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AUTUMN CARE OF RAEFORD	1206 N FULTON STREET RAEFORD, NC 28376

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F 000	INITIAL COMMENTS The survey team entered the facility on 5/2/19 to conduct a complaint survey and exited on 5/5/19. Additional information was obtained on 5/7/19 and 5/8/19. Therefore, the exit date was changed to 5/8/19. The 2567 was posted one day late due to surveyor being on another survey and QA process.	F 000		
F 607 SS=E	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, observations, staff interviews, resident interviews, nurse practitioner interview, the facility failed to implement their abuse policy in the area of reporting abuse to the administrator for two of three sampled residents reviewed for abuse (Residents #1 and #2). The findings included: The facility's policy entitled, North Carolina Abuse Policy with a revised date of 3/3/17 was reviewed. The policy specified that any suspicions of abuse would be reported to the Administrator.	F 607	Preparation and submission of this Plan of correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with state and federal requirements. Process that led to deficiency cited: A facility reportable was completed on 5/1/19 in inappropriate touching between	5/23/19

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

Electronically Signed | 05/29/2019

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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F 607	Continued From page 1 Record review revealed Resident # 1 was initially admitted to the facility on 11/1/17. The resident had diagnoses of dementia, history of cerebrovascular accident, major depressive disorder, Alzheimer's disease, and anxiety disorder. The resident was 83 years of age. Social service notes revealed on 2/11/19, the Social Worker (SW) noted his BIMS (brief interview for mental status) was 13 which indicated he was cognitively intact. On 2/18/19, the SW noted his BIMS was 14 which indicated cognitively intact. Resident # 1's last quarterly MDS (Minimum Data Set) assessment, dated 3/5/19, revealed the resident had a BIMS of a 10. This indicated the resident was moderately cognitively impaired. The resident was coded as being independent in his locomotion with the use of a wheelchair. During an interview with Resident # 1 on 5/3/19 at 4:45 PM, the resident acknowledged he had been in another resident's room. The resident denied he had touched any residents. During a follow up interview with Resident # 1 on 5/5/19 at 12:30 PM, the resident's ability to move was observed. It was observed that he could drive his motorized wheelchair both forward and backward without difficulties, and position himself easily within close proximity of a table where the interview was held. Resident # 1 was observed to move his arms freely, and wave them in the air. Record review revealed Resident # 2 was admitted to the facility on 5/18/18. At the time of the resident's admission the resident had a history of stroke resulting in hemiplegia and	F 607	Resident #1 and Resident #3. During the course of the investigation, it was determined that two facility reportables were needed for alleged inappropriate touching between Resident #1 and Resident #2. One was completed 5/3/19 and the second was completed 5/4/19. Neither incident had been reported to the Administrator or Director of Nursing per policy. Resident #1 was placed under 1:1 supervision while out of bed starting 5/3/19. Procedure for implementing plan of correction: All staff will be re-educated by 5/23/19 by the Staff Development Coordinator (SDC) and/or designee on the facility's abuse policy with focus on the different types of abuse and to report immediately to the DON and/or Administrator. Additionally, all staff will be re-educated on the facility's corporate compliance hotline as a second option for reporting concerns including possible abuse. All newly hired employees will receive education on the facility abuse policy and corporate compliance hotline. All cognitively intact residents were educated by the Activity Director and/or designee on the right to report abuse and who to report. This education was completed on 5/23/19. Monitoring procedure: Interviews will be conducted for both staff	

