STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345143	A. BUILDING _____ B. WING _____	C 08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CARE AND REHABILITATION CENTER	900 W DOLPHIN ST SILER CITY, NC 27344

(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
F 223 SS=J	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on resident observations, staff interviews, medical director interview and record review, the facility failed to prevent staff from physically abusing 2 of 8 sampled residents. During care, 2 nursing assistants (NAs #1 and # 7) " rough handled " 2 residents (Resident #2 and #8). The facility failed to prevent staff from verbally abusing one of 8 sampled residents (Resident#8). Findings include: Immediate jeopardy began on 5/11/11 with Resident #2 and was identified on 8/3/11 at 10:56 a.m. for Resident #2 and #8. Immediate Jeopardy was removed on 8/4/11 at 7 p.m. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. 1. Resident #2 was admitted to the facility on 4/11/2011. The resident's diagnoses included, but were not limited to, Alzheimer' s disease, dementia with behavioral disturbances, muscle weakness and altered mental status.	F 223	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Siler City Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. Date of Compliance: August 26, 2011 F 223 1. Resident # 2 was assessed by the Director of Nursing Services (DNS) on 5/17/11, a bruise on the chest was noted with no other findings and documented on skin assessment sheet. CNA, (NA #1), was suspended on 5/18/11 pending investigation. A 24 hour report was completed on 5/17/11 and sent to Health Care Personnel Registry by Director of Nursing Services. 5 day investigation report was completed on 5/24/11 and sent to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	8/26/11

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

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F 223	Continued From page 1 The Initial Care Plan dated 4/11/11 showed that a plan of care was initiated in the area behavior. Resident exhibited behaviors of verbal and physical aggression by being combative during care, refusing medications, and refusing to go to bed. The behavior/mood interventions read, " Approach the resident slowly and from the front. Do not argue with resident; involve family when needed. Encourage resident to call upon staff for help in coping. Remove to a quiet area. Spend time with resident and reassure resident of personal safety and stay with resident during periods of anger if appropriate or if resident wishes. Report any change in mood or behavior to charge nurse or DNS (Director of Nursing Services) immediately. Allow resident time to respond to directions or request. Be sure you have the resident's attention before speaking or touching. Give resident a clear, concise explanation of anything about to occur, avoid information overload since the angry, aggressive resident cannot assimilate many details. If strategies are not working, leave resident and re-approach in 10 minutes. " Resident #2 's Admission Minimum Data Set (MDS) dated 4/18/11, revealed he had short/long-term memory problems. The resident's decision-making skills were moderately impaired. Resident was hard of hearing in both ears. He had exhibited signs and symptoms of delirium, which fluctuate, delusions, and other behavioral symptoms not directed to others. The resident required extensive assistance from two people for bed mobility, transfers, dressing, and personal hygiene. He was totally dependent for toileting and bathing. The resident was listed as	F 223	Health Care Personnel Registry by Director of Nursing Services CNA, (NA #1) was terminated post investigation on 5/24/11. Resident's physician was notified on 5/17/11 with no change in orders. Family was notified on 5/17/11 by Director of Nursing Services. CNA (NA#2) received a final written warning regarding failure to report alleged abuse immediately on 5/21/11 and was re-educated on reporting and abuse policy and procedures by the Director of Nursing Services. The Registered Dietician was suspended on 8/2/11 pending further investigation. Registered Dietician returned to work on 8/09/11 post re-education on abuse policy and procedure by Regional Director of Clinical Operations. Licensed nurse, (SN #1), was suspended on 8/3/11 pending further investigation. SN #1 was terminated on 8/16 /11. CNA (NA#9) was suspended on 8/4/11 pending further investigation. NA#9 returned to work on 8/13 /11.	

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F 223	Continued From page 2 incontinent of bowel and bladder. The healthcare personnel registry 24-hour initial report dated 5/17/11 read in part, " [resident ' s initial] incident date: 5/11/11, allegation description: allegation made that employee (NA # 1) forced resident to sit down forcefully pushing resident in chest with hands. " The healthcare personnel registry 5-day report dated 5/24/11, read in part, " Witness stated that on 5/11/11, she witnessed CNA (NA#1) in resident ' s face hollering at him, and then she jerked him down by pulling on his upper arm. When the resident stood back up, she pushed him down with both hands on his chest. On 5/12/11, the CNA (NA#1) taking care of the resident reported to the nurse that the resident had a bruise on his chest from sternum to breast line. After speaking with the witness, the accused CNA (NA#1), CNAs on the hall, and hall nurses, it was determined that the allegation was substantiated and the accused CNA was terminated. The resident had a bruise to chest and no other injuries. Resident has advanced dementia and does not recall incident. The accused CNA (NA#1) was suspended during the investigation, and after completion she was then terminated. " During a phone interview on 8/2/11 at 12:30 p.m. with NA #2 (the aide who witnessed the alleged abuse) she stated that " (Resident #2) [name of the resident] used to be on the 500 Hall and he was moved to the 300 Hall. While he was on the 300 Hall, he became combative and disoriented. On 5/11/11 while breakfast was going on, I heard fussing in his room. I pushed the door and saw	F 223	On 7/19/11 an allegation of abuse was found on a written note under the Director of Nursing's door at approximately 3:15 pm by the Director of Nursing Services. The actual event allegedly occurred on 7/17/11 which resulted in the center submitting a late report of alleged abuse. The alleged abuse of Resident (#8) was assessed for injuries with no finding of physical injury on 7/19/11 by Director of Nursing Services. CNA, (NA#7), was suspended on 7/20/11 pending investigation. The 24 hour report was sent to Health Care Personnel Registry on 7/20/11 by the Director of Nursing Services. CNA, (NA#7), was terminated post investigation on 7/25/11 for abuse. The 5 day report investigation report was completed and sent to Health Care Personnel Registry on 7/27/11 by the Director of Nursing Services substantiating the abuse. CNA (NA#8), was suspended on 7/19/11 pending investigation and was terminated on 7/25/11 for not reporting abuse timely.	

