/19 was interviewed on 1/18/19 at 12:04 PM. NP #1 stated that 1/7/19 was the first time she had ever seen Resident #1. NP #1 stated that she did an assessment of the resident prior to sending her to the hospital. NP #1 stated was told Resident #1 that she fell off the bed. NP #1 stated she saw no deformity or bruising on the resident's skin. NP #1 stated that if the resident had fell off the bed like she had stated then she would have hit the radiator and would have had scratches and bruising. NP #1 did not understand how the resident could have sustained the fractures and had no explanation. A family member of Resident #1 was interviewed on 1/18/19 at 12:54 PM. The family member stated that in the hospital Resident #1 stated to him that a nurse aide pulled her out of the bed in the facility and she fell. The family member stated he did not know how Resident #1 could have broken both her legs. The family member revealed that at the time of the investigation the resident had both her legs in traction and was on a ventilator. The family member stated that they were in the process of making some hard decisions with regard to the care of Resident #1. The nurse aide (NA #2) who was assigned to	F 600	with 50% of alert and oriented residents by the Director of Social Services and/or the Activities Director weekly for 4 weeks, then monthly for 2 months and then quarterly for 3 quarters to ensure compliance is maintained. The results of the Abuse questionnaire will be collected by the Administrator and reported to the Quality Assurance Performance Improvement committee until 6 months of continued compliance has been sustained. On 2/13/2019, the ad-hoc QAPI committee was notified of the deficiency and the plan of correction. Date of Compliance: 3/3/2019	

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care for Resident #1 from 11:00 PM to 7:00 AM on 1/6-7/19 was interviewed on 1/18/19 at 3:46 PM. NA #2 stated that she checked on Resident #1 on the beginning of her shift and the resident was asleep and dry. NA #2 stated she checked on Resident #1 on a second time later in the shift and the resident was still asleep. NA #2 stated she did not hear any complaints of pain from Resident #1 overnight or into the morning. NA #2 stated that nothing unusual occurred on the overnight shift except for another resident falling on that same night on another hall.

The Nurse (Nurse #2), who was assigned to care for Resident #1 from 11:00 PM to 7:00 AM on 1/5/19 and 1/6/19, was interviewed on 1/18/19 at 3:50 PM. Nurse #2 stated that she did not receive any report from the nurse aides regarding any falls involving Resident #1. She stated that she monitored and checked on Resident #1 through her shift on 1/6/19. Nurse #2 stated that she checked on Resident #1 at the beginning of her shift and the resident voiced no concerns. Nurse #2 stated that at approximately 3:30 to 4:00 AM she checked on Resident #1 who was awake and watching television. Nurse #2 stated Resident #1 requested pain medication for a headache which she administered through the gastrostomy tube. Nurse #2 stated she went back to check on Resident #1 at the end of the shift and the resident was asleep. Nurse #2 revealed the resident did complain of generalized pain frequently but did not complain of leg pain to her on the 11:00 PM to 7:00 AM shift on 1/5/19 or 1/6/19.

The orthopedic surgeon who performed surgical

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repair of both fractures on Resident #1's legs was interviewed on 1/18/19 at 4:15 PM. The orthopedic surgeon stated she did not understand how Resident #1 could have sustained the fractures on her legs from a fall. The orthopedic surgeon stated, "I cannot think of a mechanism for which [Resident #1] could have broken both legs at the same time from a fall." The orthopedic surgeon did not know of any diagnoses or medical condition that Resident #1 currently had that could have given her two fractured legs. The surgeon stated that she had only seen the kind of fractures sustained by Resident #1 in car accident victims and could not think of a process or fall that would have sustained the kind of fractures seen in Resident #1.

