STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	C 11/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to have comprehensive emergency preparedness(EP) plan. The EP manual failed to include community based risk assessment, facility risk assessment and associated strategies, the emergency plan and procedures did not include missing residents in their EP program. The EP plan failed to identify its resident population. The EP manual did not include policy and procedures for sheltered residents and staff who remain in the facility,	E 001	DISCLAIMER RESPONSE PREFACE: Presbyterian Home of Hawfields Acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and	12/4/19

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

Electronically Signed | 12/04/2019

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E 001	Continued From page 1 policy and procedures to track residents and others, residents and staff who were moved to other facilities and policies and procedures for staff, residents and others who remained in the facility during and emergency. The Manual did not include policy and procedures to preserve resident information and protect resident confidentiality, secure and maintain availability of resident ' s medical records. The EP communication plan failed to include contact information of staff, resident ' s, physician and other facilities, contact information of State Licensing and Certification Agency and State Long Term Care Ombudsman. The EP Communication plane failed to include procedure of sharing information and medical documentation of its resident with other health care providers and facilities that would be providing continuity of care and method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency. The EP communication plan failed to establish a procedure of sharing information and providing documents from its emergency plan to residents, family members or representatives. The findings included: 1. A. Record review of the EP manual provided by the facility the EP manual was not completed or updated to include the community based risk assessment, the facility risk assessment and associated strategies. The emergency plan and procedures did not include missing residents in their EP program. b. Review of the EP manual provided by the facility revealed the EP communication plan did not include process or procedure as to how the	E 001	provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. Presbyterian Home of Hawfields Response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Presbyterian Home of Hawfields reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures. E 001 Presbyterian Home of Hawfields will continue to strive to ensure that the emergency preparedness requirements are met through Federal, State and local emergencies preparedness guidelines. The Presbyterian Home of Hawfields will develop and maintain a comprehensive emergency preparedness program utilizing an all-hazards approach. The Emergency Preparedness Manual was updated by SDC (staff development coordinator) on 12/4/2019 to include: 1) Community based risk assessment, facility risk assessment and associated strategies. 2) Procedures for missing residents 3) Identification of the facility resident population 4) Policy and procedures for sheltered residents and staff who remain in the	

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E 001	Continued From page 2 facility would communicate and share information of its occupancy/ residents needs and facilities ability to provide assistance to authority having jurisdiction during an emergency situation. c. Review of the Communication Plan in the EP manual provided by the facility revealed no documentation as to how the facility ' s emergency plan would be shared with its residents, family members and/ or resident representatives. d. Review of the EP manual provided by the facility revealed the facility did not establish a criteria for its residents or staff who will be sheltered in the facility in case of emergency. The facility did not include a procedure for sheltering staff, residents and others who remained in the facility in an event when evacuation could not be executed. e. Review of the EP manual provided by the facility revealed lack of policies and procedures on how residents confidentiality would be maintained, how resident ' s medical information would be protected and how residents medical records will be available for continuity of care when residents were evacuated or transferred to other facilities during an emergency. f. Review of the EP manual provided by the facility revealed the communication plan did not include names and contact information of all staff working in the facility, name and contact information of residents ' physicians and names and contact information of other facilities including but not limited to its sister facilities that would be providing services and care to the residents during an emergency.	E 001	facility. 5) Policy and procedures to track residents and staff who were moved to other facilities during an emergency. 6) Policy and procedures to preserve resident information and protect resident confidentiality, secure and maintain availability of resident□s medical record. 7) Communication plan that includes information of staff, resident□s physician and other facilities, contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman. 8) Procedure for sharing information and medical documentation of its residents and other health care providers and facilities that would be providing continuity of care and method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having to authorities having jurisdiction during an emergency. 9) Procedure for sharing information and providing documents from its emergency plan to residents, family members or resident representatives. Emergency preparedness manual has been completed. Administrator, Staff Development Coordinator, Maintenance Manager and / or designee will re-educate staff on emergencies and preparedness. Administrator, Staff Development Coordinator, Maintenance Manager and / or designee will continue to monitor and update accordingly. Administrator, Staff Development	

