STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345554	A. BUILDING _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GROVE	631 JUNCTION CREEK DRIVE WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 10/21/19 through 10/25/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #URP11.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted from 10/21/19 through 10/25/19. Immediate Jeoparty was identified at: CFR 483.12 at tag F600 at a scope and severity (J) Immediate Jeopardy began on 10/24/19 and was removed on 10/25/19. An extended survey was conducted. The Statement of Deficiencies was amended on 11/22/19 to add tag F610 and delete F585.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and a family interview, the facility failed to maintain a resident ' s dignity for 1 of 1 residents observed	F 557	All staff have been re-educated on LSC Policies: Resident Rights for Senior Services, Abuse Investigation and	11/18/19

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

Electronically Signed | 11/18/2019

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F 557	Continued From page 1 (Resident #51) as witnessed by a family member observing a nursing assistant being mean and impatient to Resident #51, and a nurse who witnessed the same nursing assistant mimicking and speaking condescendingly to an unnamed resident. Findings included: Resident #51 was admitted to the facility on 06/24/16. Diagnoses included, in part, Alzheimer's, anxiety, depression, cerebral infarction (stroke) without residual deficits and pseudobulbar affect (PBA, a neurological condition which can cause sudden, frequent, uncontrollable episodes of crying and or laughing that are exaggerated and /or don ' t match how you feel. The Minimum Data Set (MDS) quarterly assessment dated 09/01/19 revealed Resident #51 was severely cognitively impaired. A review of a grievance written by Nurse #1 on 05/06/19 revealed a statement which nursing assistant (NA) #1 mimicked an upset resident. The general tone overall with residents was negative and condescending. The grievance indicated this was also mentioned to Nurse #1 by a concerned family member. The grievance was signed by Nurse #1. The follow up documentation indicated an in service was completed. A review of an in service titled "Respect: The Resident and You" was provided. The in-service included, in part, joking or mimicking a resident can be verbal or with moves/gestures and is disrespectful and can anger/agitate an already possibly agitated resident.	F 557	Reporting and Reporting Suspected Crimes. These policies include specific language related to Dignity and Respect - as well as when and how to report suspected abuse or mistreatment. This education was completed for all staff or upon first shift worked on 10/25/19. This education has also been included in orientation for all new staff and will be repeated at least annually and as needed. Administrator, Director of Nursing and/or designee will interview at least one staff member in each resident section (4 neighborhoods) at least once per week - ensuring that there are no concerns related to staff interaction with residents that are unreported. This interviewing will continue weekly for 3 months, then at least twice per month thereafter - for one full year. Administrator, Director of Nursing and/or designee will also conduct random audits three times a week for one month, observing at least five different staff members each audit day to ensure there are no concerns with staff interactions or behaviors. After the first month, audits will be continued by observing at least three different staff members at least once per week, every week for three months, then at least once per month for the remainder of the year. If a report is received that states concern related to staff interaction with residents, a complete investigation will occur. This investigation will include interviews with all	

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F 557	Continued From page 2 A review of a signature list for the in-service regarding respect was provided and included staff members such as s NAs, nurses, medication aides, medical record personnel, and secretaries. NA #1 ' s signature was not noted on the signature list. An interview was conducted with Nurse #1 via phone on 10/24/19 at 9:15 AM. Nurse #1 stated she recalled NA #1 and stated the NA could be bold at times and she could be taken the wrong way. Nurse #1 clarified "bold" and added the NA was too "comfortable" in the way she spoke to residents and she could be offensive. Nurse #1 revealed back in May, a family member (family member #1) of another resident, came to the nurse and reported she witnessed NA #1 was talking down to a resident (Nurse #1 could not recall who the resident was that the family member was speaking of, but indicated the name of the family member). Nurse #1 stated she told the FM she would look into the situation. Nurse #1 reported she did not report the concern at that time and wanted to see if she could witness NA #1 ' s interactions with residents. Nurse #1 reported about a week later (05/06/19), she had observed NA #1 mimicking and speaking condescendingly to a resident. (Nurse #1 could not recall who the resident was). Nurse #1 stated she overheard NA #1 mimicking a resident but could not recall what NA #1 said. Nurse #1 reported NA #1 was unprofessional and the way she spoke to the resident did not "sit well with me and it bothered me." Nurse #1 stated, at that time, she wrote up a grievance regarding NA #1 because she felt NA #1 needed to get more education about how to treat residents and she did not like how loud NA #1 would get with the residents.	F 557	alert and oriented residents the staff has provided care to, staff working in same area as accused staff, the accused staff member and any other witnesses. If the staff is found to be in violation of LSC policy, re-education will occur and/or disciplinary action - up to or including termination. Reports will be created summarizing all interviews and audits completed and will be shared with governing body during quarterly QAPI meetings, with first report due on January 16, 2020.	

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F 557	Continued From page 3	F 557		

An interview was conducted with the family member (the name was provided by Nurse #1) via phone on 10/24/19 at 11:30 AM. Family member #1 stated back in May (she could not recall the date, but stated it was early May) she observed an NA being "harsh" to Resident #51. Family Member #1 reported the NA was impatient and just mean. The family member stated she reported it to Nurse #1 and the nurse told her she would keep an eye on the situation. Family member #1 indicated she recalled hearing the NA speaking meanly to Resident #51 and she thought to herself "Why is she talking to that resident like that?" Family member #1 reported Resident #51 looked frightened and her eyes were big and teary eyed. The family member stated she had to report what she saw to the nurse. The family member stated she did not know the NA ' s name, but stated she was fairly new and not long after she reported the concern to Nurse #1, she noticed the NA did not work there anymore.

An interview was attempted via phone with NA #1 on 10/23/19 at 11:32 AM. The message on the phone indicated the phone number was changed, disconnected or no longer in service. The Administrator was unable to provide an alternative number.

An interview was conducted with the Director of Nursing (DON) on 10/24/19 at 12:00 PM. The DON revealed she received the grievance dated 05/06/19 from the Administrator on 05/07/19. The DON stated she spoke with NA #1 individually and NA #1 reported she was not aware she was mimicking and speaking to the residents condescendingly. The DON reported

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F 557	Continued From page 4 she conducted a one on one in-service with NA #1 regarding dignity and how to speak to residents so that the demeanor did not come across as mimicking or condescending. The DON was not able to provide any signed in-services by NA #1. The DON reported she conducted a facility wide in-service with staff and specifically added mimicking and how it was disrespectful to the in-service and stated that NA #1 was not part of that in-service. The DON reported her expectation of the facility staff was to treat residents with respect and dignity and to be mindful about the way they could be presenting themselves to residents and others. The DON stated, this was the resident ' s home and they deserved to be treated respectfully.	F 557		
F 572 SS=C	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and	F 572		11/18/19

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F 572	Continued From page 5 obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review the facility failed to orally communicate information to 6 of 6 sampled residents (Resident #'s 11, 12, 17, 21, 38, and 60) attending a group meeting about their rights in the nursing home environment. Findings included: Review of Resident Council minutes from the 05/29/19, 06/24/19, 07/29/19, 08/26/19, and 09/30/19 meetings revealed there was no documentation of resident rights having been discussed with attendees. During a group meeting on 10/22/19 at 3:00 PM Resident #'s 11, 12, 17, 21, 38, and 60 stated they all attended Resident Council meetings whenever they got the chance. All six residents were unable to acknowledge that they had ever been told that they had the right to review their medical record, the right to receive mail unopened and have the benefit of Saturday delivery, and the right to complain to the State if they had concerns which the management team was unable to resolve. During a 10/25/19 9:13 AM interview with the facility's Social Worker (SW), who coordinated the Resident Council meetings, she stated she did not review resident rights with residents who attended these meetings unless the residents initiated a resident rights question or they expressed a concern which was related to resident rights. She explained she did not know it	F 572	Resident Rights were provided orally by New Hanover County Ombudsman on 11/15/19. All residents and their family members were invited to attend via newsletter, activity schedule and advertisement on each neighborhood. Social Worker or designee will review at least one resident right orally in monthly resident council meeting and document this and any related discussion in the resident council meeting minutes. Additional group setting opportunities to learn about Resident Rights may occur as needed. Social Worker will report which resident rights were reviewed orally in the quarterly Social Work report - submitted for review by the Governing Body in quarterly QAPI meeting, with first report due on January 16, 2020.	