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F 607	Continued From page 2 hemiparesis. Review of Resident # 2's annual MDS assessment, dated 4/24/19, revealed the resident had a BIMS score of 10, which indicated she was moderately cognitively impaired. Review of the BIMS assessment revealed the resident did not know the day of the week and needed cueing for memory recall. The resident also was coded as being able to independently move with the use of a wheelchair. The resident was coded as having little interest or pleasure in doing things and had no behaviors. Resident # 2 was interviewed on 5/5/19 at 1:31 PM and answered questions by nodding her head. The resident nodded she was not touched by a resident, did not want to be touched, and felt safe. Nurse Aide (NA) # 2 was interviewed on 5/2/19 at 12:15 PM. NA # 2 stated she often worked with Resident # 2, and stated her mind was "like a child" and she does what she is told. NA # 2 stated she had witnessed Resident # 1 touch Resident # 2's breast, and in her brief. When she would ask Resident # 2, "Why do you let him do that to you?" the resident would respond in a slurred voice, "I don't know." NA # 2 stated Resident # 1 seeks Resident # 2 out, and Resident # 1 touching Resident's 2's body had been going on for months. NA # 2 stated the staff try to watch over Resident # 2, but she just knew what she observed happening to Resident # 2 was not right. During a follow up interview with NA # 2 on 5/4/19 at 5:00 PM, NA # 2 stated since February 1, 2019 she witnessed Resident # 1 touching the breast of Resident # 2, and he had his hand in her brief. There was also an incident	F 607	and residents using a created audit tool regarding the facility abuse policy and if any knowledge of abuse. A Minimum of three staff and three residents will be interviewed for ninety days with the frequency of 5 times a week for 4 weeks; 3 times a week for 4 weeks and then 1 time a week for 4 weeks. The results of the interviews will be reviewed I our daily M-F clinical meetings and monthly QAA meeting. The facility's decision to extend the interviews will be based o the audit results. Title of Person Responsible for implementing plan of correction: Administrator	

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she observed in which Resident # 2 had her hand on the front of Resident # 1's pants. NA # 2 also stated Resident # 1 rubbed Resident # 2's thigh. NA # 2 stated these incidents occurred in the dining room or in the dayroom when there was no one around.

During a follow up interview with NA # 2 on 5/6/19 at 11:20 AM, NA # 2 stated she did not report the incidents that she observed of Resident #1 touching Resident #2 or Resident #2 touching Resident #1 since February 1, 2019. NA #2 specified she no longer reported her observations of what she believed was inappropriate touching between these residents because she had previously informed the Administrator about incidents of Resident # 1 touching Resident # 2's breast and having his hand in her brief and nothing was done. According to the NA, prior to February 1, 2019, the Administrator "blew her off" when she tried to talk to him about Resident # 1 touching Resident #2's breasts and having his hand down the front of her brief, and she was never asked to write a statement about what she had observed.

Nurse # 1, who routinely cared for Resident # 2, was interviewed on 5/2/19 at 10:00 AM and again on 5/6/19 at 9:20 AM. Nurse # 1 confirmed that she had received reports that Resident # 1 had touched Resident # 2 on her breasts and in her brief. The nurse did not recall the exact date of the reports, and stated she no longer reported any instances to the Administrator because it was her current understanding that Administration had said that Resident # 2 had the capability to say "yes" or "no" to being touched and therefore there was nothing that was going to be done about it. Nurse # 1 stated she did not think that Resident #

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2 had the capability to say "yes or no."

Nurse # 3, who routinely cared for Resident # 2, was interviewed on 5/2/19 at 3:16 PM. Nurse # 3 reported that "it was not unusual" for Resident # 2 to go where she was alone with Resident # 1 such as an area of the dining room. Nurse # 3 reported that Resident # 1 called to Resident # 2 to follow him. Nurse # 3 stated "She is like an adult to me with a child's mind-she is friendly and you would think she would know better but she doesn't." According to Nurse # 3, her current practice was to try to keep Resident # 1 and Resident # 2 separated.

On 5/4/19 at 10:30 AM, the DON stated it was inappropriate for Resident #1 to be touching Resident #2's breast. The DON stated she was not aware Resident # 1 had ever had his hand on someone's crotch or breast, and it was her expectation that it would have been reported to her. Interview with the Director of Nursing on 5/8/19 at 12:39 PM revealed it was her expectation that behaviors of any kind would also be charted in either the episodic notes or the monthly summaries of a resident's medical record.