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F 223	Continued From page 3 [NA #1] in the resident ' s face hollering and telling him to sit down. The resident stood up and she pulled him down by his upper arm. The resident immediately stands back up and she pushed him down forcefully with the palm of both hands. She pushed him hard enough that the wheelchair rolled back against the wall. [NA #1] saw me and shoved the door in my face. During an interview on 8/2/11 at 10:00 a.m. with SN #1, who was assigned to the resident the day of the alleged abuse and was the first staff nurse the bruise was reported to, stated that at " [NA #1] went to do care on [Resident #2] and she came and got me immediately and showed me the bruise on [Resident #2 ' s] chest. It was a large black and purplish bruise covering one nipple to another nipple. She further stated that it was the same day (5/11/11) when he was moved back to the 500 Hall. SN#1 indicated that she did not witness the abuse. During a phone interview on 8/2/11 at 12:00 noon with NA #1, who allegedly caused the bruising to Resident #2's chest, she stated that " the Director of Nursing called me at home on 5/17/11 and told me that I should make an appointment to come and see her at 3:30 p.m. on 5/18/11, because someone made an allegation about me on 5/11/11. I told her that I did not do care on the resident on 5/11/11. On 5/12/11 at 11:00 a.m., I took the resident ' s shirt off to do a.m. care, and I saw a large, black-purplish bruise all over his chest, from one nipple to another, going down into his upper stomach. I went and got my supervisor [Staff Nurse (SN) #1], and she came and look[ed] at it, and she got the nursing supervisor. They call me back on May 24th and substantiated the investigation and let me go. "	F 223	2. Nursing Management completed a center wide skin re-assessment on residents in-house on 8/3/11 and no identified injuries of unknown origin were found. Residents were interviewed for any allegation of abuse beginning 8/4/11 using the ambassador rounds by department heads. 3. Re-education of the staff was completed following the abuse allegation of Resident (#2) on 5/26/11, 5/31/11, and 6/1/11 by the Director of Nursing Services. 109 staff members attended. Re-education included types of abuse, who abuse is reported to, timeline for reporting, how to care for residents that resist care and how to let an agitated resident have time to calm and then re-approach in a timeline. Re-education of all facility staff was started on 8/3/11 and included types of abuse, who abuse is reported to, timeline for reporting, how to care for residents that resist care and how to let an agitated resident have time to calm and then re-approach in a timely manner. This re-education was conducted by the Director of Nursing Services or designee; employees who	

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F 223	Continued From page 4 When asked by the surveyor what happened on 5/11/11, she stated that nothing happened. During an interview on 8/2/11 at 11:00 a.m. and again on 8/4/11 at 11:30 a.m. with the Director of Nursing (DON), she stated that the resident was moved on 4/29/11 to the 300 Hall. Upon being moved, the resident became very agitated, more verbally abusive, and loud, so he was moved back to the 500 Hall on 5/12/11. The DON stated " it was reported to me on 5/17/11 by [NA #2] that [NA #1] abused Resident #2. " She further stated that on 5/11/11 while NA #1 was providing care to Resident #2, NA #2 heard " fussing " in Resident #2 ' s room; NA #2 entered the room and saw NA #1 forcefully push the resident down in the wheelchair by pulling on his upper arm. The DON further stated that NA #2 reported that when the resident stood back up, the aide pushed him down in his wheelchair with both hands and the wheelchair rolled into the wall. The DON further stated that on 5/17/11, " I assessed the resident and he had a purplish-yellowish large bruise at the center of his chest from one nipple to another nipple; no other bruises or redness was noted. The resident denied pain. The DON further stated that the resident had a fall on 5/11/11 and the incident report stated he fell on his bottom with no injury. She added, " When I assessed the resident on 5/17/11, the bruise was from nipple to nipple, large, and encompassed the entire chest. It was impossible for the resident to fall on his bottom and sustain a bruise to his chest. " The DON stated that " I felt [NA #1] had hit the resident willfully and put him in the chair. " When asked by the surveyor what evidence she used to substantiate the abuse allegation, the DON stated, " I had noticed earlier in the week that	F 223	were not scheduled will complete re-education prior to returning to work. 126 employees were re-educated on the abuse, neglect and misappropriation policy and procedure as of 8/3/11. The re-education also includes where the phone numbers are posted for the Administrator, Director of Nursing Services, the Sun Quality Compliance number and the contact information for the Regional Human Resources for immediate reporting of the abuse should the caller want to remain anonymous. The contacts are available 24/7. Re- education is on-going and staff must attend prior to being allowed to return to work. Re-education of staff on the abuse policy that addressed residents that resist care was completed on 8/10/11 to staff by Regional Director of Clinical Operations and on 8/17/11 by the Staff Development Coordinator. Re-education on abuse will be conducted 2 more times weekly with the Ombudsman of Chatham County conducting re-education on 8/24/11. Abuse re-education will continue monthly times 3 months.	