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F 572	Continued From page 6	F 572		

was necessary to provide oral communication about resident rights since written information was provided to residents about this topic during their nursing home stay. The SW reported residents received some of this written information during the admission process, and the Bill of Rights for Nursing Home Residents was posted on the bulletin boards in each neighborhood in the facility. The SW commented she could see where providing continued oral communication about resident rights would be beneficial since so much information was provided during the admission process that it was overwhelming, and it was difficult for residents and family members to remember all the information that was provided.

During an interview with the Admissions Director on 10/25/19 at 9:37 AM she stated during the admission process residents received a handbook which contained a list of resident rights, and resident rights were also documented in the Welcome Book which was kept in each resident room. However, she reported she was uncertain about if and how residents were educated orally about their rights throughout their nursing home stay.

During an interview with the facility's Director of Nursing (DON) on 10/25/19 at 12:37 PM she stated since the facility was without a dedicated Staff Development Coordinator she had some involvement in educating staff and residents. She reported as far as she knew the facility had not provided oral communication about resident rights unless residents had questions that pertained to that topic.

During an interview with the facility's Administrator

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F 572	Continued From page 7 on 10/25/19 at 2:34 PM she stated the facility had not provided opportunities for residents to receive oral education about their rights in the nursing home. She reported that the facility thought it was meeting the needs of the residents when they provided written information about resident rights, but she understood the rationale behind re-enforcing the printed information with periodic oral communication so that it would be easier for residents to remember.	F 572		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Nurse Practioner interview, family member interview and observations, the facility failed to protect a resident ' s right to be free from mistreatment (Resident #51) when a nursing assistant, witnessed by the facility beautician, physically abused Resident #51 when she entered the beauty salon "Like a bull" "grabbed her so hard"	F 600	All staff have been re-educated on LSC Policies: Resident Rights for Senior Services, Abuse Investigation and Reporting and Reporting Suspected Crimes. These policies include specific language related to Dignity and Respect - as well as when and how to report suspected abuse or mistreatment. This	11/18/19

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F 600	Continued From page 8 to pick the resident up that the beautician could hear a "thump sound," and "dropped" her from 8 inches in the air into her wheelchair during a transfer. Resident #51 cried, moaned and looked fearful. The mistreatment affected one of two sampled residents reviewed for mistreatment. Following the incident, the facility did not assess other residents for whom this nursing assistant provided care to determine if other residents had been affected. The immediate jeopardy began on 05/15/19 when the beautician witnessed Resident #51 being physically mistreated in the beauty salon by NA #1. Resident #51 cried, moaned and demonstrated fear. The immediate jeopardy was removed on 10/25/19. The facility provided a plan for immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimum harm that is not an immediate jeopardy (D). Continued education will be given by the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or neighborhood coordinator that will include comprehensive review of all policies related to abuse, reporting crimes and resident rights - in their entirety. Education will be completed on 10/25/19 for all staff with the exception of staff who have not worked or cannot be reached by phone; every employee will be educated before their next working shift by the Administrator, Director of Nursing, Assistant Director of Nursing, neighborhood coordinator or charge nurse. Findings included:	F 600	education was completed for all staff or upon first shift worked on 10/25/19. This education has also been included in orientation for all new staff and will be repeated at least annually and as needed. Administrator, Director of Nursing and/or designee will interview at least one staff member in each resident section (4 neighborhoods) at least once per week - ensuring that there are no concerns related to staff interaction with residents that are unreported. This interviewing will continue weekly for 3 months, then at least twice per month thereafter - for one full year. Administrator, Director of Nursing and/or designee will also conduct random audits three times a week for one month, observing at least five different staff members each audit day to ensure there are no concerns with staff interactions or behaviors. After the first month, audits will be continued by observing at least three different staff members at least once per week, every week for three months, then at least once per month for the remainder of the year. If a report is received that states concern related to staff interaction with residents, a complete investigation will occur. This investigation will include interviews with all alert and oriented residents the staff has provided care to, staff working in same area as accused staff, the accused staff member and any other witnesses.	

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F 600	Continued From page 9 Resident #51 was admitted to the facility on 06/24/16. Diagnoses included, in part, Alzheimer's disease, anxiety, depression, cerebral infarction (stroke) without residual deficits and pseudobulbar affect (PBA, a neurological condition which can cause sudden, frequent, uncontrollable episodes of crying and or laughing that are exaggerated and/or don ' t match how you feel). The Minimum Data Set annual assessment dated 03/18/19 revealed Resident #51 was severely cognitively impaired and had no behaviors. Resident #51 required extensive assistance with one staff physical assistance with transfers and used a walker and a wheelchair. A review of the care plan dated 07/10/19 revealed Resident #51 was forgetful, could not recognize people and places and was confused about time. The resident was not able to remember things, had difficulty organizing thoughts and performing activities of daily living. Resident #51 had difficulty expressing needs and was unable to make decisions. The goal in place was to help the resident to feel comfortable and safe. Interventions in place dated 06/19/19 were for NAs to help her the same way every time, give non-verbal cues, verbal cues, to face the resident, and speak clearly, and use yes or no questions when speaking to the resident. The Medication Administration Record (MAR) for the month of May revealed Resident #51 was receiving Nudexta (a medication to treat pseudobulbar affect) 20-10 milligrams (mg) twice per day for pseudobulbar affect. A physician's progress note written on 06/05/19	F 600	If anyone makes a report of potential abuse or mistreatment, the person in questions would be immediately suspended, pending investigation. If the allegation is substantiated, the person in question would be terminated. A physical assessment will be completed for the resident affected and for every resident on the neighborhood where the abuse incident occurred. In addition, an interview will be completed by the Social Worker or Administrator for the affected resident and for every resident on the neighborhood where the abuse incident occurred to ensure no other residents are affected. Further, if an allegation is substantiated, all employees will be educated by Administrator, Director of Nursing or designee on "Reporting Suspected Crimes" policy and "Abuse Investigation and Reporting for Senior Services" policy. If the allegation is not substantiated, his/her behavior and performance will be monitored by department manager or nursing supervisor three times per week for one month (or next twelve shifts; if he/she works less than three shifts per week). This monitoring will include interviews with residents, staff and family members and observation. If new concerns arise as result of this audit, disciplinary action will occur - up to or including termination. Reports will be created summarizing all interviews and audits completed and will be shared with governing body during	

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F 600	Continued From page 10	F 600		

revealed the resident ' s PBA was stable on current medication. (Nudexta 20 - 10 mg twice per day for pseudobulbar affect)

A psychiatry note written on 06/12/19 revealed no psychiatric medication changes recommended at this time as mood and behaviors appear relatively stable.

A psychiatry note written by the Psychiatric Nurse Practioner (NP) on 07/10/19 revealed the NP was going to decrease the Nudexta from twice per day to once every day in the morning.

The July MAR revealed Resident #1 was receiving Nudexta 20-10 mg daily in the morning for pseudobulbar affect.

A review of a psychiatry note written on 10/09/19 revealed Resident #51' s family member had reported Resident #51 had been getting anxious when new staff members worked with her and denied any significant change in Resident #51 ' s yelling since the Nudexta was reduced. The psychiatric recommendation was to consider stopping Nudexta 20 mg-10 mg daily for PBA since the yelling had not worsened since last gradual dose reduction in July, 2019.