On 5/3/19 at 3:55 PM, the facility Social Worker stated that she was not aware of Resident # 1 touching any resident in the crotch or the breast.

On 5/3/19 at 8:45 AM, the Administrator stated he had no reports of Resident # 1 having his hands on a female resident's breasts or vaginal area before 5/1/19. The Administrator stated if Resident # 1 had been touching another resident's breast or vaginal area he would want to know about it to assess the situation, and if a

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F 607	Continued From page 5 resident was being abused it was his expectation that he or the DON would be informed.	F 607		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		6/4/19

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community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff and resident interviews the facility failed to implement or update the care plans to address inappropriate behaviors for 2 (Residents # 1, and # 2) of 9 sampled residents whose care plans were reviewed. The findings included.

1. Record review revealed Resident # 1 was initially admitted to the facility on 11/1/17. Record review revealed the resident had diagnoses of dementia, history of cerebrovascular accident, major depressive disorder, Alzheimer's disease, and anxiety disorder.

Review of Resident # 1's last quarterly MDS (Minimum Data Set) assessment, dated 3/5/19, revealed the resident had a BIMS (brief interview for mental status) of a 10. This indicated the resident was moderately cognitively impaired. The resident was coded as being independent in his locomotion with the use of a wheelchair. The resident was not coded as having behaviors during the assessment period.

Review of the resident's care plan, dated 3/27/19, revealed the resident had impaired thought processes related to his Alzheimer's disease. Additionally, the resident was noted to have a history of going into other resident's rooms uninvited. This was added to the care plan on

Process that led to deficiency cited:

Resident #1's care plan was updated on 5/4/19 to reflect his current behaviors.
Resident #2's care plan was updated on 5/4/19 to reflect her current behaviors.

Procedure for implementing plan of correction:

Each resident's care plan will be reviewed by 6/1/19 by the interdisciplinary team including the following: Director of Nursing, Social Worker, MDS Coordinator, Dietary Manager, Activity Director, Assistant Director of Nursing, and Unit Managers. The IDT team will ensure resident behaviors are addressed on the care plan. The DON is responsible for ensuing any identified care plans are updated appropriately.

Education will be provided to all licensed nursing staff by the DON and/or designee on updating the care plan to reflect the needs of each resident by 6/1/19. Newly hired licensed nurses will receive the same education during orientation.

Monitoring procedure:

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F 656	Continued From page 7 10/9/18 and continued to be a part of his 3/27/19 care plan. The care plan interventions, which were added on 10/9/18, were: Complete behavior contract as needed; Be reassuring and listen to concerns, Encourage family involvement, observe for and report any behavior issues, Redirect resident as needed and reinforce positive behaviors, Refer to psych as needed. Interview with the Administrator and Social Worker on 5/4/19 at 9:30 AM revealed the resident was observed going into rooms and touching residents on the hands or shoulder when the intervention to place him under a behavior contract was added to the care plan on 10/09/18. The Administrator stated he felt the resident's behavior was solely intended to be comforting to residents, but that some of the nurses had concerns about Resident # 1 being alone in rooms with female residents who might be confused. The Administrator and SW provided a copy of the resident's Behavior Contract. Resident #1's Behavior contract which was referenced in the resident's current care plan intervention of "complete behavior contract as needed," and was initiated on 10/9/18 had two items checked on the contract as applicable to Resident # 1. They were "I am not permitted to enter other resident's rooms. If a resident would like to visit with me it must occur in the back lobby, front lobby or the dining room only. I am not permitted to touch others residents in any way. This includes handshakes, pats or touches of any kind." There was a notation by the Social Worker at the bottom of the contract which noted, "Resident refused to sign contract."	F 656	The 24 hour report and concerns/grievances will be audited by the DON and/or designee M-F to identify behaviors that may need to be updated on an individual's care plan. This audit will be conducted daily M-F for 12 weeks. The audits will be based on the audit results. Title of Person Responsible for implementing plan of correction: Administrator	