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F 223	Continued From page 5 [NA #1] had spoken loudly to [Resident #2], out in the hallway, and I came out of my office when I heard the disturbance and asked [NA #1] if everything was ok. [NA #1] stated, ' everything is fine; I ' m just frustrated. ' " When asked what the DON had done about NA#1 behavior she indicated she offered to move the aide off Hall 300 and/or change the assignment. NA #1 told her she would be off the next day and everything was fine. A review of the facility ' s daily staffing revealed NA #1 and NA #2 were assigned and worked on the 300 Hall on 5/11/11 during the 7-3 shift. A review of the facility ' s daily staffing revealed NA #1 worked on the 300 Hall on 5/12/11 during the 7-3 shift. During a phone interview on 8/4/11 at 12:55 p.m. with the medical director (MD), he stated " I was over at the facility on 5/19/11 when it was brought to my attention that an aide allegedly abused [Resident #2]. When I saw the chest, it was yellowish; the bruise was several days old, maybe 1 week old. 2. Resident #8 was admitted to the facility on 9/18/07. The resident's diagnoses included, but were not limited to, Parkinson ' s disease, osteoarthritis, glaucoma, history of muscular disorder and psychosis. The Care Plan dated 6/13/11 showed that a plan of care was initiated in the areas of self-care deficit and impaired mobility, cognition, and behavior. According to the plan, " Resident exhibits behaviors of verbal, physical aggression,	F 223	The Department heads are assigned specific rooms to make rounds and complete interviews to insure residents are monitored for safety and well being. Non-interviewable residents' family members will be interviewed as they are in the center and alert/oriented room-mates will be interviewed as well. The ambassador rounds questions include: have you been mistreated by staff and do you have concerns regarding missing property. Any concerns/allegations will be reported immediately to the Administrator/designee with investigation starting immediately. 4. Ambassador rounds findings will be reviewed at the morning meeting with the department heads and Administrator present. Administrator will assure that concerns have been delegated to the staff for interventions and solutions. Findings will be monitored monthly at the Performance Improvement Committee meeting for 3 months. The Director of Social Services and the Director of Nursing will complete random interviews with 5 staff members on each shifts weekly x 4 weeks, questions will include types of	

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F 223	Continued From page 6 easily agitated, slapping and cursing staff. " The behavior/mood interventions read, " Allow resident time to respond to directions or request, (d/t (due to) dementia more time to absorb instruction). Do not argue with resident; report any change in mood or behavior to charge nurse immediately. Report any verbal or physical, sexual or aggressive expression to the charge nurse immediately. Psychiatric consult as needed. " Resident #8 ' s minimum data set (MDS) dated 6/28/11 revealed she had short/long-term memory problems. The resident ' s decision-making skills were moderately impaired. She had exhibited signs and symptoms of delirium present, which fluctuate, and physical and verbal behavioral symptoms directed towards others, and other behavioral symptoms not directed to others. The resident required extensive assistance of two people for bed mobility, transfers, dressing, and personal hygiene. She was totally dependent for toileting and bathing. A review of the note that NA # 8 (the witness of the abuse) left under the Director of Nursing ' s (DON) door dated 7/17/11 read, " on July 17, 2011, I worked on the 100 Hall with [name of the aide (NA#7)]. We were in [Resident #8 ' s] room. [Resident #8] became combative and hit [name of the aide], then [name of the aide] grabbed [Resident #8 ' s] arm and punched her left upper arm and held her hands down. " The healthcare personnel registry 24-hour initial report dated 7/20/11 read in part, " allegation	F 223	abuse, where phone numbers are posted, who is the abuse coordinator and reporting of abuse immediately.. . A report will be submitted to the Performance Improvement Committee monthly for 3 months. Date of Compliance: August 26, 2011	

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F 223	Continued From page 7	F 223		

description: CNA (NA# 8) reported that on Sunday 7/17/11 she worked with the accused CNA (NA# 7). She (NA#8) stated the accused CNA hit a resident in the shoulder while providing care. She also states that the accused CNA told the resident she did not belong in this facility, that she belongs in mental institution. "

The healthcare personnel registry 5-day report dated 7/27/11 read in part, " the CNA who was in the room with the accused CNA at the time of the incident stated that while putting the resident to bed, the resident became combative. When this happened, the CNA stated that the accused CNA hit the resident in the arm and grabbed her hand. The accused CNA stated that while putting the resident to bed, she [the resident] became combative. She (NA#7) states the resident swung at her, and then she grabbed the resident arm to keep her from hitting her. The resident has dementia and is confused. She was unable to answer questions about the injury. The investigation determined that the allegations were substantiated and the CNA was terminated. "

During a phone interview on 8/4/11 at 10:40 a.m., with NA #7, she stated, " I went to help NA #8 put Resident #8 to bed. " NA #7 further stated, " I started to put on [Resident #8 ' s] night gown, and the resident hit me. I caught her hand and held it for while, and I told her not to hit me. I was not verbally abusive to her. I did not tell my supervisor because I do not think it was important. " NA #7 further stated that, she worked 7/18/11 and 7/19/11, but Resident #8 was not assigned to her. She added, " I only had her that night because I went to help [NA #8]. "

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F 223	Continued From page 8 During an interview on 8/4/11 at 11:00 a.m., with the DON, she stated that the alleged abuse occurred on 7/17/11. " The aide put a note under my office door. The DON further stated that " the note stated that one aide was assisting another aide with getting a resident to bed. The resident became combative, and the accused aide became physically and verbally abusive to the resident. The DON added that on 7/19/11, " I assessed the resident for any bruising secondary to alleged abuse. I completed a full-body assessment: no bruising was found. I assessed the left upper shoulder, both arms, no bruising or redness was noted. The DON further stated that " I substantiated the allegation because the aide who allegedly physically and verbally abused (Resident #8) told me that when the resident became combative she held the resident ' s hand for a while and she also made a statement that ' that type of resident does not belong in this facility. ' " That statement is consistent with the witness ' s statement. During an interview on 8/11/11 at 10:05 a.m., with NA #8 who witnessed the abuse, she stated that on 7/17/11, " a little after dinner I requested help from [NA #7]. We lifted Resident #8 from her chair to the bed with the lift. The resident became combative. The resident hit [NA #7], and [NA#7] grabbed the resident ' s shoulder and punched her in the shoulder and held the resident ' s arm in a restrained position. She looked at the resident and told her that she ' does not belong in the facility ' ; she ' belongs to a mental institution. ' I went outside and I did not see the supervisor; someone said she went to get meds	F 223		