An interview was conducted with the Psychiatric Nurse Practioner (NP) via phone on 10/30/19. The NP stated she had been following Resident #51 for a couple of years. The NP reported Resident #51 was pleasantly confused, had very little awareness, and demonstrated no signs of agitation or aggression, but the resident had anxiety. The NP added, staff informed her when family visited, it would cause more anxiety for the resident and her voice would get loud and she

quarterly QAPI meetings, with first report due on January 16, 2020.

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F 600	Continued From page 11	F 600		

would scream. The NP reported the resident had a diagnosis of PBA which was defined, by the NP, when a resident ' s laugh or cry is disproportionate to what was going on around them. The NP stated the laughing or crying was uncontrollable and usually at nothing and lasts about 10 minutes and goes away. The NP stated the resident would have no idea why they were laughing or crying. The NP stated Resident #51 was being treated with Nudexta and had been stable over the past year. The NP added she had not seen any PBA symptoms for Resident #51 for the past year and a half. The NP stated, in fact, it was being considered at this time to discontinue the Nudexta all together. The NP stated staff had not reported anything to her regarding the resident crying or laughing at random times.

An interview was conducted with Nurse #1 via phone on 10/24/19 at 9:15 AM. Nurse #1 stated she recalled Nursing Assistant (NA) #1 and stated the NA could be bold at times and she could be taken the wrong way. Nurse #1 clarified "bold" and added the NA was too "comfortable" in the way she spoke to residents and she could be offensive. Nurse #1 revealed back in May, a family member (family member #1) came to the nurse and reported she witnessed NA #1 talking down to a resident (Nurse #1 could not recall who the resident was that family member #1 was speaking of, but indicated the name of the family member). Nurse #1 reported about a week later (05/06/19), she had observed NA #1 mimicking and speaking condescendingly to a resident. (Nurse #1 could not recall who the resident was). The nurse stated she overheard NA #1 mimicking a resident but could not recall what NA #1 said. Nurse #1 reported NA #1 was unprofessional and the way she spoke to the resident did not "sit well

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with me and it bothered me." The nurse reported, at that time, she wrote up a grievance regarding NA #1 because she felt NA #1 needed to get more education about how to treat residents and she did not like how loud NA #1 would get with the residents.
A grievance was written by Nurse #1 on 05/06/19. It revealed a statement that nursing assistant (NA) #1 mimicked an upset resident and the general tone overall with residents was negative and condescending. The grievance indicated the same behavior from NA #1 was mentioned to Nurse #1 by a concerned family member.
An interview was conducted with family member #1 (the name was provided by Nurse #1) via phone on 10/24/19 at 11:30 AM. The family member stated back in May she observed an NA being "harsh" to Resident #51. Family member #1 reported the NA was impatient and just mean. Family member #1 stated she reported it to Nurse #1 and the nurse told her she would keep an eye on the situation. Family member #1 indicated she recalled hearing the NA speaking meanly to Resident #51 and she thought to herself "Why is she talking to that resident like that?" Family member #1 reported Resident #51 looked frightened and her eyes were big and teary eyed. The family member stated she had to report what she saw to the nurse. Family Member #1 added, she did not know the NA ' s name, but stated she was fairly new and not long after she reported the concern to Nurse #1, she noticed the NA did not work there anymore.
An interview was conducted with the beautician on 10/23/19 at 11:00 AM. The beautician reported she recalled Resident #51 and reported she was in the beauty salon waiting to get her hair done on 05/15/19. The beautician stated Resident #51 had a tendency to slump over in her

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chair and she was slumped over in the hairdressing chair unusually bad. The beautician stated she called to the nursing station to have an NA come help her reposition the resident. The beautician reported NA #1 came into the salon "like a bull." The beautician stated when NA #1 first walked through the door, the resident cried. NA #1 yelled at Resident #51 and said "You raise yourself up! You know you are not supposed to do that!" The beautician stated Resident #51 continued crying and NA #1 yelled "Now I want you to stand up, you know you can't do this!" The beautician reported NA #1 then told the resident "Just sit back down." The beautician stated NA #1 was standing in front of the Resident and "grabbed her so hard" the beautician could hear a "thump sound" when NA #1 grabbed Resident #51 from the front, picked her up and "dropped" her about 8 inches from the air into the wheelchair and then turned to the beautician and said "I hope your happy now!" The beautician reported she observed Resident #51 wrap her legs around NA #1 as she picked her up. The beautician stated Resident #51 looked scared and moaned really loud and once she was dropped into the wheelchair, began to cry again. The beautician stated after she was in her wheelchair, the NA left and she hugged Resident #51 and asked if she was okay, but she was still crying a little. The beautician reported she then proceeded to do the resident ' s hair and the resident was calm while getting her hair done. The beautician reported when she was done with the resident ' s hair, she called the nursing station to have someone come and get her. The beautician stated her husband told her to report it to the Administrator. The beautician reported after lunch, she went right into the Administrator ' s office and told her what she had witnessed.

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The beautician added that it was about an hour later when she told the Administrator. The beautician stated she had never seen this NA.

An interview was attempted via phone with NA #1 on 10/23/19 at 11:32 AM. The message on the phone indicated the phone number was changed, disconnected or no longer in service. The Administrator was unable to provide an alternative number.

An interview was conducted with Nurse #1 via phone on 10/23/19 at 2:00 PM. Nurse #1 revealed she was familiar with Resident #51. Nurse #1 stated she was working on 05/15/19 when Resident #51 went to the hair salon to get her hair done. Nurse #1 indicated she was not aware of anything that happened in the hair salon because she was not in the hair salon. Nurse #1 reported she did not recall who brought the resident back from the hair salon and NA #1 did not report anything to her about Resident #51. Nurse #1 reported the resident did not appear to be upset or in any distress when she saw the resident after being in the beauty salon that day.

An interview was conducted with the Administrator on 10/23/19 at 4:12 PM. The Administrator reported on 05/15/19, the beautician had come to her and reported what she had observed in the beauty salon that day with Resident #51. The Administrator stated the beautician was visibly upset about what she observed in the beauty salon. The Administrator stated she immediately pulled NA #1 from the unit and brought her into the office and explained what the beautician had told her. The Administrator reported she and the Director of Nursing (DON) interviewed NA #1 and NA #1

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stated that she did come to the beauty salon at the request of the beautician, but she did not say anything to Resident #51 or to the beautician. The Administrator stated NA #1 was very dismissive and continued to deny saying anything to Resident #51 or the beautician. The Administrator reported she suspended NA #1 pending the investigation. The Administrator stated the resident ' s family and the physician were notified, the resident was assessed and seemed fine and a skin check was completed indicating no injury. The Administrator stated as part of her investigation, she had checked to see if there were any grievances about NA #1 and reviewed a grievance written by Nurse #1 from 05/06/19 regarding NA #1 mimicking and speaking in a condescending way to residents. The Administrator stated based on the beautician ' s verbal and written statement, she substantiated the allegation and terminated NA #1. The Administrator confirmed the mistreatment was physical due to NA #1 grabbing the resident, picking up the resident and then dropping her in the wheelchair. The Administrator reported she felt it was an isolated situation and did not assess other residents to see if they had been affected by the actions of NA #1.

An interview was conducted with NA #2 on 10/25/19 at 1:20 PM. NA #2 stated she worked on the unit where Resident #51 resided. NA #2 stated she was working on 05/15/19 during the day shift. NA #2 reported she believed she brought Resident #51 back from the hair salon. NA #2 reported, as far as she can recall, the resident did not appear to be in any distress such as crying or moaning. NA #2 stated she was familiar with Resident #51 and staff had to make sure to talk to her gently and kind and sweet and

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to be very patient with her. NA #2 stated once the resident got to know you and got used to the person taking care of her, she would be easier to care for. NA #2 stated staff had to be very patient when doing a transfer with her because she would have a hard time trying to get up and once she was up she would want to stand for a minute and then sometimes may sit back down again. NA #2 stated Resident #51 could follow simple commands but staff had to be patient and give step by step instruction of what the staff was doing. NA #2 stated she recalled NA #1 and reported NA #1 had Resident #51 on her assignment a lot of the time. NA #2 stated she did not recall any changes in the resident when NA #1 was in her care.