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E 001	Continued From page 3 g. Review of the EP manual provided by the facility revealed the communication plan did not include contact information of the North Carolina Nursing Home Licensure and Certification Agency and contact information of LongTerm Care Ombudsman. h. Review of the EP manual provided by the facility revealed the EP communication plan did not include process or procedure that indicated how resident information and medical documents would be shared with other facilities and health care providers who would be providing continuity of care for residents who are sheltered by other facilities and at other locations in an emergency situation. i. Review of the EP manual provided by the facility revealed the EP communication plan did not include process or procedure as to how the facility would communicate and share information of its occupancy/ residents needs and facilities ability to provide assistance to authority having jurisdiction or "the Incident Command Center" during an emergency situation. j. Review of the Communication Plan in the EP manual provided by the facility revealed no documentation as to how the facility ' s emergency plan would be shared with its residents, family members and/ or resident representatives. k. Review of the Communication Plan and the EP manual provided by the facility revealed there was no documentation of the dates when the emergency drills, comprehensive or table discussion were completed.	E 001	Coordinator, Maintenance Manager and / or designee have a meeting set for 1/8/2020, with the Alamance County Emergency Management Coordinator to develop the emergency preparedness plan. This plan will entail a full-scale evacuation of the facility. Plans are for this drill to be done in spring (March or April 2020). Administrator, Staff Development Coordinator, Maintenance Manager and / or designee will continue conducting random practice fire drills. Evacuation drills will be conducted yearly with all staff and evaluation of the outcomes. The QAPI Committee will audit, at least quarterly to assure the Emergency Plan drills were completed and results will be recorded on an Audit tool titled Emergency Drills. The Emergency Plan will be reviewed at least annually to determine if updates or revisions are needed. Results will be reviewed and discussed in the quarterly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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E 001	Continued From page 4 During an interview on 11/8/19 at 4:00 PM, the Staff Development Coordinator(SDC) stated he was aware the facility needed a full complete EP plan designated to the facility. The training dates should be included in book with facility contact information, hospital resources, information for families, resident and visitors, staffing, state agency information, etc. SDC reviewed the EP manual and confirmed the EP program was incomplete. The SDC confirmed the initial EP manual was dated 6/18/18 and had not been updated. During an interview on 11/8/19 at 4:15 PM, the Maintenance Director stated there was no hard copy of the emergency preparedness plan available for staff of the facility. Maintenance Director was unable to provide training dates of when the comprehensive or table discussion for the emergency plan was completed. Maintenance Director was unsure how the tracking of residents and staff would be conducted during an emergency situation. Maintenance Director indicated that he had no access to resident ' s electronic records and it was the management decision on how these documents would be handled. Maintenance Director indicated that the names and contact information of facility staff were easily assessable from facility Human Resource personnel. Maintenance Director indicated that he was unaware that all contact information needed to be included. He further stated that he had no assess to the facility electronic medical records and it was the facility Administration who needed to decide as to how it would be included in the communication plan. Maintenance Director indicated that he had no documentation or	E 001		

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E 001	Continued From page 5 information that he could share with residents, family members or resident representatives related to emergency preparedness. Maintenance Director was unsure how the tracking of residents and staff would be conducted during an emergency situation. Maintenance Director indicated that he had no access to resident ' s electronic records and it was the management decision on how these documents would be handled. Maintenance Director indicated that the names and contact information of facility staff were easily assessable from facility Human Resource personnel. Maintenance Director indicated that he was unaware that all contact information needed to be included. He further stated that he had no assess to the facility electronic medical records and it was the facility Administration who needs to decide as to how it would be included in the communication plan. Maintenance Director indicated that he had no documentation or information that he could share with residents, family members or resident representatives related to emergency preparedness. During an interview on 11/8/19 at 4:30 PM, the Administrator reviewed the emergency preparedness manual and confirmed the emergency plan for the facility was incomplete. The Administrator also acknowledge the identified areas were missing needed to be included in a comprehensive emergency preparedness program. The Administrator also acknowledged all staff had not completed the EP training and all required training needed to be updated.	E 001		
F 000	INITIAL COMMENTS A recertification and complaint investigation	F 000		

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F 000	Continued From page 6 survey was conducted from 11/4/19 through 11/8/19. Event ID# 76T711. 1 of the 10 complaint allegations was substantiated resulting in deficiencies.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of	F 567		12/4/19