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F 223	Continued From page 9 [medications]. On 8/2/11 at 10:56 a.m., the facility Interim Administrator and the Director of Nursing were notified of the Immediate Jeopardy. An acceptable allegation of compliance was provided by the facility on 8/4/11 at 5:45p.m. Credible Allegation of Compliance The following plan of action outline immediate interventions taken by the Center to abate any further concerns surrounds the above issue: Specific Residents Identified Resident (#2) was assessed by Director of Nursing Services (DNS) on 5/17/11 to have a bruise on chest with no other findings and documented on skin assessment sheet. CNA, (NA #1), was suspended on 5/18/11 pending investigation. A 24 hour report was completed on 5/17/11 and sent to Health Care Personnel Registry by Director of Nurses. 5 day investigation report completed on 5/24/11 and sent to Health Care Personnel Registry by Director of Nurses. CNA, (NA#1) was terminated post investigation on 5/24/11. Resident physician was notified on 5/17/11 with no change in orders. Family was notified on 5/17/11 by DNS. Nursing Management completed a center wide full body assessment on all residents in house on 8/3/11 and no identified injuries of unknown origin were found. Re-education of the staff was completed following	F 223		

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the abuse allegation of Resident (#2) on 5/26/11, 5/31/2011 and 6/1/2011 by the Director of Nursing Services. 109 staff members attended. Re-education included types of abuse, who abuse is reported to, timeline for reporting, how to care for residents that resist care and how to let an agitated resident have time to calm and then re-approach in an appropriate timeline.

CNA (NA#2) received a final written warning regarding failure to report alleged abuse immediately on 5/21/11 and was re-educated on reporting and abuse policy and procedures. The RD was suspended on 8/2/11 pending further investigation. Licensed nurse, (SN#1) was suspended on 8/3/11 pending further investigation. CNA (NA#9) was suspended on 8/4/11 pending further investigation.

On 7/19/11 an allegation of abuse was found on a written note under the Director of Nursing ' s door at approximately 3:15pm by the Director of Nursing. The actual event allegedly occurred on 7/17/11 which resulted in the center submitting a late report of alleged abuse. Upon report, investigation and re-education of staff was started immediately. The alleged abuse of Resident (#8) was assessed for injuries with no finding of physical injury on 7/19/11 by Director of Nurses. The alleged CNA, (NA#7) was suspended on 7/20/11 pending investigation. The 24 hour report was sent to Health Care Personnel Registry on 7/20 by the Director of Nursing. CNA (NA#7) was terminated post investigation on 7/25/11 for abuse. The 5 day investigation report was completed and sent to the Health Care Personnel Registry on 7/27/11 by the Director of Nursing validating abusive behavior. CNA (NA#8)

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was suspended on 7/19/11 pending investigation and was terminated on 7/25/11 for not reporting abuse timely.

Re-education of all facility staff was started on 8/3/11 and included types of abuse, who abuse is reported to, timeline for reporting, how to care for residents that resist care and how to let an agitated resident have time to calm and then re-approach in an appropriate timeline. This education was conducted by the Director of Nursing Services or designee; employees who were not scheduled will complete re-education prior to returning to work. 126 employees have been re-educated on the abuse, neglect and misappropriation policy and procedure as of 8/3/11. The re-education also includes where the phone numbers are posted for the Administrator, Director of Nurses, the Sun Quality Compliance number and the contact information for the Regional Human Resources for immediate reporting of the abuse should the caller want to remain anonymous. The contacts are available 24/7. Re-education is on-going and staff must attend prior to being allowed to return to work.

Residents will be interviewed for any allegation of abuse beginning 8/4/11 and ongoing during daily ambassador rounds by department heads. Ambassador rounds have been in place for the last year but have not encompassed all of the components issues we will be implementing going forward from this date. The department heads will be assigned specific rooms to make rounds and interview residents so all residents will be interviewed/monitored. Non-interviewable residents ' family members will be interviewed as they are in the center and room-mates will be

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questioned as appropriate. The ambassador rounds questions include: have you been mistreated by staff and do you have concerns regarding missing property. Any concerns/allegations will be reported immediately to the Administrator/designee with investigation starting immediately. Ambassador rounds findings will be reviewed at the morning meeting with the department heads and Administrator present. Administrator will assure that concerns have been delegated to the appropriate staff for interventions and solutions. Trends will be monitored monthly at the Performance Improvement meeting.

The Director of Social Work and the Director of Nursing will complete random interviews with 5 staff members on all shifts weekly x 4 weeks, questions will include types of abuse, where phone numbers are posted, who is the abuse coordinator and reporting of abuse immediately. Re-education of staff on the abuse policy that will also address residents that resist care will be completed weekly for one month then monthly times 3 months.