The Nurse aide (NA # 3), who was assigned to provide care for Resident #1 from 3:00 PM to 11:00 PM on 1/6/19, was interviewed on 1/18/19 at 6:00 PM. NA #3 stated Resident #1 did not get up at all on 1/6/19 but remained in bed the entire shift. NA #3 stated that after dinner Resident #1 told her that her legs hurt and she had fallen. NA #3 said she went to tell the nurse (Nurse #3) who was on duty. NA #3 said Nurse #3 came into the room and Resident #1 told the nurse she was itchy and thirsty. NA #3 stated that nothing unusual happened on the shift but Resident #1 was complaining of pain in her legs after dinner. NA #3 confided she was upset she was providing care to Resident #1 on the 3:00 PM to 11:00 PM shift without the knowledge the Resident #1 had broken legs.

Nurse #3 was assigned to care for Resident #1 on 1/5/19 from 3:00 PM to 11:00 PM and on

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1/6/19 from 7:00 AM to 11:00 PM. Nurse #3 was interviewed on 1/18/19 at 6:27 PM. Nurse #3 stated she was at the nurses station on 1/6/19 between the time of 7:00 PM and 9:00 PM. Nurse #3 said she was alerted by the nurse aide (NA #3) that Resident #1 was saying that she fell. Nurse #3 stated her first thought was the possibility Resident #1 might have a urinary tract infection because Resident #1 did not walk and was a total care resident. Nurse #3 said she went to see Resident #1 and asked her if she was alright. Nurse #3 stated Resident #1 requested water from Nurse #3 and she was given water. Nurse #3 stated that Resident #1 did not complain of pain to her at all on 1/5/19 or 1/6/19. Nurse #3 stated that there was no way Resident #1 could have fallen out of bed because it would have taken two people to put her back in bed. Nurse #3 stated that she was constantly checking on the residents and making rounds. Nurse #3 stated that Resident #1 frequently requested water to drink and complained of generalized pain at times. Nurse #3 confirmed the resident was alert and oriented and was familiar with the nurse aides providing care for her.

The facility documentation of investigation into the injuries to Resident #1 was reviewed. Statements were obtained by the facility of all staff members who cared for or were working on the same floor as Resident #1 from Friday, January 4, 2019 to Monday, January 7, 2019. None of the statements revealed a causative factor for the injuries on Resident #1.

Documentation of a statement provided by the facility from the nurse aide (NA #6) who cared for

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Resident #1 on 1/6/19 on the 7:00 AM to 3:00 PM shift revealed, "On Sunday which was January 6, 2019 I [NA #6] was the CNA for [Resident #1] on first shift, 7:00 AM -3:00 PM. At around 10:00 AM - 10:45 AM I went to give [Resident #1] a bed bath and she seemed to not be doing well. She was doing a lot of moaning and groaning, so I proceeded to give her a quicker bed bath and made her more comfortable. I then told the nurse (Nurse #3) that she was in pain. I remember asking [Resident #1] was her leg or arm in pain and she said yes."

Documentation of a statement provided by the facility from the nurse aide (NA #7) who cared for Resident #1 on 1/5/19 on the 11:00 PM to 7:00 AM shift revealed, "When I went to do care with [Resident #1] at about 6:30 AM I cut off her feed(ing) tube I laid her flat down. I clean her up change her then I let her head back up I then turn her feed tube back on. The whole time that I cared for her if anything was wrong with the lady she never said anything to me. She was asleep the whole time. I put her cover back on her clean up the little mess around her bed then I left the room. The lady never fell on my shift at all."

Interviews were conducted with the Director of Nursing (DON) and the Administrator on 1/18/19 at 5:30 PM. Both the DON and the Administrator had submitted a 24 hour report and a 5 day investigation preceding the surveyor's investigation. The facility was unable to come up with a causative factor for the injuries of unknown origin for Resident #1 sustained on 1/7/18.

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An interview was conducted on 2/12/19 at 9:30 AM with a hospital radiologist who reviewed the 1/7/19 x-ray results for Resident #1. The radiologist stated that the femur fractures for Resident #1 appeared to him as acute recent injuries as evidenced by the jagged edges of the bone. He stated that he saw no manifestations of healing that would have typically be seen had the fractures occurred at an earlier time period.