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Housekeeper # 1 was interviewed on 5/2/19 at 2:40 PM. Housekeeper #1 stated on 4/30/19 around 1:00 PM she was on the hallway when she saw Resident # 1 go into Resident # 3's room. She noticed he did not come out right away, so she went to the door and listened. She heard Resident # 1 ask Resident # 3 how old she was. She heard Resident # 3 reply her age, and then Resident # 1 told her she looked older than that. Then she heard Resident # 1 tell Resident # 3 that she was pretty, and he thought she needed some loving. Then Housekeeper # 1 stated she told Resident # 1 he needed to depart from the room, and she told Nurse # 7. Housekeeper # 1 stated NA # 10 went to tell the social worker. The housekeeper stated she did not see Resident # 1 touch Resident # 3.

During an interview with Resident # 1 on 5/3/19 at 4:45 PM, the resident acknowledged he had been in another resident's room, but he denied that he had touched any residents.

Nurse Aide (NA) # 2 was interviewed on 5/2/19 at 12:15 PM. NA # 2 stated she often worked with Resident # 2, and stated her mind was "like a child" and she does what she is told. NA # 2 stated she had witnessed Resident # 1 touch Resident # 2's breast, and in her brief. When she would ask Resident # 2, "Why do you let him do that to you?" the resident would respond in a slurred voice, "I don't know." NA # 2 stated Resident # 1 seeks Resident # 2 out, and Resident # 1 touching Resident's 2's body had been going on for months. The NA stated the staff try to watch over Resident # 2, but she just knew what she observed happening to Resident # 2 was not right. During a follow up interview with NA # 2 on 5/4/19 at 5:00 PM, NA # 2 stated

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since February 1, 2019 she witnessed Resident # 1 touching the breast of Resident # 2, and he had his hand in her brief. There was also an incident she observed in which Resident # 2 had her hand on the front of Resident # 1's pants. NA # 2 also stated Resident # 1 rubbed Resident # 2's thigh. NA # 2 stated these incidents occurred in the dining room or in the dayroom when there was no one around.

Nurse # 7 was interviewed on 5/4/19 at 11:25 AM. Nurse #7 stated the nurses try to redirect Resident # 1 when he comes on the hall because he wants to go into others rooms, but when he is redirected he gets irritated. Nurse # 7 stated she had tried to explain to him that he could not be in rooms uninvited, and he had told her, "I can go anywhere I want to go." Nurse # 7 also said that sometimes both the nurses and NAs were busy with other residents, and they could not watch Resident # 1 all the time. The nurse stated Resident # 1 had been in Resident # 3's room about two times in the past two months of which she was aware, and he did not reside on Resident # 3's hall. Nurse # 7 stated on 5/1/19 the facility put a velcro stop sign on the door entrance to Resident # 3's room, and that was the first time this intervention was attempted to keep Resident #1 out of Resident #3's room.

NA # 10 was interviewed on 5/3/19 at 11:42 AM. NA # 10 stated that she was aware Resident # 3's RP did not want Resident # 1 in Resident # 3's room, but he would still go in the room and sit close to the bed by her anyway. NA #10 stated since February 1, 2019 she observed Resident # 1 in Resident #3's room and he was rubbing her legs. She had redirected him out of the room, and let Nurse # 7 and the SW know. NA # 10 stated

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she reported everything she observed to the social worker, but Resident # 1 continued to enter other resident's rooms. NA # 10 stated on 4/30/19, Resident # 1 entered Resident # 3's room when no staff were in the room with Resident # 3. NA # 10 stated she informed the social worker of this incident. NA # 10 also reported that she had witnessed Resident # 1 holding onto Resident # 2's (who was another cognitively impaired resident) arm the past week-end and Resident # 2 was trying to get away from him. She reported this to Nurse # 7.