The 5-Day Investigation Report stated the Administrator spoke to NA #1 and a statement was received by the beautician verbally and then again a written statement on 05/16/19. The 5-Day Investigation Report indicated the Administrator spoke to Nurse #1 and the nurse stated that sounded like something NA #1 would say, but Nurse #1 did not think she was trying to be mean. The report stated Nurse #1 wrote a grievance on 05/06/19 and stated NA #1 mimics and speaks in a condescending tone to the residents. The report stated the Medical Director was informed and assessed the resident on 05/16/19. The Medical Director reported there were no signs or symptoms of mental anguish or other injury. The report indicated the facility had substantiated employee to resident mistreatment and NA #1 was terminated.

An interview was conducted with Nurse #3 on 10/25/19 at 11:30 AM. Nurse #3 indicated Resident #51 was hard to get up to a standing

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position and could be resistant at times. Nurse #3 stated she would walk with one assist with a walker. She stated some days Resident #51 was verbal and she had a laugh that was hard to tell sometimes if she was laughing or crying. Nurse #3 stated it was important to take your time with the resident and explain everything you are going to do and move slowly when approaching her. Nurse #3 stated if you move too fast toward her, it frightens her. Nurse #3 stated she was not familiar with NA #1.

An observation of Resident #51 on 10/21/19 at 10:50 AM revealed the resident was sitting upright in a reclining chair in her room. The resident was non-verbal and stared when spoken to. The resident was not observed crying out or making laughing sounds.

An observation of Resident #51 on 10/22/19 at 11:35 AM revealed the resident was sitting upright in a reclining chair in her room The resident was non-verbal and stared when spoken to, but offered a slight smile. The resident was not observed crying out or making laughing sounds.

An observation of Resident #51 on 10/23/19 at 2:45 PM revealed the resident appeared to be sleeping in a reclining chair in her room.

An observation of Resident #51 on 10/24/19 at 1:30 PM revealed the resident was sitting upright in a reclining chair in her room. She was non-verbal, but appeared to be comfortable. Resident #51 was noted to stare and had a slight smile when spoken to. She was not observed crying out or making laughing sounds.

An observation of Resident #51 on 10/25/19 at

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12:05 PM revealed the resident was alert and walking with her walker with one assist in the dining area to her seat. The resident did not appear to be frightened and was not exhibiting any signs of moaning or crying out.

The Administrator was notified of the immediate jeopardy on 10/24/19 at 3:40 PM.

On 10/25/19 at 3:17 PM, the facility provided an acceptable removal plan to remove the immediate jeopardy (IJ).

The facility removal plan for the immediate jeopardy removal for the deficiency at F600 included the following information:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

On 05/15/19, the Administrator was notified by the beautician of an incident that occurred at approximately 1:00 pm on 05/15/19 involving Resident #51 and NA #1. Following the report, the Administrator immediately suspended NA #1 and the NA left the building. The Administrator completed an Initial Allegation Report on 05/16/2019 and an Investigation Report on 05/24/19 and substantiated the mistreatment. NA #1 was terminated and never returned to work and therefore was never the NA for Resident #51 or any other resident after 05/15/19.

On 10/24/19, the Director of Nursing and the Assistant Director of Nursing completed a physical assessment for all residents who reside on the neighborhood that Resident #51 resides. Two residents were found to have new bruises.

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These were investigated by the Director of Nursing and the Administrator and their origins are known. Staff were interviewed at the time of the nursing assessments, with no reported concerns. Residents were asked if they were experiencing pain, but further interview was not appropriate as all residents on memory care neighborhood on 10/24/19 have cognitive impairment and short-term memory loss.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 10/23/19, education with all staff, including contract and agency, began and included in-services on the following Lutheran Services Carolinas policies:

· Reporting Suspected Crimes
· Abuse Investigation and Reporting for Senior Services
· Resident Rights for Senior Services

Abuse Investigation and Reporting for Senior Services policy includes specific language related to different types of abuse, examples of each and defines how to identify potential abuse. This policy also outlines the requirements for all staff to report suspected abuse or mistreatment - which includes direction to immediately report to his/her department manager or nursing supervisor. If anyone makes a report of potential abuse or mistreatment, the person in question would be immediately suspended, pending investigation. If the allegation is substantiated, the person in question would be terminated. If the allegation is not substantiated, his/her

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behavior and performance will be monitored by department manager or nursing supervisor three times per week for one month (or next twelve shifts, if he/she works less than three shifts per week). This monitoring will include interviews with residents, staff and family members and observation. If new concerns arise as result of this audit, disciplinary action will occur - up to and including termination.

Continued education will be given by the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or neighborhood coordinator that will include comprehensive review of all policies related to abuse, reporting crimes and resident rights - in their entirety. Education will be completed on 10/25/19 for all staff with the exception of staff who have not worked or cannot be reached by phone; every employee will be educated before their next working shift by the Administrator, Director of Nursing, Assistant Director of Nursing, neighborhood coordinator or charge nurse.

When a report of potential abuse is reported to the administrator, the administrator or director of nursing will immediately initiate an investigation. If an abuse allegation is substantiated, a physical assessment will be completed for the resident affected and for every resident on the neighborhood where the abuse incident occurred. In addition, an interview will be completed by the social worker or administrator for the affected resident and for every resident on the neighborhood where the abuse incident occurred to ensure no other residents are affected. Further, if an allegation is substantiated all employees will be educated by administrator, the

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director of nursing, assistant director of nursing or neighborhood coordinator on the "Reporting Suspected Crimes" policy and the "Abuse Investigation and Reporting for Senior Services" policy. Further, the director of nursing, assistant director of nursing, staff development coordinator or neighborhood coordinator will conduct random audits three times a week for one month observing at least five different staff members each audit day to ensure there are no concerns with staff interactions or behaviors.

If an abuse allegation is reported, for the resident affected the following will occur:

· A physical assessment
· An interview to assess the resident ' s psychosocial status
· The resident ' s family and physician will be notified
· Any immediate threat to the resident will be removed. For example, staff members involved in an allegation of abuse or mistreatment will be immediately suspended, pending investigation.

Date IJ removed: October 25, 2019. The person responsible for implementation of the plan is the Administrator.
The immediate jeopardy was removed on 10/25/19 at 4:50 PM.

Validation of the immediate jeopardy removal plan was completed as evidenced by interviews with 18 staff members representing nurses, nursing assistants, social worker, dietary manager, MDS nurse, assistant director of nursing and the director of nursing on all shifts to verify abuse and abuse reporting in-services.