On 2/12/19 at 1:49 PM, the administrator was informed of the immediate jeopardy. The facility provided a credible allegation of compliance on 2/14/19 at 9:03 AM. The allegation of compliance indicated:

This plan of correction constitutes a written Allegation of Compliance with federal and state requirements. Preparation and submission of this Allegation of Compliance does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.
Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
Resident no longer resides in the facility.
On 1/7/2019 at around 9:30am, resident told a nurse aide that her leg was hurting and said that she fell out of bed. When asked by the nurse aide when she fell, the resident stated that it was at 3:00am in the night. The nurse aide immediately notified the charge nurse. The charge nurse immediately went in and asked the resident what happened, and the resident reiterated that she fell out of bed and the nurse aide put her back in bed.

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The charge nurse immediately did a head to toe skin assessment with no notable bruising or scratches to the skin except for slight swelling on the leg. The charge nurse notified the Unit Coordinator, the Director of Health Services (DHS) and, the physician. The charge nurse got an order for X-ray from the physician. Tylenol was given as ordered for pain while waiting for X-ray results. The X-ray results indicating bilateral femur fractures were sent to the facility around 2:00pm. Upon notification, the physician gave orders to send the resident to the emergency room for further evaluation and treatment. The Administrator was notified and immediately started interviewing employees that had worked with the resident the day before and the night of the alleged event. All employees denied knowledge of this resident ever falling that night or the day before. On 1/8/2019, after interviewing employees, the Administrator decided to conduct a full-scale investigation for injury of unknown origin for the bilateral femur fractures. On 1/8/2019, the Administrator sent report to NCDHSR at 1:18pm for a self-reported injury of unknown origin.
The Administrator and the DHS re-interviewed all staff that worked with the resident on the days leading to the morning (1/7/2019) of the alleged incident. All staff denied the resident ever falling and all the interview responses were consistent with the initial interviews conducted independently by the Administrator and the DHS.
The injuries occurred while the resident was in the facility. The facility failed to prevent alleged abuse that may have caused the bilateral femur fractures.

Address how the facility will identify other residents having the potential to be affected by

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F 600	Continued From page 13 the same deficient practice: On 2/13/2019, skin audits were initiated and will be completed the same day by the Director of Health Services (DHS), Unit Coordinators and, charge nurses for all residents in the facility. At the same time, all residents were assessed for possible fractures by the DHS, Unit Coordinators and, charge nurses. The Senior Clinical Nurse Consultant was present to ensure skin audits and pain assessments were initiated and done properly. Residents admitted in the hospital will be assessed for fractures and skin audits conducted upon re-admission to the facility. Any residents who exhibit any signs of pain for possible fractures, a charge nurse and/or the Unit Coordinator will immediately notify the physician and an order will be obtained for X-ray and further evaluation as needed. Therapy referrals will be made based on the assessments for recommendation on resident transfers in accordance with the diagnoses to minimize any injuries during resident transfers. On 2/13/2019, MDS Coordinators printed out a diagnoses sequence for all to ensure all residents with diagnoses including but not limited to Osteopenia, Osteoporosis, Osteoarthritis, Osteomyelitis, and Cerebrovascular Accident (CVA) to be used by the nursing team to conduct weekly assessments for possible fractures for residents at high risk. Interviews on abuse and neglect for alert and oriented residents were conducted by the Director of Social Services and completed by 2/13/2019. For alert and oriented residents admitted to the hospital, interviews for abuse and neglect will be conducted by the Director of Social Services upon readmission to the facility.	F 600		