Nurse Aide # 3 was interviewed on 5/2/19 at 11:45 AM. NA # 3 stated she observed Resident # 1 with his hand on Resident # 2's leg, and that it happened about every other day. NA # 3 described Resident # 2 as "having the mind of a child." NA # 3 also stated that sometimes Resident # 1 will hold onto Resident # 2's wheelchair and not let her go. During a follow up interview with NA # 3 on 5/5/19 at 6:30 PM, NA # 3 clarified that she observed Resident #1 place his hand on Resident #2's mid- thigh area, and he rested it there. She stated this typically happened in the dining room, and she did not perceive Resident #1 touching Resident #2 in this manner to be appropriate behavior. She reported it to the nurses on duty when she saw it happen because that was what she was trained to do.

On 5/2/19 at 3:45 PM an interview was conducted with NA # 6, who was an evening shift nurse aide. The NA reported that she had witnessed Resident # 1 with his hand on Resident # 2's thigh while they were alone in the middle of the hall. The NA specified, that this behavior had been going on for a couple of months and the last time she observed it was the last week in April, 2019. NA #

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AUTUMN CARE OF RAEFORD	1206 N FULTON STREET RAEFORD, NC 28376

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6 stated, "She (Resident #2) is just like a little child." NA # 6 stated Resident # 1 was "good to get her (Resident # 2) to follow him to the lobby or the dining room to be by themselves." NA # 6 stated when this occurred, she tried to separate them and she would tell the nurse who was on duty. During a follow up interview with NA # 6 on 5/5/19 at 6:50 PM, the NA reported that it was Resident # 2's mid-thigh area that she observed Resident # 1 rest his hand.

During an interview with Resident #8 on 5/5/19 at 2:30 PM he stated sometime at the end of April, 2019 he was in the dining room participating in an art activity. He observed Resident # 1 and Resident # 2 off by themselves in the dining room sitting near each other and were not involved in the activity. Resident # 8 stated he saw Resident # 1's hand on Resident # 2's breast. Resident # 8 asked Resident # 1 what he was doing, and Resident # 1 looked at him with a smirk

Review of Resident # 1's care plan, revealed no interventions were added or changed to the care plan between the dates of 1/27/19 and 5/1/19 to address the resident's behaviors of continuing to go into other residents' rooms uninvited and his touching of other residents which his behavior contract did not allow.

On 5/4/19 at 10:30 AM, the DON stated it was inappropriate for Resident #1 to be touching Resident #2's breast. The DON stated she was not aware Resident # 1 had ever had his hand on someone's crotch or breast, and it was her expectation that it would have been reported to her. Interview with the Director of Nursing on 5/8/19 at 12:39 PM revealed it was her expectation that behaviors of any kind would also

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be charted in either the episodic notes or the monthly summaries of a resident's medical record.

On 5/3/19 at 8:45 AM, the Administrator stated he had no reports of Resident # 1 having his hands on a female resident's breasts or vaginal area before 5/1/19. The Administrator stated if Resident # 1 had been rubbing another resident's breast, vaginal area, or thighs he would want to know about it to assess the situation.

Interview with the Administrator on 5/5/19 at 10:34 AM revealed there should have been updates to the resident's care plan prior to 5/1/19 to address the resident going into other resident's rooms and his touching of other residents.

2. Record review revealed Resident # 2 was admitted to the facility on 5/18/18. At the time of the resident's admission the resident had a history of hemiplegia and hemiparesis following a cerebral vascular accident secondary to an embolism to the right middle cerebral artery.

Review of Resident # 2's annual MDS assessment, dated 4/24/19, revealed the resident had a BIMS score of 10, which indicated she was moderately cognitively impaired. Review of the BIMS assessment revealed the resident did not know the day of the week and needed cueing for memory recall. The resident also was coded as being able to independently move with the use of a wheelchair. The resident was coded during the MDS assessment period as having little pleasure in activities, but had no behavioral problems.