The Credible allegation was validated via interviews with 3 licensed nurses, Director of Social Work, housekeeping staff and 8 nursing assistants that were on duty on 8/4/11 during the second shifts. 2) Record review of the in-services on types of abuse; who the abuse is reported to; timeline for reporting abuse; how to care for residents that resist care; were reviewed for all employees (not just nursing employees, all other disciplines as well - 126 signatures were recorded on the in-service records), 3) Staff abuse interviews including staff verification of

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F 223	Continued From page 13 recent abuse in-service on 8/3/11. 4) Record review of the facility ' s QI committee meeting dates and members attending. Validation was also accomplished via review of the records of all residents who received full body assessment on 8/3/11.	F 223		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	**F 225** 1.Resident # 2 was assessed by the Director of Nursing Services (DNS) on 5/17/11 a bruise on the chest was noted with no other findings and documented on skin assessment sheet. CNA, (NA #1), was suspended on 5/18/11 pending investigation. A 24 hour report was completed on 5/17/11 and sent to Health Care Personnel Registry by Director of Nursing Services. 5 day investigation report was completed on 5/24/11 and sent to Health Care Personnel Registry by Director of Nursing Services. CNA, (NA #1) was terminated post investigation on 5/24/11. Resident's physician was notified on 5/17/11 with no change in orders. Family was notified on 5/17/11 by Director of Nursing Services. CNA (NA#2) received a final written warning regarding failure to report	

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F 225	Continued From page 14 representative and to other officials in accordance with State law (including to the State survey and certification 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 resident observations, staff interviews and record review, the facility failed to immediately report allegations of abuse for 2 of 2 residents (Residents #2 and #8) and failed to report to the state agency within the 24 hour and five day timeframe. Findings include: Immediate jeopardy began on 5/11/11 with Resident #2 and was identified on 8/3/11 at 10:56 a.m. for Residents #2 and #8. Immediate Jeopardy was removed on 8/4/11 at 7p.m. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. 1. Resident #2 was admitted to the facility on 4/11/2011. The resident's diagnoses included, but were not limited to, Alzheimer ' s disease, dementia with behavioral disturbances, muscle weakness and altered mental status. The healthcare personnel registry 24-hour initial report dated 5/17/11 read in part, " [resident ' s initial] incident date: 5/11/11, allegation description: allegation made that employee	F 225	alleged abuse immediately on 5/21/11 and was re educated on reporting and abuse policy and procedures by the Director of Nursing Services. The Registered Dietician was suspended on 8/2/11 pending further investigation. Registered Dietician returned to work on 8/ 09/11 post re-education on abuse policy and procedure by Regional Director of Clinical Operations. Licensed nurse, (SN #1), was suspended on 8/3/11 pending further investigation. SN #1 was terminated on 8/16/11. CNA (NA#9) was suspended on 8/4/11 pending further investigation. NA#9 returned to work on 8/13/11. On 7/19/11 an allegation of abuse was found on a written note under the Director of Nurse's door at approximately 3:15 pm by the Director of Nursing Services. The actual event allegedly occurred on 7/17/11 which resulted in the center submitting a late report of alleged abuse. The alleged abuse of Resident (#8) was assessed for injuries with no finding of physical injury on 7/19/11 by Director of Nursing Services. CNA, (NA#7), was suspended on 7/20/11 pending investigation. The 24 hour report was sent to Health Care	

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F 225	Continued From page 15 (NA#1) forced resident to sit down forcefully pushing resident in chest with hands. " The healthcare personnel registry 5-day report dated 5/24/11, read in part, " Witness stated that on 5/11/11, she witnessed CNA (NA#1) in resident ' s face hollering at him, and then she jerked him down by pulling on his upper arm. When the resident stood back up, she pushed him down with both hands on his chest. On 5/12/11, the CNA (NA#1) taking care of the resident reported to the nurse that the resident had a bruise on his chest from sternum to breast line. After speaking with the witness, the accused CNA (NA#1), CNAs on the hall, and hall nurses, it was determined that the allegation was substantiated and the accused CNA was terminated. The resident had a bruise to chest and no other injuries. Resident has advanced dementia and does not recall incident. The accused CNA (NA#1) was suspended during the investigation, and after completion she was then terminated. " During a phone interview on 8/2/11 at 12:30 p.m. with NA #2 (the aide who witnessed the alleged abuse) she stated that " (Resident #2) [name of the resident] used to be on the 500 Hall and he was moved to the 300 Hall. While he was on the 300 Hall, he became combative and disoriented. On 5/11/11 while breakfast was going on, I heard fussing in his room. I pushed the door and saw [NA #1] in the resident ' s face hollering and telling him to sit down. The resident stood up and she pulled him down by his upper arm. The resident immediately stands back up and she pushed him down forcefully with the palm of both hands. She pushed him hard enough that the	F 225	Personnel Registry on 7/20/11 by the Director of Nursing Services. CNA, (NA#7), was terminated post investigation on 7/25/11 for abuse. The 5 day report investigation report was completed and sent to Health Care Personnel Registry on 7/27/11 by the Director of Nursing Services substantiated the abuse. CNA (NA#8), was suspended on 7/19/11 pending investigation and was terminated on 7/25/11 for not reporting abuse timely. 2. Nursing Management completed a center wide skin re-assessment on residents in-house on 8/3/11 and no identified injuries of unknown origin were found. Residents were interviewed for any allegation of abuse beginning 8/4/11 using the ambassador rounds by department heads. 3. Re-education of the staff was completed following the abuse allegation of Resident (#2) on 5/26/11, 5/31/11, and 6/1/11 by the Director of Nursing Services. 109 staff members attended. Re-education included types of abuse, who abuse is reported to, timeline for reporting, how to care for	