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F 600	Continued From page 22 There were no concerns or reports of abuse by these staff members. Additionally, interviews with 12 residents having intact cognition about whether or not they have been abused by facility staff. The residents had no concerns regarding abuse. The Administrator and the DON had been re-educated on abuse, policy and procedures and conducting proper thorough abuse investigations by the Regional Consultant.	F 600		
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 and staff interviews the facility failed to report allegations of abuse to the Health Care Personnel Registry (HCPR) by: 1) the policy did not indicate abuse should be reported within 2 hours of being notified and therefore, the submission of the Initial Allegation Report for abuse within 2 hours of the Administrator being notified was not done for 1 of 2 residents (Resident #51), not submitting the 5-Day Investigation Report within 5 working days for 1 of 2 residents (Resident #51), and 2) failed to conduct a thorough investigation and submit a	F 607	Administrator and Director of Nursing were educated on the requirements related to all allegations of abuse - as defined by the State Operations Manual on 10/23/19. All alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of property will be reported immediately but not later than 2 hours after allegation is made if the	11/18/19

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F 607	Continued From page 23 5- Day Investigation Report for 1 of 2 residents (Resident #234) observed for mistreatment. Findings included: 1. The facility ' s Abuse Investigation and Reporting for Senior Services policy dated 04/19/06 and revised on 03/05/18 under "Reporting" revealed, in part, as follows: All alleged violations of abuse, neglect, exploitation, misappropriation of property, mistreatment, including injuries of unknown source, must be reported immediately, but not later than 2 hours after the allegation is made if the events result in serious bodily injury, OR not later than 24 hours if the event did not involve serious bodily injury, to the Administrator of the facility and to the state agency in accordance with state law. The Administrator will ensure that a completed Department of Health Service Regulation (DHSR) form - Initial Allegation Report is submitted to the HCPR section of the DHSR within 2 hours after the allegation is made if the event that caused the allegation resulted in serious bodily injury. An interview was conducted with the Administrator on 10/23/19 at 4:12 PM. The Administrator reviewed the Abuse Investigation and Reporting for Senior Services policy compared to the State Operations Manual (SOM) and realized there was an error in her policy whereas in addition to serious bodily harm, any allegation of abuse was also to be indicated on the policy to be reported within 2 hours. The SOM read "ensure that all alleged violations involving abuse, neglect, exploitation, or	F 607	events that cause the allegation involve abuse or result in serious bodily injury. If a report is received that states concern related to staff interaction with residents, a complete investigation will occur. This investigation will include interviews with all alert and oriented residents the staff has provided care to, staff working in same area as accused staff, the accused staff member and any other witnesses. If anyone makes a report of potential abuse or mistreatment, the person in question would be immediately suspended, pending investigation. If the allegation is substantiated, the person in question would be terminated. A physical assessment will be completed for the resident affected and for every resident on the neighborhood where the abuse incident occurred. In addition, an interview will be completed by the Social Worker or Administrator for the affected resident and for every resident on the neighborhood where the abuse incident occurred to ensure no other residents are affected. Further, if an allegation is substantiated, all employees will be educated by Administrator, Director of Nursing or designee on "Reporting Suspected Crimes" policy and "Abuse Investigation and Reporting for Senior Services" policy. If the allegation is not substantiated, his/her behavior and performance will be monitored by department manager or nursing supervisor three times per week	

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F 607	Continued From page 24 mistreatment including injuries of unknown source and misappropriation of property are reported immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. 2. A review of an Initial Allegation Report regarding an employee to resident abuse allegation for an incident involving Resident #51 which was reported to the Administrator by the beautician on 05/15/19 at 4:30 PM revealed the report was faxed 24 hours after the incident occurred to the HCPR on 05/16/19 at 4:04 PM. The Initial Allegation Report regarding an employee to resident abuse allegation for Resident #51 written on 05/15/19 stated the beautician reported to the Administrator that she witnessed a staff member being mean to a resident. The report indicated a resident in the beauty salon was "slumped over in a chair" so the beautician asked someone to send her aide to sit with the resident. A short time later a Nurse ' s Aide (NA) came in and yelled at the resident, "I told you not to put your head down!" The beautician stated the resident began to cry. The beautician stated the NA then attempted to transfer her to another chair, but the resident was unable to assist. The beautician reported the NA then said to the resident "Guess I have to do it myself" and lifted the resident and transferred her. The report stated the beautician reported the resident was crying at the time of the interaction and the beautician comforted the resident with hug and said she was fine once returning to the unit. An interview was conducted with the beautician	F 607	for one month (or next twelve shifts; if he/she works less than three shifts per week). This monitoring will include interviews with residents, staff and family members and observation. If new concerns arise as result of this audit, disciplinary action will occur - up to or including termination. Prior to close of an investigation, Administrator and Director of Nursing will each review all parts of the investigation - auditing and ensuring a comprehensive investigation. Upon completion of investigation, an Investigation Report will be completed within 5 business days from the original report. Any subsequent actions (re-education or disciplinary action) that takes place as a result of an investigation will be cosigned by the Administrator and Director of Nursing. Administrator will summarize all abuse allegations in a report to be reviewed by the Governing body during quarterly QAPI meeting, with first report due on January 16, 2020. This report will include a timeline for each allegation (open date, key investigation dates, closing date, reporting dates, disciplinary action dates) and whether the allegation was substantiated or unsubstantiated.	

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on 10/23/19 at 11:00 AM. The beautician reported she recalled Resident #51 and reported she was in the beauty salon waiting to get her hair done on 05/15/19. The beautician stated Resident #51 had a tendency to slump over in her chair and she was slumped over in the hairdressing chair unusually bad. The beautician stated she called to the nursing station to have an NA come help her reposition the resident. The beautician reported NA #1 came into the salon "like a bull." The beautician stated when NA #1 first walked through the door, the resident cried. NA #1 yelled at Resident #51 and said "You raise yourself up! You know you are not supposed to do that!" The beautician stated Resident #51 continued crying and NA #1 yelled "Now I want you to stand up, you know you can't do this!" The beautician reported NA #1 then told the resident "Just sit back down." The beautician stated NA #1 was standing in front of the Resident and grabbed Resident #51 so hard the beautician could hear a thump sound when NA #1 grabbed Resident #51 and wrapped her arms around the resident from the front, picked her up and "dropped her about 8 inches into the wheelchair and then turned to the beautician and said "I hope your happy now!" The beautician reported she observed Resident #51 wrap her legs around NA #1 as she picked her up. The beautician stated Resident #51 looked scared and moaned really loud and once she was dropped into the wheelchair, began to cry again. The beautician stated after she was in her wheelchair, the NA left and she hugged Resident #51 and asked if she was okay, but she was still crying a little. The beautician reported she then proceeded to do the resident ' s hair and the resident was calm while getting her hair done. The beautician reported when she was done with the resident ' s hair, she

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called the nursing station to have someone come and get her. The beautician reported after lunch, she went right into the Administrator ' s office and told her what she had witnessed. The beautician added that it was about an hour later when she told the Administrator.

An interview was conducted with the Administrator on 10/23/19 at 4:12 PM. The Administrator reviewed the Abuse Investigation and Reporting for Senior Services policy compared to the State Operations Manual (SOM) and realized there was an error in her policy whereas in addition to serious bodily harm, any allegation of abuse was also to be indicated on the policy to be reported within 2 hours. The SOM read "ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment including injuries of unknown source and misappropriation of property are reported immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury.

b. A review of the 5-Day Investigation Report regarding the employee to resident abuse allegation for Resident #51 for the incident which occurred on 05/15/19 revealed the report was faxed on the 7th working day to the HCPR on 05/24/19.

An interview was conducted with the Administrator on 10/23/19 at 4:12 PM. The Administrator reported she completed the investigation for Resident #51 on 05/24/19 and stated that she realized it should have been submitted on 05/22/19 which would have been the 5th working day. The Administrator stated

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she did not know why the 5-Day Investigation Report was submitted late.

3. The facility ' s Abuse Investigation and Reporting for Senior Services policy dated 04/19/06 and revised on 03/05/18 under "Identification and Investigation" revealed, in part, as follows:

The nursing supervisor or department manager must notify the Administrator and the Director of Nursing immediately. The Administrator or designee is responsible for ensuring the thorough investigation of the allegation

The Administrator will ensure that a report of the investigation is printed or typed within five working days of the allegation. The Department of Health Service Regulation form - Investigation Report may be used to complete this report.