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F 600	Continued From page 14 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was initiated on 2/13/2019 by the Administrator, Director Health Services, Clinical Competency Coordinator, Nursing Management team and Department managers for all staff on Prevention of Patient Abuse (mental, verbal, sexual, physical -including injuries of unknown origin), Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property. 100% education will be completed by 2/19/2019. Staff members who have not completed the education will not be allowed to work until they are educated. All newly hired staff will be educated on Prevention of Patient Abuse (mental, verbal, sexual, and physical -including injuries of unknown origin), Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property during new hire orientation by the Director of Health Services and/or the Clinical Competency Coordinator. Skin audits and pain assessments will be completed on admission/readmission and then weekly using the skin audit tool and the pain assessment tool. Care plans will be updated with assessment/observation as needed to ensure compliance. On 2/13/2019, Unit Managers/Coordinators and charge nurses were notified by the DHS of their responsibility to do skin audits and pain assessments and they will immediately notify the DHS and the physician of any concerns for appropriate recommendations. The Unit Coordinators/Managers and MDS Coordinators are responsible for updating care plans and have been notified of the same on 2/13/2019 by the Administrator and the DHS.	F 600		

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The Senior Clinical Nurse Consultant will conduct unannounced audits/checks for skin audits and pain assessments monthly for 3 months. The Senior Clinical Nurse Consultant will attend Quality Assurance and Performance Improvement meetings to ensure compliance is maintained.

Starting on 2/18/2019, a questionnaire on Abuse will be completed with 10% of all staff by the Administrator, Director of Health Services, Clinical Competency Coordinator and, Department Managers weekly for 4 weeks then monthly for 2 months and then quarterly for 3 quarters to ensure compliance is maintained. The results of the Abuse questionnaire will be collected by the Administrator and reported to the Quality Assurance / Performance Improvement Committee until 6 months of continued compliance has been sustained.
Starting on 2/18/2019, a questionnaire on Abuse will be conducted and completed with 50% of alert and oriented residents by the Director of Social Services and/or the Activities Director weekly for 4 weeks, then monthly for 2 months and then quarterly for 3 quarters to ensure compliance is maintained. The results of the Abuse questionnaire will be collected by the Administrator and reported to the Quality Assurance / Performance Improvement Committee until 6 months of continued compliance has been sustained.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

A skin audit tool and a pain assessment tool with

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utilized by Unit Coordinators/Managers starting on 2/13/2019 and reviewed by the Director of Health Services and/or the Clinical Nurse Consultant daily for 1 week, then 2x weekly for 3 weeks, then weekly for 4 weeks and, monthly for 1 month and then quarterly thereafter. The results of audits and assessments will be collected and presented to the Quality Assurance / Performance Improvement Committee by the Director of Health Services until 6 months of continued compliance has been sustained.

Starting on 2/13/2019, a questionnaire on Abuse was initiated with 10% of all staff by the Administrator, Director of Health Services, Clinical Competency Coordinator and, Department Managers weekly for 4 weeks then monthly for 2 months and then quarterly for 3 quarters to ensure compliance is maintained. The results of the Abuse questionnaire will be collected by the Administrator and reported to the Quality Assurance / Performance Improvement Committee until 6 months of continued compliance has been sustained.

Starting on 2/13/2019, a questionnaire on Abuse was initiated and will be completed with 50% of alert and oriented residents by the Director of Social Services and/or the Activities Director weekly for 4 weeks, then monthly for 2 months and then quarterly for 3 quarters to ensure compliance is maintained. The results of the Abuse questionnaire will be collected by the Administrator and reported to the Quality Assurance / Performance Improvement Committee until 6 months of continued compliance has been sustained. On 2/13/2019, the ad-hoc QAPI committee was notified of the deficiency and the plan of correction.

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F 600	Continued From page 17 The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 2/13/2019 The credible allegation was verified on 2/19/19 as evidenced by record review of the staff abuse education, abuse interviews with residents, body audit forms, pain observation forms and quality assurance. Interviews with the staff were conducted to validate the abuse education.	F 600		