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F 225	Continued From page 16 wheelchair rolled back against the wall. [NA #1] saw me and shoved the door in my face. I went to [the Director of Nursing ' s (DON)] office crying. I attempted to tell her, but SN #1 came into the DON ' s office and started to accuse me of not giving care to my residents. I left the office (without telling the DON of what happened) and I saw the registered dietitian and I told her about the abuse that I saw. She told me that I should tell my supervisor. NA #2 added, " I told [name of the family member], and she took pictures of the bruise. " During an interview on 8/2/11 at 10:00 a.m. with SN #1, who was assigned to the resident the day of the alleged abuse and was the first staff nurse the bruise was reported to, stated that " [NA #1] went to do care on [Resident #2] and she came and got me immediately and showed me the bruise on [Resident #2 ' s] chest. It was a large black and purplish bruise covering one nipple to another nipple. I reported it to the nurse supervisor. She told me not to worry about it because she was going to put it in the incident report relating it to one of his falls. I do not normally document until the end of the shift and I forgot to document the bruise on resident #2 ' s chest. I never assessed [name of the resident], because that is not my job; that is my supervisor ' s job. " During a phone interview on 8/2/11 at 12:00 noon with NA #1, who allegedly caused the bruising to Resident #2's chest, she stated that " the director of nursing called me at home on 5/17/11 and told me that I should make an appointment to come and see her at 3:30 p.m. on 5/18/11, because someone made an allegation about me on	F 225	residents that resist care and how to let an agitated resident have time to calm and then re-approach in an timely manner. Re-education of all facility staff was started on 8/3/11 and included types of abuse, who abuse is reported to, timeline for reporting, how to care for residents that resist care and how to let an agitated resident have time to calm and then re-approach in a timely manner. This re-education was conducted by the Director of Nursing Services or designee; employees who were not scheduled will complete re-education prior to returning to work. 126 employees were re-educated on the abuse, neglect and misappropriation policy and procedure as of 8/3/11. The re-education also includes where the phone numbers are posted for the Administrator, Director of Nursing Services, the Sun Quality Compliance number and the contact information for the Regional Human Resources for immediate reporting of the abuse should the caller want to remain anonymous. The contacts are available 24/7. Re- education is on-going and staff must attend prior to being allowed to return to work.	

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F 225	Continued From page 17 5/11/11. I told her that I did not do care on the resident on 5/11/11. On 5/12/11 at 11:00 a.m., I took the resident ' s shirt off to do a.m. care, and I saw a large, black-purplish bruise all over his chest, from one nipple to another, going down into his upper stomach. I went and got my supervisor [Staff Nurse (SN) #1], and she came and look[ed] at it, and she got the nursing supervisor. She further stated, " They call me back on May 24th and substantiated the investigation and let me go. " When asked by the surveyor what happened on 5/11/11, she stated that nothing happened. During an interview on 8/2/11 at 10:30 a.m. with the nurse supervisor, she stated that about the first week in May- " I do not know the date-[name of the resident] had the large bruise on his chest. I waited to document it because he had multiple falls. We [everyone in the facility] thought the bruise was from one of his falls. I did not look at the bruise. I did not assess him. A week later, the aide [NA #2] came forward and told us that [NA #1] pushed the resident in his chest. During the investigation, we found out that when [SN #1] found the bruise, she did not put any nursing notes in the chart and she did not assess the resident. I never saw the bruise on the resident ' s chest. From what I heard, it was a large bruise. " She further stated that injuries from unknown origin must be investigated immediately, or when a staff member notes a new injury such as bruising to the resident, the supervisor should be notified. An incident report is filled out and the resident is assessed. The floor supervisor also documents the incident in the chart. The nurse notifies the medical doctor and the family. She further added that this reporting procedure was	F 225	Re-education of staff on the abuse policy that addressed residents that resist care was completed on 8/10/11 to staff by Regional Director of Clinical Operations and on 8/17/11 by the Staff Development Coordinator. Re-education on abuse will be conducted 2 more times weekly with the Ombudsman of Chatham County conducting the re-education on 8/24/11. Abuse re-education will continue monthly times 3 months. Nurses were re-educated on doing weekly skin assessments by Director of Nursing Services on 8/10/11. The Department heads are assigned specific rooms to make rounds and complete interviews to insure residents are monitored for safety and well-being. Non-interviewable residents' family members will be interviewed as they are in the center and alert/oriented room-mates will be interviewed as well. The ambassador rounds questions include: have you been mistreated by staff and do you have concerns regarding missing property. Director of Nurses/designee will validate weekly skin assessments by completing random skin assessments on residents who were identified to have no skin integrity	