The Director of Nursing or designee will begin the abuse investigation which will consist of:

· Completing the Department of Health Service Regulation (DHSR) required reporting form (Initial Allegation Report
· Interviewing the person(s) reporting the incident
· Interviewing any witnesses to the incident
· Reviewing the resident ' s medical record
· Interviewing staff members (on all shifts) that have had contact with the resident during the period of this alleged incident
· Interviewing the resident ' s roommate, family members and visitors
· Interviewing other residents to whom the employee provides care or services

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F 607	Continued From page 28 A review of an Initial Allegation Report regarding an employee to resident mistreatment allegation for Resident #234 for an incident of mistreatment which occurred on 01/22/19 at 7:00 PM revealed Resident #234 reported to the nurse a black girl came into his room sometime after lunch and found him in the bed and seemed to be frustrated with him that he was in the bed. She was quite loud and he normally had 2 people transferring him to his wheelchair, but she transferred him alone. The NA pulled him by his hands out of the bed and put him in his wheelchair. The NA wanted to things her way and not his way. The Resident was noted to have 2 bruises to the top of both hands. A record review revealed there was no 5-Day Investigation Report completed or submitted for the employee to resident mistreatment allegation for Resident #234 for the incident of mistreatment which occurred on 01/22/19. An interview was conducted with the Administrator on 10/25/19 at 9:25 AM. The Administrator reported she did not know why the 5-Day Investigation Report was not completed and submitted by 5th working day according to the policy for Resident #234. She stated she took full responsibility for the lack of attention to this allegation. The Administrator added, it was her responsibility to ensure the 5-Day Investigation Report was completed and submitted according to the regulation.	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 610		11/18/19

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F 610	Continued From page 29 must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and an interview by a family member, the facility failed to fully investigate concerns of resident mistreatment for 1 of 1 residents reviewed (Resident #51) and an unnamed resident. Findings included: Resident #51 was admitted to the facility on 06/24/16. Diagnoses included, in part, Alzheimer's disease, anxiety, depression, cerebral infarction (stroke) without residual deficits and pseudobulbar affect (PBA, a neurological condition which can cause sudden, frequent, uncontrollable episodes of crying and or laughing that are exaggerated and /or don ' t match how you feel.) The Minimum Data Set quarterly assessment dated 09/01/19 revealed Resident #51 was severely cognitively impaired.	F 610	All staff have been re-educated on LSC Policies: Resident Rights for Senior Services, Abuse Investigation and Reporting and Reporting Suspected Crimes. These policies include specific language related to Dignity and Respect - as well as when and how to report suspected abuse or mistreatment. This education was completed for all staff or upon first shift worked on 10/25/19. This education has also been included in orientation for all new staff and will be repeated at least annually and as needed. Administrator, Director of Nursing and/or designee will interview at least one staff member in each resident section (4 neighborhoods) at least once per week - ensuring that there are no concerns related to staff interaction with residents that are unreported. This interviewing will continue weekly for 3 months, then at	

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F 610	Continued From page 30 A grievance was written by Nurse #1 on 05/06/19. It revealed a statement that Nursing Assistant (NA) #1 mimicked an upset resident and the general tone overall with residents was negative and condescending. The grievance indicated this was also mentioned to Nurse #1 by a concerned family member. The grievance was signed by Nurse #1. The follow up documentation on the grievance form indicated an in-service was completed. A review of an in-service titled "Respect: The Resident and You which was not dated was provided. The in-service included, in part, "joking or mimicking a resident can be verbal or with moves/gestures and is disrespectful and can anger/agitate an already possibly agitated resident." A review of a signature list for the in service regarding respect was provided and included staff members such as NAs, nurses, medication aides, medical record personnel, and secretaries. NA #1 ' s signature was not noted on the signature list. An interview was conducted with Nurse #1 via phone on 10/24/19 at 9:15 AM. Nurse #1 stated she recalled NA #1 and stated the NA could be bold at times and she could be taken the wrong way. Nurse #1 clarified "bold" and added the NA was too "comfortable" in the way she spoke to residents and she could be offensive. Nurse #1 revealed back in May, a family member (family member #1) of another resident came to the nurse and reported she witnessed NA #1 talking down to a resident (Nurse #1 could not recall who the resident was that the family member was speaking of, but indicated the name of the family	F 610	least twice per month thereafter - for one full year. Administrator, Director of Nursing and/or designee will also conduct random audits three times a week for one month, observing at least five different staff members each audit day to ensure there are no concerns with staff interactions or behaviors. After the first month, audits will be continued by observing at least three different staff members at least once per week, every week for three months, then at least once per month for the remainder of the year. If a report is received that states concern related to staff interaction with residents, a complete investigation will occur. This investigation will include interviews with all alert and oriented residents the staff has provided care to, staff working in the same area as accused staff, the accused staff member and any other witnesses. If the staff is found to be in violation of LSC policy, re-education will occur and/or disciplinary action - up to or including termination. Reports will be created summarizing all interviews and audits completed and shared with governing body in the next four quarterly QAPI meetings, with the first report due January 16,2020.	

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member). Nurse #1 stated she told family member #1 she would look into the situation. Nurse #1 reported she did not report the concern at that time and wanted to see if she could witness NA #1 ' s interactions with residents. Nurse #1 reported about a week later (05/06/19), she had observed NA #1 mimicking and speaking condescendingly to a resident. (Nurse #1 could not recall who the resident was). The nurse stated she overheard NA #1 mimicking a resident but could not recall what NA #1 said. Nurse #1 reported NA #1 was unprofessional and the way she spoke to the resident did not "sit well with me and it bothered me." The nurse reported, at that time, she wrote up a grievance regarding NA #1 because she felt NA #1 needed to get more education about how to treat residents and she did not like how loud NA #1 would get with the residents. Nurse #1 stated she had no idea what the outcome was after she submitted the grievance. She stated there was no follow up.

An interview was conducted with the family member #1 (the name was provided by Nurse #1) via phone on 10/24/19 at 11:30 AM. Family member #1 stated back in May she observed an NA being "harsh" to Resident #51. The family member reported the NA was impatient and just mean. Family member #1 stated she reported it to Nurse #1 and the nurse told her she would keep an eye on the situation. Family member #1 indicated she recalled hearing the NA speaking meanly to Resident #51 and she thought to herself "Why is she talking to that resident like that?" Family member #1 reported Resident #51 looked frightened and her eyes were big and teary eyed. Family member #1 stated she had to report what she saw to the nurse. Family member #1 reported she did not know the NA ' s

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name, but stated she was fairly new and not long after she reported the concern to Nurse #1, she noticed the NA did not work there anymore.

An interview was conducted with the Director of Nursing (DON) on 10/24/19 at 12:00 PM. The DON revealed she received the grievance dated 05/06/19 from the Administrator on 05/07/19. The DON reported the process for the grievances was to address any concerns that were brought to the management team, investigate the concern, and follow up with the person who wrote the grievance as to the outcome of the investigation. The DON stated she spoke with NA #1 individually and NA #1 reported she was not aware she was mimicking and speaking to the residents condescendingly. The DON reported she conducted a one on one in-service with NA #1 regarding dignity and how to speak to residents so that the demeanor did not come across as mimicking or condescending. The DON was not able to provide any signed in services by NA #1. The DON reported she conducted a facility wide in-service with staff and specifically added in the in service that mimicking was disrespectful. The DON confirmed that NA #1 was not part of that in service. The DON stated she should have looked at the grievance in totality and should have done a full investigation upon receipt of the grievance to include interviewing the family member who witnessed NA #1 being disrespectful, the nurses on the unit, the other NAs on the unit, and any alert and oriented residents, and monitor NA #1 with the residents to make sure this behavior by NA #1 was not reoccurring.