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F 567	Continued From page 7 the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to provide residents access to their personal funds after the facility ' s business hours and during the weekend for 3 of 3 residents reviewed (Resident #52, 46 and 28) for personal funds. Findings included: Review of the information handbook, included in the facility's admission packet, revealed the Personal Found section A, indicated that residents can withdraw from personal account Monday through Friday, between 8:30 AM and 4:45 PM, excluding holidays. 1. Resident #52 was admitted on 8/3/17. Review of her recent quarterly Minimum Data Set assessment, dated 8/30/19, revealed her intact cognition. The resident ' s diagnoses included psychotic disorder, diabetes mellitus, depression and anxiety. On 11/4/19 at 11:30 AM, during an interview, Resident #52 indicated that she did not have access to her personal funds account on the weekends. The resident mentioned, she was told by the staff, she could only get money from her account during business office hours. She continued that on weekends she received money	F 567	F 567 Presbyterian Home of Hawfields will strive to ensure residents will have access to their personal funds the same day, regardless of time, for amounts less than $100.00 ($50.00 for Medicaid Residents). Three banking days for amounts of $100.00 ($50.00 for Medicaid Residents) or more. Business Office personnel, and /or designee apologized to Resident #52, 46 and 28 and explained the change in policy for obtaining funds after hours and on weekends as outlined below. All other residents with personal fund accounts managed by the facility will be interviewed to determine if they had been provided funds upon request. The facility policy was reviewed and revised to provide resident□s access to their personal funds after the facility□s business hours and on weekends. Residents and resident family members were made aware of this revision in the policy through □The Chatterbox□, which goes out to residents / family members	

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F 567	Continued From page 8	F 567		

from her relatives but should not "bother them with that question". The resident preferred to have an access to her money on weekend.

2. Resident #46 was admitted on 4/5/18. Review of her recent quarterly Minimum Data Set assessment, dated 8/23/19, revealed her severely impaired cognition. Resident diagnoses included dementia, depression and malnutrition.

On 11/4/19 at 12:15 PM, during an interview, Resident #46 indicted that she could not get her money on weekend. On weekdays, she could come to the front desk to request money. On weekend, the facility did not have money available for residents.

3. Resident #28 was admitted on 11/28/18. Review of her recent quarterly Minimum Data Set assessment, dated 8/9/19, revealed her moderately impaired cognition. The resident ' s diagnoses included malnutrition, depression and anxiety.

On 11/4/19 at 12:30 PM, during an interview, Resident #28 indicated that she preferred to take her money when she needed, including evening hours and weekends. She was told by the staff that the facility could access her personal fund account during business hours only. The resident continued that she felt it would be "reasonable to receive money on weekends".

On 11/6/19 at 3:00 PM, during an interview, Business Office #1 indicated that money from personal fund account was available for residents during business hours. The residents were notified about it at the time of admission. The business office had petty cash boxes to keep

monthly.

" Residents will have access to their personal funds the same day, regardless of time, for amounts less than $100.00 ($50.00 for Medicaid Residents). Three banking days for amounts of $100.00 ($50.00 for Medicaid Residents) or more.
" The facility will keep $ 200.00 in a petty cash box located in central location for specific nursing employees, who have been granted computer access to resident fund balances, to dispense funds to residents when requested after business hours and on weekends.
" The Nursing employee will record the amount of money dispensed, to whom and the date on a Quality Assessment Audit tool named.
" The Business Office Manager and / or designee will audit petty cash fund box by the next business day to assure the transactions taken were accurate.

At least 5 residents who have personal funds managed by the facility will be interviewed by the Business Office personnel, Social Worker and / or designee to determine if they had access to their personal funds the same day, regardless of time, for amounts less than $100.00 ($50.00 for Medicaid Residents). The interviews will be completed monthly for three months. The results will be recorded on a Quality Assurance audit tool titled Personal Fund Access After Business Hours/Weekends. Results will be reviewed and discussed in the quarterly Quality Assurance Performance

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F 567	Continued From page 9 money for residents. Per resident ' s request, the business office could check resident ' s account, and if the resident had enough money on the account, it could be withdrawn between 8:30 AM and 4:45 PM during the week. At times, the business office was open until 5 PM, but once the business office staff had left the facility, nobody had access to residents ' personal fund accounts. She confirmed that money from personal account was not available to residents on the weekend. On 11/6/19 at 3:10 PM, during an interview, Business Office #2 indicted per the admission book, the residents had access to their personal fund account during the business hours only. The business office person mentioned that all the residents/representatives signed the admission documents, including notification of the personal fund account access procedure. On 11/7/19 at 10:00 AM, during an interview, the Administrator confirmed that residents had no access to their personal fund accounts after the normal business hours, including weekends.	F 567	Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 600 SS=G	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.	F 600		12/4/19