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F 225	Continued From page 18 not followed for the resident, because around that time he had multiple falls, on 4/17, 5/8/, 5/9, and 5/11, and no injuries were found. During an interview on 8/2/11 at 11:00 a.m. and again on 8/4/11 at 11:30 a.m. with the Director of Nursing (DON), she stated that the resident was moved on 4/29/11 to the 300 Hall. Upon being moved, the resident became very agitated, more verbally abusive, and loud, so he was moved back to the 500 Hall on 5/12/11. The DON stated " it was reported to me on 5/17/11 by [NA #2] that [NA #1] abused Resident #2. " She further stated that on 5/11/11 while NA #1 was providing care to Resident #2, NA #2 heard " fussing " in Resident #2 ' s room; NA #2 entered the room and saw NA #1 forcefully push the resident down in the wheelchair by pulling on his upper arm. The DON further stated that NA #2 reported that when the resident stood back up, the aide pushed him down in his wheelchair with both hands and the wheelchair rolled into the wall. The DON further stated that on 5/17/11, " I assessed the resident and he had a purplish-yellowish large bruise at the center of his chest from one nipple to another nipple; no other bruises or redness was noted. The resident denied pain. I immediately completed a 24-hr report, faxed it to the healthcare registry, and started the investigation. " The DON further stated that the resident had a fall on 5/11/11 and the incident report stated he fell on his bottom with no injury. She added, " When I assessed the resident on 5/17/11, the bruise was from nipple to nipple, large, and encompassed the entire chest. It was impossible for the resident to fall on his bottom and sustain a bruise to his chest. " The DON stated that " I felt [NA #1] had hit the resident willfully and put him in	F 225	concerns by the licensed nurse. These validations will be completed on each shift for 2 residents per shift per day for a total of 6 residents per day x 4 weeks. Any concerns/allegations will be reported immediately to the Administrator/designee with investigation starting immediately. 4. Ambassador rounds findings will be reviewed at the morning meeting with the department heads and Administrator present. Administrator will assure that concerns have been delegated to the appropriate staff for interventions and solutions. Findings will be monitored monthly at the Performance Improvement Committee meeting for 3 months. The Director of Social Services and the Director of Nursing will complete random interviews with 5 staff members on each shifts weekly x 4 weeks, questions will include types of abuse, where phone numbers are posted, who is the abuse coordinator and reporting of abuse immediately.. . A report will be submitted to the Performance Improvement Committee monthly for 3 months. Date of Compliance: August 26, 2011	

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the chair. " When asked by the surveyor what evidence she used to substantiate the abuse allegation, the DON stated, " I had noticed earlier in the week that [NA #1] had spoken loudly to [Resident #2], out in the hallway, and I came out of my office when I heard the disturbance and asked [NA #1] if everything was ok. [NA #1] stated, ' everything is fine; I ' m just frustrated. ' " When asked what the DON had done about NA#1 behavior she indicated she offered to move the aide off Hall 300 and/or change the assignment. NA #1 told her she would be off the next day and everything was fine.

A review of the facility ' s daily staffing revealed NA #1 and NA #2 were assigned and worked on the 300 Hall on 5/11/11 during the 7-3 shift.

A review of the facility ' s daily staffing revealed NA #1 worked on the 300 Hall on 5/12/11 during the 7-3 shift. (NA#2 was not assigned to resident #2 but as a CNA team leader she had access to resident #2).

A review of the facility ' s daily staffing revealed NA #1 worked on the 300 Hall on 5/16/11 during the 7-3 shift. (NA#2 was not assigned to resident #2 but as a CNA team leader she had access to resident #2).

A review of the facility ' s daily staffing revealed that NA #1 worked on the 300 Hall on 5/17/11 during the 7-3 shift. (NA#2 was not assigned to resident #2 but as a CNA team leader she had access to resident #2).

During an interview on 8/2/11 at 2:30 p.m. with the Registered Dietician (RD), she stated, " I

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F 225	Continued From page 20 remember I saw [NA #2] very upset sometime in May, and she mentioned something about someone roughing a resident, and I directed her to her supervisor. I thought everything was resolved. I did not follow up on it. " During an interview on 8/4/11 at 12:20 p.m. with SN #3, she stated that " the day after [Resident #2] came back to Hall 500 [5/13/11], at about 8:00 a.m. during my medication pass; I reported to the DON that [Resident #2] had a large bruise on his chest. SN #3 added that NA #6 [the aide who was assigned to Resident #2] called me to the resident ' s room and showed the bruise on the resident ' s chest. " It was brought to SN #3 ' s attention that the DON was not in the building on May 13. SN #3 insisted that the DON accompany her to the resident ' s room and look at the bruise and that (NA #6) [the aide assigned to the resident] witness the DON ' s observation. During an interview on 8/4/11 at 1:00 p.m. with SN #3, she stated " the bruise was purple and black, and there was no yellow. There were no marks on his abdomen, just the lower ribs and up. " SN #3 indicated " I really wanted someone to see this bruise, because I did not want it to come back on me. " SN #3 further indicated that she documented the bruise, and " all of my documentation was missing out of the record. " SN #3 added that she had received abuse training during orientation and several times since the allegation. She further stated that they were required to do the in-service training on the computerized training program. SN #3 stated that abuse allegations should be reported to the supervisor "just as soon as possible."	F 225		

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F 225	Continued From page 21 During an interview on 8/4/11 at 1:16 p.m., the administrator stated he was an interim administartor and he was not here when the alleged allegation took place. He added that he has zero tolerance for abuse in the facility, and he expected an incident report to be completed immediately when an allegation of abuse or injury of unknown origin was made. He further added that any staff who allegedly abused a resident must leave the premises as soon as their statement was obtained. A 24-hour report is to be filled out immediately. The facility then has up to 5 days to complete an investigation.The administrator indicated that training files should be reviewed. A head-to-toe assessment was to be completed on the resident as soon as an allegation was made. If the allegation was made to the nurse, then she will conduct the assessment. During an interview on 8/4/11 at 5:13 p.m., the DON stated that her expections are that the nurse on the hall immediately inform her or the charge nurse of any allegations. The nurse should call the doctor and document the allegation in the nurse's notes. If the nurse is busy, she can tell the supervisor, administrator, or DON. An incident report should be filled out. If the allegation is made after an employee has gone home, the employee should be called and suspended. If the allegation is made during the employee's working hours, the employee is called into the office, where the employee is to write a statement. The employee is subsequently suspended with pay pending the outcome of an investigation. The facility has 24 hours to send in the initital report to the state agency and 5 days to complete the	F 225		