An interview was conducted with the Administrator on 10/25/19 at 4:00 PM. The

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F 610	Continued From page 33 Administrator revealed her expectation of the management staff was to ensure any grievances that were received were fully investigated and followed up on.	F 610		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to complete a comprehensive significant change assessment within 14 days when the resident was diagnosed with a life expectancy of 6 months or less and experienced a significant weight loss for 1 of 21 residents (Resident #18) reviewed. Findings included: Resident #18 was admitted to the facility on 12/04/18. Diagnoses included congestive heart failure, basal cell carcinoma of the skin to right ear and external auricular canal, thrombocytopenia, acute post hemorrhagic anemia, depression, anxiety, and presence of	F 637	Administrator completed in-service with MDS Nurses on 11/18/19 - reviewing LSC policies: "Change in Resident's Status or Condition", "Care Plans - Nursing Facility" and the RAI manual. These policies and the RAI manual contain specific language related to when and why a significant change assessment should be completed. Administrator completed in-service with other Department Heads responsible for completing portions of MDS assessments (Social Worker, Food Service Director, Activities, Therapy Manager) - outlining the importance of notifying MDS Nurses of changes they may observe in residents	11/18/19

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F 637	Continued From page 34 other vascular implants and grafts. A review of a physician ' s progress note written on 08/01/19 revealed, in part, the physician felt the resident did not have the will to live. The note indicated the resident was refusing medications and had a decline in health with a 20 lb. weight loss due to refusing meals. The note stated the resident ' s prognosis of less than 6 months life expectancy was due to chronic medical conditions and the progression of the conditions. The Data Set Minimum Data Set (MDS) quarterly assessment dated 05/05/19 revealed Resident #18 was moderately cognitively impaired. Resident #18 required extensive assistance with one staff physical assistance with bed mobility, transfers, dressing and toileting and limited assistance with one staff physical assistance with personal hygiene. Resident #18 was occasionally incontinent with bowel and frequently incontinent with bladder and the resident ' s weight was noted to be 162 lbs. The MDS quarterly assessment dated 08/02/19 revealed Resident #18 was moderately cognitively impaired. Resident #18 required extensive assistance with two staff physical assistance with bed mobility, transfers, and toileting and extensive assistance with one staff physical assistance with personal hygiene. Resident #18 was frequently incontinent of bowel and bladder and the resident ' s weight was noted to be 140 lbs. Section J1400 under Prognosis "does the resident have a condition or chronic disease that may result in life expectancy of less than 6 months?" This question was noted to be answered "no."	F 637	as they complete their assessments. MDS Nurses will attend daily clinical meeting where they will listen for indications that a Significant Change has occurred for any resident. If a Significant Change is discussed, and MDS Nurse states that a Significant Change Assessment is needed - it will be completed within 14 days. If uncertain at the time of the clinical meeting - MDS will report to Administrator, in writing, that they will research changes for a specific resident and follow-up with Administrator when the determination is made on whether or not to complete a significant change assessment. This determination will be made in 14 days or less. When completing assessments, each MDS Nurse will review the prior assessment before closing the current assessment. In review, the MDS Nurse will be looking for changes that may indicate the need for a Significant Change assessment. If it is determined through this method that a Significant Change Assessment should be completed - this information will be recorded on MDS log. MDS will maintain a list of all residents they have made such a determination for and will include this list in their quarterly QAPI report. Administrator or designee will audit MDS assessments for all known chances for completion of a Significant Change Assessment. The results of this audit will be reported for the next four quarters to the governing body during	

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F 637	Continued From page 35 A review of Resident #18 ' s care plan dated 08/07/19 for at risk for decreased nutrition revealed the weights were discontinued and the resident had a prognosis of 6 months or less life expectancy. A review of the MDS record revealed there was an "in process" significant change assessment dated 10/21/19. An interview was conducted with the MDS Nurse on 10/25/19 at 3:50 PM. The MDS explained when she was completing a resident ' s assessment in the MDS, the process was to interview the resident, review the electronic chart including physician ' s notes, and review the physician orders. She stated she used a worksheet to gather her information regarding any changes for a resident. The MDS Nurse reported she knew Resident #18 had some decline and she was expecting him to improve because she felt the resident ' s condition could have been acute. The MDS stated the resident ' s condition did not improve and that was when it was decided to do a significant change assessment on 10/21/19. The MDS Nurse stated we usually wait a couple of weeks to see if there was any improvement and if there was none, then she would complete a significant change assessment. The MDS nurse reported that it had been almost 3 months since the doctor documented his end of life expectancy was less than 6 months and that was an unacceptable amount of time to wait before completing a significant change assessment. The MDS Nurse stated if a resident had a decline in two or more areas and the condition was not going to resolve within 14 days, the significant change assessment should have been completed. The	F 637	QAPI meetings, with first report due on January 16, 2020. If it is found that an assessment was not completed, responsible MDS Nurse will received disciplinary action - up to or including termination.	

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F 637	Continued From page 36 MDS Nurse stated she missed what the doctor had documented regarding the resident ' s prognosis of life expectancy of less than 6 months on 08/01/19 and should have noticed it when doing her chart review. An interview was conducted with the Director of Nursing (DON) on 10/25/19 at 5:00 PM. The DON reported her expectation of the MDS Nurse was to utilize her resources such as resident ' s charts and assessments and if there was a decline in two or more activities of daily living and no improvement within 14 days, the MDS nurse have should completed a significant change assessment.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code prognosis of life expectancy of less than 6 months or less in the Minimum Data Set (MDS) quarterly assessment completed on 08/01/19 for 1 of 21 residents (Resident #18) reviewed. Findings included: Resident #18 was admitted to the facility on 12/04/18. Diagnoses included congestive heart failure, basal cell carcinoma of the skin to right ear and external auricular canal, thrombocytopenia, acute post hemorrhagic anemia, depression, anxiety, and presence of	F 641	Administrator completed in-service with MDS Nurses on 11/14/19 - showing alternate ways to look up pertinent information in the EMR. Complete audit of current residents' most recent assessment was completed on 11/14/19 - ensuring that prognosis of less than six months to live was not overlooked for other residents and that it was recorded accurately in the most recently completed MDS. Beginning on 11/20/19, facility provider will write an order when prognosis for less than six months life expectancy is added	11/18/19

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F 641	Continued From page 37 other vascular implants and grafts. A review of a physician ' s progress note written on 08/01/19 revealed, in part, the physician felt the resident did not have the will to live. The note indicated the resident was refusing medications and had a decline in health with a 20 lb. weight loss due to refusing meals. The note stated the resident ' s prognosis of less than 6 months life expectancy was due to chronic medical conditions and the progression of the conditions. The MDS quarterly assessment dated 08/02/19 revealed section J1400 under Prognosis "does the resident have a condition or chronic disease that may result in life expectancy of less than 6 months?" This question was noted to be answered "no." An interview was conducted with the MDS Nurse on 10/25/19 at 3:50 PM. The MDS nurse explained when she was completing a resident ' s assessment in the MDS, the process was to interview the resident, review the electronic chart including physician ' s notes, and review the physician orders. She stated she used a worksheet to gather her information regarding any changes for a resident. The MDS nurse reported she missed what the doctor had documented regarding Resident #18 ' s prognosis of life expectancy of less than 6 months on 08/01/19 and should have noticed it when doing her chart review when she was completing the 08/02/19 quarterly assessment. An interview was conducted with the Director of Nursing (DON) on 10/25/19 at 5:00 PM. The DON reported her expectation of the MDS Nurse was to ensure the MDS was accurate and	F 641	for any resident. These orders will be reviewed in morning clinical meeting. MDS Nurses will be responsible for noting the addition of this prognosis and including this information in the next MDS assessment. Administrator or designee will audit all transmitted MDS assessments each month to ensure that prognosis is coded accurately in the MDS assessment. The results of these audits will be reported in quarterly QAPI meeting for the next four quarters, beginning on January 16, 2020. If an inaccuracy is found, the MDS Nurse who completed the assessment will be re-educated on the process for gleaning this information from the chart and will receive disciplinary action, up to or including termination.	