Review of Resident # 2's care plan, dated 4/30/19, revealed the resident had impaired

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cognition and periods of disorientation and forgetfulness related to her cerebrovascular accident. This had been initially added to the resident's care plan on 5/31/18 and remained as an active problem on the resident's current care plan. Care plan interventions included to redirect when the resident made inappropriate actions, and to report changes to the physician. The care plan also noted the resident had a psychosocial well-being issue.

Nurse Aide (NA) # 2 was interviewed on 5/2/19 at 12:15 PM. NA # 2 stated she worked often with Resident # 2, and her mind was "like a child" and she does what she is told.

Nurse Aide # 3 was interviewed on 5/2/19 at 11:45 AM and reported, "Resident # 2 had the mind of a child."

On 5/7/19 a review of a psychosocial therapy consultants notes, dated 3/26/19, revealed that Resident # 2 did not socialize and that sometimes she would flash a male resident who would give her attention. The clinical social worker had documented that nursing staff had walked in on a gentleman fondling her.

An interview with the clinical social worker, who saw Resident # 2 for psychosocial counseling, was conducted on 5/2/19 at 1:35 PM. The clinical social worker stated she had been informed by the nursing staff that Resident # 2 was being fondled and that Resident # 2 flashed people (exposed her breasts to others). The clinical social worker stated a psychological assessment had not been done, but she would recommend one be done. The clinical SW stated the way the resident acted did not correspond to her age, and

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F 656	Continued From page 14 that she would at times get "giddy." A review of the resident's 4/30/19 care plan was conducted on 5/2/19. The review revealed no updates had been made regarding the resident being fondled and exhibiting behaviors of exposing her breasts to other residents. During an interview with the Administrator and Social Worker on 5/2/19 at 9:30 AM they both stated they were unaware Resident #2 was being fondled or was having behaviors that needed to be added to the care plan. The Administrator stated as of 5/2/19, they had no records from the clinical consulting social worker, and the facility was working on obtaining them. The facility social worker stated she thought the reason the resident was being seen by psychosocial therapy was because of other reasons related to her age.	F 656		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		6/4/19

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F 842	Continued From page 15 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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F 842	Continued From page 16 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure the medical record was complete for two (Residents # 1 and # 2) of three sampled residents reviewed for accuracy of records. The findings included: 1. Record review revealed Resident # 1 was initially admitted to the facility on 11/1/17. Record review revealed the resident had diagnoses of dementia, history of cerebrovascular accident, major depressive disorder, Alzheimer's disease, and anxiety disorder. Review of the resident's care plan, dated 3/27/19, revealed the resident had a history of behaviors which included wandering into other residents' rooms uninvited and verbally abusive behaviors. Review of episodic nursing notes and nursing monthly summaries from 2/1/19 through 4/29/19 revealed no documentation that the resident was displaying any behaviors of wandering into rooms uninvited, verbally abusive behaviors, or any other type of behaviors. Nurse Aide (NA) # 2 was interviewed on 5/2/19 at 12:15 PM and reported the following. NA # 2 stated she had witnessed Resident # 1 touch	F 842	Resident #1's medical record was reviewed on 5/4/2019 and care plan was updated to reflect his current behaviors by the Director of Nursing. resident #2's medical record was reviewed on 5/4/2019 and care plan was updated to reflect current behaviors by the Director of Nursing. Procedure for implementing plan of correction: Each resident's medical record will be reviewed by 6/1/2019 by the interdisciplinary team including the following: Director of Nursing, Social Worker, MDS Coordinator, Dietary Manager, Activity Director, Assistant Director of Nursing, and Unit Managers. The IDT team will ensure resident behaviors are addressed on the care plan. The DON is responsible for ensuring any identified care plans are updated appropriately. The DON and/or designee will provide education to all nurses on documentation requirements that reflect the behaviors for	