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F 600	Continued From page 10 §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 resident, staff and family interviews and record review, the facility failed to protect a resident from verbal abuse by a contracted therapist for 1 of 3 residents reviewed for abuse (Resident #69). The resident stated the way the therapist spoke to her and about her to her family member made her feel like everyone hated her, afraid to say anything, terrible and humiliated. The resident chose to be discharged from the facility and to finish her therapy at home because she did not want to be treated badly by anyone. The findings included: Resident #69 was admitted to the facility on 9/20/19. The diagnoses included cellulitis of left lower limb, low back pain, rheumatoid arthritis and depression. Care plan dated 9/20/19 identified Resident #69 had as having an activities of daily living (ADL) self-care performance deficit. The goal was for the resident ' s current level to improve. Interventions included 1-person assistance with all activities of daily living. The most recent Minimum Data Set (MDS) dated 9/28/19, specified Resident #69 ' s cognition was intact, and she was totally dependent upon staff for all activities of daily living. The facility ' s 24-hour report submitted to the	F 600	F 600 It is the policy of Presbyterian Home of Hawfields to assure the residents have the right to be free from abuse. When Resident # 69 voiced the allegation, the following actions were taken: 1) The Director of Nursing initiated an investigation which included speaking to Resident # 69 and Resident #69□s family member. 2) A 24-hour report was completed by the Director of Nursing and submitted to the State Agency on 9/26/19. 3) The Director of Nursing spoke with PT #1 about the incident and sent him home, 4) After a full investigation had been conducted, the findings were reported on a 5-day investigation report and submitted to the State Agency on 10/1/19 by the Director of Nursing Resident #69 left the facility on 9/30/19, per her request. One on one Customer Service training using The 4 Pillars of Service. The Healthcare Warriors Customer Service Standards, was provided to PT#1 by the Director of Nursing with return demonstration of scenarios mimicking resident to staff interaction / conversations.	

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F 600	Continued From page 11 state agency dated 9/26/19, specified that Physical Therapist (PT) #1, who was a contracted employee, stopped in Resident #69 ' s room. The resident ' s family member, who was in the room, stated the therapist told the resident she was now a two person assist because she got somebody in trouble yesterday. The family member told the therapist not to talk or yell at Resident #69 like that. The therapist told the family member to take Resident #69 to another facility that she doesn't need to be here anyway. The report specified, Resident #69 stated she did not want the therapist in her room anymore and she wanted to do therapy at home. Resident #69 stated it hurt her feelings and she had tears in her eyes. The facility ' s 5-day report submitted to the state agency dated 10/1/19, specified PT #1 stated he was never rude to anyone. The report noted, Resident #69 was upset and at times still talked about the interaction with the therapist. The report ' s "summary of facility action" noted, the therapist was spoken to and sent home. Additionally, both the resident and family member were spoken to about the incident. The family member stated the therapist could have approached the room and situation better. The report noted, that It was decided it was more of the therapist ' s approach. Re-educating staff on abuse and approach would be implemented, making sure staff were knocking before entering rooms and to use certain tones when speaking to a visitor. During a telephone interview on 11/6/19 at 4:08 PM, Resident #69 stated that she put her call light on and was waiting to be changed when a man came to the room, who she thought was with therapy. Resident #69 stated, "I told him I was not ready for therapy because I was waiting to be	F 600	The Director of Nursing and Staff Development Coordinator and / or designee will interview all residents who have been on PT#1□s case load for the past 2 months to determine if the therapist has ever spoken to them in a manner that was offensive, hurtful, or abusive. The other therapists employed / contracted by the facility will also be interviewed to determine if they have witnessed or heard allegations of PT#1 speaking to residents in an offensive, hurtful, or abusive manner. " After the Administrator and Director of Nursing conducted an in-depth analysis of the mechanisms, policies, training of staff relative to Abuse prevention on 12/2/19 it was determined that all contracted therapy staff would be required to attend Abuse Training upon hire and annually as is the policy for all other employees. The Policy was revised by Administrator and Director of Nursing to include Contract Therapy Staff. Other specifics include: " All therapy staff were in-serviced on the Abuse and Neglect Policy and Procedure on 12/3/19 by Director of Nursing. " Education and training on Abuse will continue to be provided to all staff that will now include contract therapy staff upon hire during the facility orientation. The Abuse and Neglect Policy and Procedure will continue to be given to all new employees and contract therapy staff, abuse policy and procedures will be	