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F 641	Continued From page 38 reflected the current clinical condition during that look back period for Resident #18.	F 641		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to air dry items of kitchenware before stacking them on top of one another in storage, and failed to remove grease and dust from filters above the stove system. The facility also failed to discard abraded kitchenware, failed to remove stains from kitchenware, and failed to label and date opened food items found in storage areas. Findings included: 1. During initial tour of the neighborhood/auxiliary kitchens, beginning at 11:25 AM on 10/21/19, 7 of	F 812	All food Service staff were in-serviced on procedures and expectations for sanitation related to washing, air drying dishes and labeling/dating of open food items on 10/31/19. All Food Service staff also received education on procedure for discarding abraded kitchenware or de-staining kitchenware as needed on 11/18/19. Food Service Director was in-serviced on protocols related to cleaning the filters above the stove and a log documenting cleaning was created on	11/18/19

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F 812	Continued From page 39 15 eight-ounce cups in 1 of 4 of the kitchens were found stacked wet with moisture trapped between the cups. During a follow-up observation in the main kitchen on 10/23/19 at 9:12 AM 2 of 12 tray pans were stacked wet with moisture trapped between the two pieces of kitchenware. During a follow-up observation of the neighborhood/auxiliary kitchens on 10/23/19 at 12:02 PM 11 of 18 eight-ounce cups in 1 of 4 kitchens were found stacked wet with moisture trapped between the cups. During an interview with the Dietary Manager (DM) on 10/24/19 at 4:20 PM she stated she had only held her present position for a couple of weeks, and had not had a chance to start in-servicing her dietary staff. However, she reported that she expected her staff to air dry kitchenware and make sure it was free of dried food particles before stacking it in storage. She commented trapped moisture could support the growth of mold which could make residents sick. During an interview with Dietary Employee #1 on 10/24/19 at 4:28 PM she stated she had been taught to make sure kitchenware was dry before stacking it in storage. She explained that bacteria could grow in the moisture, and had the potential of making residents sick. 2. During initial tour of the main kitchen, beginning at 10:53 AM on 10/21/19, 11 of 12 filters above the stove/oven/deep fryer system had a build-up of grease and dust on them. Food was being prepared in the stove and ovens.	F 812	11/18/19. Food Service Director or designee will complete random audits of stacked kitchenware - ensuring that items are air dried and not stacked when wet. Food Service Director or designee will also audit for abraded or stained kitchenware by inspecting at least 10 items on each audit day. These audits will be completed at least three times per week for one month, then at least once per week thereafter. If Food Service Director finds that an employee is not following proper procedure related to wet dishes, abraded or stained kitchenware, the employee will receive re-education on proper procedure and/or disciplinary action - up to or including termination. Food Service Director or designee will audit food storage areas (dry storage, refrigerator, freezer and neighborhood kitchens) to make sure that food is labeled and within expiration date. This audit will be completed at least three times per week for one month, then at least once per week thereafter. If Food Service Director finds that an employee is not following proper procedure related to food storage and labeling, the employee will receive re-education on proper procedure and/or disciplinary action - up to or including termination. Food Service Director or designee will clean the filters over the stove at least once per week. Person who cleans the filters will sign and date that it was	

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F 812	Continued From page 40 During a follow-up tour of the main kitchen, on 10/23/19 at 9:29 AM, 11 of 12 filters above the stove/oven/deep fryer system had a build-up of grease and dust on them. Food was being prepared in the stove and ovens. During an interview with the Dietary Manager (DM) on 10/24/19 at 4:20 PM she stated the filters were cleaned quarterly by an outside source in conjunction with the cleaning of the hood system, but between this quarterly service a dietary employee was supposed to clean the filters weekly. However, she commented the employee designated to do this cleaning was out on leave, and she had just appointed a replacement to take on the responsibility. According to the DM, greasy and dusty filters posed the risk of cross contamination if the dust and dirt fell into food which was being prepared below the filter system. During an interview with Dietary Employee #1 on 10/24/19 at 4:28 PM she stated she thought the maintenance department was responsible for cleaning the filters weekly. She reported unclean filters created a risk that grease and dust could contaminate fresh foods that were being cooked in the area. 3. During an inspection of kitchenware, beginning at 9:57 AM on 10/23/19, plastic soup and cereal bowls were found with abraded interior surfaces in 4 of 4 neighborhood/auxiliary kitchens. 9 of 35 bowls or 26% of the bowls examined had begun to break down/slough off, and since they had not been discarded, they were available for serving residents at the next meal. During an interview with the Dietary Manager	F 812	completed on the "Filter Cleaning Log" that will be maintained by the Food Service Director. Findings related to weekly audits and filter cleaning log will be included in the quarterly QAPI report for Governing Body review for the next four quarters, beginning on January 16, 2020.	

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F 812	Continued From page 41	F 812		

(DM) on 10/24/19 at 4:20 PM she stated she had only held her present position for a couple of weeks, and had not had a chance to start in-servicing her dietary staff. However, she reported that she expected her staff to discard damaged kitchenware, but to inform her of the quantities that were disposed of so she could order replacements. She commented it was harder to keep abraded surfaces clean, and the abrasions could more easily harbor bacteria and germs.

During an interview with Dietary Employee #1 on 10/24/19 at 4:28 PM she stated kitchenware that was chipped, cracked, or abraded was supposed to be discarded because some of the kitchenware could slough or break off and cause the mouths and throats of residents to be injured or make the residents sick.

4. During an inspection of kitchenware, beginning at 9:57 AM on 10/23/19, 23 side dishes and 2 sectional plates in 3 of 4 neighborhood/auxiliary kitchens had dark brown stains on their interior surfaces. 23 out of 34 side dishes and 2 of 2 sectional plates for 25 out of 36 pieces (69%) of kitchenware examined were significantly stained. Since this kitchenware had not been removed for de-staining, it was available for serving residents at the next meal.

During an interview with the Dietary Manager (DM) on 10/24/19 at 4:20 PM she stated she was informed the facility had a de-staining program in place, but apparently kitchenware was not being de-stained once a month as scheduled. She reported serving food in kitchenware that had dark brown stains on it was not appetizing.

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F 812	Continued From page 42	F 812		

During an interview with Dietary Employee #1 on 10/24/19 at 4:28 PM she stated a commercial product was used to de-stain kitchenware weekly, but she could not remember that last time she saw this de-staining occurring.

5. During initial tour of the main kitchen, beginning at 10:53 AM on 10/21/19, in the walk-in refrigerator a bag of carrot sticks, a 80-ounce bag of shredded cheddar cheese, two packages of orange sliced cheese, two packages of Swiss cheese, a 135-ounce bottle of enchilada sauce, and a gallon container of teriyaki marinade were all found to be opened but without labels and dates. Half of a green pepper in plastic wrap was also found in the walk-in refrigerator without a label and date. In the dry storage room a 80-ounce box of pancake mix was opened, but did not have a label or date on it. In the walk-in freezer bags of broccoli and Normandy blend vegetables were opened, but were also without labels and dates.

During a follow-up tour of the main kitchen, beginning at 9:36 AM on 10/23/19, a 40-ounce bag of blanched almonds in the dry storage room was opened, but did not have a label or date on it. A storage bag of shredded mozzarella cheese in the walk-in refrigerator was without a label and date. A bag of tater tots in the walk-in freezer was opened, but did not have a label or date on it.

During an interview with the Dietary Manager (DM) on 10/24/19 at 4:20 PM she stated all dietary employees who opened food items but did not use them all were supposed to make sure they had labels and dates on their containers. She reported she did not think the facility had assigned anyone in dietary to audit the storage

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F 812	Continued From page 43 areas to make sure the storage policies were being followed. She commented it was important to label and date foods to make sure residents received the freshest food possible. During an interview with Dietary Employee #1 on 10/24/19 at 4:28 PM she stated it was the responsibility of all dietary employees to label and date opened food items or foods which were transferred from their original packaging into storage containers. She reported the labeling and dating procedure helped to reduce food spoilage and reduced the chance residents would get stale or tasteless foods.	F 812		