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F 842	Continued From page 17 Resident # 2's breast, and in her brief. During a follow up interview with NA # 2 on 5/6/19 at 11:20 AM, NA # 2 stated she was sure she had witnessed this behavior since February 1, 2019, and that nurses were aware of the behavior. Interview with Nurse # 5 on 5/3/19 at 6:00 PM revealed she witnessed Resident # 1 curse at staff. Interview with NA # 10 on 5/3/19 at 11:42 AM revealed she had witnessed Resident # 1 in Resident # 3's room and rub the resident's legs. NA # 10 stated Resident # 3 had not been invited into the room. This occurred sometime between 2/1/19 and 4/29/19, and she reported the incident to the social worker and Nurse # 7. Interview with Nurse # 7 on 5/4/19 at 11:25 AM revealed she was aware Resident # 1 had entered Resident # 3's room sometime prior to 4/29/19 within the last two months, and he became loud and hard to redirect. According to Nurse # 7, Resident # 1 was not assigned to Nurse's # 7's hall for care and documentation. On 5/6/19 at 9:20 AM interview with Nurse # 1, who routinely cared for Resident # 1, revealed Resident # 1 was verbally abusive to residents and staff, and it was her current understanding that she was not to place this information in the resident's monthly summaries. Interview with the Director of Nursing on 5/8/19 at 12:39 PM revealed it was her expectation that behaviors of any kind would be charted in either the episodic notes or the monthly summaries, and that placing it in the episodic charting helped track the actual dates the behaviors were	F 842	each resident by 6/1/2019. Newly hired licensed nurses will receive the same education during orientation. All staff will receive education by the DON and/or designee on the eINTERACT Stop and Watch program (a tool that focuses on improving the identification and management of changes in a Resident's condition or behavior, thereby allowing for appropriate interventions to be implemented related to the Resident's plan of care) by 6/4/2019. This will include location of Stop and Watch tools and instructions for use including behavior notification. Newly hired staff will receive the same education during orientation. Monitoring procedure: The 24 hour report will be compared to facility's concern/grievances and Stop and Watch tools by the DON and/ or designee to ensure the resident's medical record reflects behaviors and that care plan is updated. This audit will be conducted 5 times a week for 4 weeks; 3 times a week for 4 weeks and then 1 time a week for 4 weeks. The audits will be reviewed at the monthly QAA meeting for 90 days. The facility's decision to extend the audits will be based on the audit results. Title of Person Responsible for implementing plan of correction: Administrator	

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occurring.

2. Record review revealed Resident # 2 was admitted to the facility on 5/18/18.

An interview with a consulting clinical social worker (SW), who saw Resident # 2 for psychosocial counseling, was conducted on 5/2/19 at 1:35 PM. The consulting clinical social worker stated she had worked with Resident # 2 since 3/26/19. During the interview, the SW stated that she had been informed by nursing staff that the resident would sometimes flash a gentleman who would give her attention and she was being fondled.

Review of Resident # 2's facility record from 2/1/19 to 5/1/19 revealed no documentation by nursing staff or the facility social worker that Resident # 2 was being fondled or that she had flashed a male resident for attention.

On 5/4/19 at 9:30 AM, interview with the Administrator and facility Social Worker revealed the consulting clinical social worker, who saw Resident # 2, was part of a consulting psychosocial therapy group, and the facility had no documentation from the consulting social worker to incorporate into the facility record. It was their expectation that the consulting therapy group would have provided some documentation to the facility to incorporate into the facility record.

Interview with the Director of Nursing on 5/8/19 at 12:39 PM revealed it was her expectation that behaviors of any kind would be charted in either the episodic notes or the monthly summaries by her nursing staff, and that placing it in the episodic charting helped track the actual dates

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F 842	Continued From page 19 the behaviors were occurring.	F 842		