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F 600	Continued From page 12 changed. My family member was with me and he began telling me that two people had to get me up because I had gotten a staff in trouble and lied. He was yelling and screaming that I got staff in trouble, I felt bad and that it was a problem for telling my family member about what happened to me. I felt like everyone hated me and was against me, it was terrible. I was afraid to say anything after that." Resident #69 further stated, the therapist said to her family member that "she (Resident #69) doesn ' t need to be here anyway." The resident explained, "I felt terrible and humiliated. I did not want to do anymore therapy at that place, because he made me feel terrible and accusing me of getting staff in trouble for reporting what happened to me. I would have stayed but I didn't want to be treated badly by anyone, so I asked my family member to get me out of there and let me do therapy at home." Review of PT #1 ' s statement dated 9/26/19 read in part: while walking down E-Hall rehab gym around 7:40 AM I noted a call light on in Resident #69 ' s room. When I walked back to E-Hall around 8:00 AM I noted the same call light on. I entered the room for customer service to educate the resident on the reason there was a delay in the nurse aide responding to her call bell was because on the previous day she reported an incident about a staff member, who was working with her, and got the staff member in trouble. So, it was decided two staff members needed to assist with her care instead of only 1 staff member. PT #1 ' s written statement specified the resident ' s family member said to him, "it is a disgrace the way residents are treated around here" and PT #1 reminded her that "she has a right to take her mother elsewhere."	F 600	posted throughout the facility visible to employees, contract staff, families and residents, and the policies and procedures will be given to all employees and contract therapy staff on a quarterly basis and at the Annual Employee in-service. The Director of Nursing and/or designee will observe interaction between therapy staff and residents for at least 5 residents during facility rounds daily times 5 days, then weekly times 3 weeks, then monthly times 1 month. The results will be recorded on a Quality Assurance audit tool titled Observation of Therapy Interaction. Results will be reviewed and discussed in the quarterly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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During an interview on 11/7/19 at 10:55 AM, PT #1, confirmed he did go into Resident #69 ' s room on 09/26/19 and told the resident and the family member that the resident now had to have two staff to provide care because the staff had gotten in trouble for doing their job when working with Resident #69. The PT explained, the conversation did get intense between he and the family member. The PT stated, "I was a bit snotty when I was walking out of the room and the family member told me to come back. I am being honest all I wanted to do was get out of the room because I was a bit mad." The therapist stated, "It was not my intent to verbally abuse the resident and to disclose any part of the investigation or make statements about the resident leaving and going elsewhere." PT #1 specified, "I know now that I should have handled the situation much differently and it was not part of the policy or abuse training to share or discuss any part of an investigation." The therapist further explained, "I know I did not scream or yell at either of them and should not have said the things I said or in the way I said them. I did speak with the administrator and the director of nursing (DON) following the incident and they all have informed me that I should have handled things differently." The PT specified, "I realized after the fact that how things happened it could be perceived as verbal abuse when that was not my intent."

During a telephone interview on 11/6/19 at 3:39PM, the family member of Resident #69 stated, on 9/26/19, in the morning she was visiting with Resident #69 to make sure she was alright. When she arrived at the facility Resident #69 turned on her call light at a little after 8:30 AM. PT #1 came to the room and we were thinking he was there to do therapy with Resident

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#69. The family member stated that Resident #69 told him she could not do therapy right then because she was waiting to be changed. PT #1 was very rude, aggressive and angry. PT #1 told us Resident #69 got staff in trouble, and he was yelling and screaming at her. The family member stated, Resident #69 was upset and was crying that he came in and accused her of getting staff in trouble. The family member explained, that she told PT #1 that he could not talk to Resident #69 in that tone of voice or accuse her of getting anyone in trouble. He was making Resident #69 feel bad and upset. PT #1 was so rude and disrespectful. He was very disrespectful and stated, "if we didn't like it here, we could take _____(Resident #69) somewhere else." The family member said, Resident #69 was crying and felt like she had done something wrong and wanted to leave before her therapy was completed at the facility. I had never seen anyone come and talk to a resident like that making Resident #69 feel so small. The family member stated, "This should never happen to anyone else." She said, she took Resident #69 home for her safety and wellbeing because she was too scared to stay. The family member stated, she felt Resident #69 was verbally abused by PT #1. The resident ' s family member stated, "A therapist should not be talking to anyone like that." The way he was talking to (Resident #69) accusing her of getting someone trouble was appalling."

During an interview on 11/6/19 at 2:30 PM, the Director of Nursing stated on 09/26/19 the family member of Resident #69 reported that PT #1 came into Resident #69's room and was yelling and screaming inappropriately at her and making accusations that Resident #69 had gotten a staff

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F 600	Continued From page 15 person in trouble and was making statements if her and Resident #69 didn't like it at the facility to take the resident somewhere else. The DON stated she did abuse/neglect in-service with direct nursing staff, therapy was not involved. The administrator informed the DON he would handle communication and action for the therapy staff. During an interview on 11/7/19 at 12:40 PM, the Administrator indicated PT #1 was a contract employee at the facility for many years. The administrator stated, the PT should not have made any inappropriate or accusatory statements about Resident #69. The administrator further stated following the incident PT #1 was sent home and when the staff discussed the situation, it was not brought to his attention as verbal or mental abuse toward the resident. The administrator stated the therapist should have followed the abuse/neglect policy to get staff assistance for the resident either from an aide or nurse. There should not have been any verbally abusive dialogue between PT #1 to the resident or the family member. He stated the DON reported the incident to the state agency, but he was unaware of any further action taken after that point, since the resident discharged from the facility. The administrator stated, "I didn't think of what was said as verbal abuse or mental abuse. I just kind of said to therapist to change your approach on how you deal or speak with resident."	F 600		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and	F 867		12/4/19

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F 867	Continued From page 16 assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to effectively maintain implemented procedures and effectively monitor these interventions that the committee put into place in October of 2018. There were for two deficiency, which were originally cited on 10/25/18 during the recertification survey and on the current recertification and complaint survey (11/8/19). The repeated deficiencies were in the areas of Emergency Preparedness (E0001) and Quality Assurance and Performance improvement (QAPI)/ QAA improvement activities (F 867). The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective quality assurance program. Findings included: This tag is cross-referred to: 1. During the recertification survey on 11/8/19, E0001 was cited. Based on record reviews and staff interviews the facility failed to have comprehensive emergency preparedness (EP) plan. The EP manual failed to: include community-based risk assessment, facility risk assessment and associated strategies, the emergency plans and procedures did not include missing resident in their EP program failed to identify its resident population. The EP did not include policy and procedures for sheltered residents and staff who remained in the facility,	F 867	F867 QAPI/QAA Improvement Activities Presbyterian of Hawfields strives to implement appropriate plans of action to correct identified quality deficiencies as part of the activities of the Quality Assurance Committee. E001: Presbyterian Home of Hawfields will continue to strive to ensure that the Emergency Preparedness requirements are met through Federal, State, and Local emergency preparedness guidelines. The Emergency Plan Manual was updated by SDC on 12/4/2019 to include: 1) Community based risk assessment, facility risk assessment and associated strategies. 2) Procedures for missing residents 3) Identification of the facility resident population 4) Policy and procedures for sheltered residents and staff who remain in the facility. 5) Policy and procedures to track residents and staff who were moved to other facilities during an emergency. 6) Policy and procedures to preserve resident information and protect resident confidentiality, secure and maintain availability of resident's medical record. 7) Communication plan that includes information of staff, resident's physician and other facilities, contact information of the State Licensing and Certification	

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F 867	Continued From page 17 policy and procedures to track residents and staff who were moved to other facilities and policy and procedure for staff, residents and others who remained in the facility during an emergency. The EP did not include policy and procedures to preserve resident information and protect resident confidentiality, secure and maintain availability of resident ' s medical records. The communication plan failed to include contact information of staff, resident ' s physician and other facilities, contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman. The plan failed to include procedure of sharing information and medical documentation of its resident with other health care providers and facilities that would be providing continuity of care and method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency. The EP failed to establish a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives. During the annual recertification survey in October 2018 the facility was cited for failure to have comprehensive emergency preparedness (EP) plan. The EP manual failed to: include community-based risk assessment, facility risk assessment and associated strategies, the emergency plans and procedures did not include missing resident in their EP program failed to identify its resident population. The EP did not include policy and procedures for sheltered residents and staff who remained in the facility, policy and procedures to track residents and staff who were moved to other facilities and policy and procedure for staff, residents and others who remained in the facility during an emergency. The	F 867	Agency and State Long Term Care Ombudsman. 8) Procedure for sharing information and medical documentation of its residents and other health care providers and facilities that would be providing continuity of care and method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having to authorities having jurisdiction during an emergency. 9) Procedure for sharing information and providing documents from its emergency plan to residents, family members or resident representatives. The facility Quality Assessment and Assurance Program (QAA) was re-assessed by the Administrator and Staff Development Coordinator on 12/4/2019. The following revisions were made and approved by the Medical Director and QAA committee members: • The agenda was revised to include the reporting of audit results for cross referenced citation E001 Establishment of Emergency Program (EP). • The agenda was also revised to include an annual review of and updates to the Emergency Program. Results of audits related to E001 outlined above will be reported to the Quality Assessment and Assurance Committee by the Staff Development Coordinator and / or designee on a monthly basis beginning with the next meeting scheduled for Monday 12/9/2019.	

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F 867	Continued From page 18 EP did not include policy and procedures to preserve resident information, protect resident confidentiality, secure, and maintain availability of resident ' s medical records. The communication plan failed to include contact information of staff, resident's physician and other facilities, contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman. The plan failed to include procedure of sharing information and medical documentation of its resident with other health care providers and facilities that would be providing continuity of care and method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency. The EP failed to establish a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives. 2. During the recertification and complaint survey on 11/8/19, F867 was cited. Based on observations, record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to effectively maintain implemented procedures and effectively monitor these interventions that the committee put into place in October of 2018. During the recertification survey on 10/25/18, the facility was cited for failure to effectively maintain implemented procedures and effectively monitor the interventions that the committee put into place in September 2017. This was for three recited deficiencies, which were originally cited on 9/21/17 during the recertification survey and on the current recertification survey. The deficiencies were in the area of, Homelike Environment, Food	F 867	The QAA committee will continue to analyze trends/possible causal factors and act accordingly to resolve instances of non- compliance.	

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Procurement and Quality Assessment and Assurance improvement. The continued failure of the facility during three federal surveys of record show an isolated pattern of the facilities inability to sustain an effective quality assurance program.

On 11/8/19 at 4:00 PM, during an interview, the Staff Development Coordinator (SDC) stated he was aware the facility needed a full complete EP plan designated to the facility. The training dates should be included in book with facility contact information, hospital resources, information for families, resident and visitors, staffing, state agency information. SDC reviewed the EP manual and confirmed the EP program was incomplete. The SDC confirmed the initial EP manual was dated 6/18/18 and had not been updated.

On 11/8/19 at 4:15 PM, during an interview, the Maintenance Director stated there was no hard copy of the emergency preparedness plan available for staff of the facility. Maintenance Director was unable to provide training dates of when the comprehensive or table discussion for the emergency plan was completed. Maintenance Director was unsure how the tracking of residents and staff would be conducted during an emergency situation. Maintenance Director indicated that he had no access to resident ' s electronic records and it was the management decision on how these documents would be handled. Maintenance Director indicated that the names and contact information of facility staff were easily assessable from facility Human Resource personnel. Maintenance Director indicated that he was unaware that all contact information needed to be included. He further stated that he had no assess to the facility

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F 867	Continued From page 20	F 867		

electronic medical records and it was the facility Administration who needed to decide as to how it would be included in the communication plan. Maintenance Director indicated that he had no documentation or information that he could share with residents, family members or resident representatives related to emergency preparedness. Maintenance Director was unsure how the tracking of residents and staff would be conducted during an emergency situation. Maintenance Director indicated that he had no access to resident ' s electronic records and it was the management decision on how these documents would be handled. Maintenance Director indicated that the names and contact information of facility staff were easily assessable from facility Human Resource personnel. Maintenance Director indicated that he was unaware that all contact information needed to be included. He further stated that he had no assess to the facility electronic medical records and it was the facility Administration who needs to decide as to how it would be included in the communication plan. Maintenance Director indicated that he had no documentation or information that he could share with residents, family members or resident representatives related to emergency preparedness.

On 11/8/19 at 4:30 PM, during an interview, the Administrator reviewed the emergency preparedness manual and confirmed the emergency plan for the facility was incomplete. The Administrator also acknowledge the identified areas were missing needed to be included in a comprehensive emergency preparedness program. The Administrator also acknowledged all staff had not completed the EP training and all required training needed to be updated.

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