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F 225	Continued From page 22 investigation. 2. Resident #8 was admitted to the facility on 9/18/07. The resident's diagnoses included, but were not limited to, Parkinson ' s disease, osteoarthritis, glaucoma, history of muscular disorder and psychosis. A review of the note that NA # 8 (the witness of the abuse) left under the Director of Nursing ' s (DON) door dated 7/17/11 read, " on July 17, 2011, I worked on the 100 Hall with [name of the aide (NA#7)]. We were in [Resident #8 ' s] room. [Resident #8] became combative and hit [name of the aide], then [name of the aide] grabbed [Resident #8 ' s] arm and punched her left upper arm and held her hands down. The healthcare personnel registry 24-hour initial report dated 7/20/11 read in part, " allegation description: CNA (NA# 8) reported that on Sunday 7/17/11 she worked with the accused CNA (NA# 7). She (NA#8) stated the accused CNA hit a resident in the shoulder while providing care. She also states that the accused CNA told the resident she did not belong in this facility, that she belongs in mental institution. " The healthcare personnel registry 5-day report dated 7/27/11 read in part, " the CNA who was in the room with the accused CNA at the time of the incident stated that while putting the resident to bed, the resident became combative. When this happened, the CNA stated that the accused CNA hit the resident in the arm and grabbed her hand. The accused CNA stated that while putting the	F 225		

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resident to bed, she [the resident] became combative. She (NA#7) states the resident swung at her, and then she grabbed the resident arm to keep her from hitting her. The resident has dementia and is confused. She was unable to answer questions about the injury. The investigation determined that the allegations were substantiated and the CNA was terminated. "

During a phone interview on 8/4/11 at 10:40 a.m., with NA #7, she stated, " I went to help NA #8 put Resident #8 to bed. " NA #7 further stated, " I started to put on [Resident #8 ' s] night gown, and the resident hit me. I caught her hand and held it for while, and I told her not to hit me. I was not verbally abusive to her. I did not tell my supervisor because I do not think it was important. " NA #7 further stated that, she worked 7/18/11 and 7/19/11, but Resident #8 was not assigned to her. She added, " I only had her that night because I went to help [NA #8]. "

During an interview on 8/4/11 at 11:00 a.m., with the DON, she stated that the alleged abuse occurred on 7/17/11. " The aide put a note under my office door. I was in Raleigh the following Monday [7/18/11], and it was not until late Tuesday evening [7/19/11] that I saw the note under a pile of papers on my desk. " The DON further stated that " the note stated that one aide was assisting another aide with getting a resident to bed. The resident became combative, and the accused aide became physically and verbally abusive to the resident. I suspended the aide on 7/20/11 because she was off on [7/19/11] pending the investigation, but she worked that Monday (7/18/11). I immediately suspended the other aide for not reporting the verbal and

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physical abuse immediately. " The DON further stated that " the aide who put the note under my door had just attended mandatory abuse training and completed the abuse procedure [the company ' s online abuse training program] on 5/26/11, with a 100% score. " The DON added that any alleged abuse has to be reported immediately. The DON further added that the abuse of the resident was not reported or investigated timely, " because we did not know. "

The DON added that on 7/19/11, " I assessed the resident for any bruising secondary to alleged abuse. I completed a full-body assessment: no bruising was found. I assessed the left upper shoulder, both arms, no bruising or redness was noted. I immediately completed a 24-hr report and faxed it to the healthcare registry, and started the investigation. I faxed the 5-day investigation. I knew according to policy they were late, but we did not know of the abuse allegation because we [she and the administrator] were in Raleigh that Monday, and we encouraged the staff to report alleged abuse immediately to their supervisors. "

The DON further stated that " I substantiated the allegation because the aide who allegedly physically and verbally abused (Resident #8) told me that when the resident became combative she held the resident ' s hand for a while and she also made a statement that ' that type of resident does not belong in this facility. ' " That statement is consistent with the witness ' s statement.

During an interview on 8/11/11 at 10:05 a.m., with NA #8 who witnessed the abuse, she stated that on 7/17/11, " a little after dinner I requested help from [NA #7]. We lifted Resident #8 from her

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chair to the bed with the lift. The resident became combative. The resident hit [NA #7], and [NA#7] grabbed the resident ' s shoulder and punched her in the shoulder and held the resident ' s arm in a restrained position. She looked at the resident and told her that she ' does not belong in the facility ' ; she ' belongs to a mental institution. ' I went outside and I did not see the supervisor; someone said she went to get meds [medications]. There was a nurse on the floor but I do not trust that nurse. So I wrote a note and put it under [DON ' s] door. I was terminated because I did not report it to my supervisor. I know the chain of command, but the supervisors do not do anything when you report anything to them.

During an interview on 8/4/11 at 1:16 p.m., the administrator stated he was an interim administartor and he was not here when the alleged allegation took place. He added that he has zero tolerance for abuse in the facility, and he expected an incident report to be completed immediately when an allegation of abuse or injury of unknown origin was made. He further added that any staff who allegedly abused a resident must leave the premises as soon as their statement was obtained. A 24-hour report is to be filled out immediately. The facility then has up to 5 days to complete an investigation.The administrator indicated that training files should be reviewed. A head-to-toe assessment was to be completed on the resident as soon as an allegation was made. If the allegation was made to the nurse, then she will conduct the assessment.

On 8/2/11 at 10:56 a.m., the facility Interim Administrator and the Director of Nursing were

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F 225	Continued From page 26 notified of the Immediate Jeopardy. An acceptable allegation of compliance was provided by the facility on 8/4/11 at 5:45p.m. Credible Allegation of Compliance Resident (#2) was assessed by Director of Nursing Services (DNS) on 5/17/11 to have a bruise on chest with no other findings. CNA, (NA#1), was suspended on 5/18/11 pending investigation. A 24 hour report was completed on 5/17/11 and sent to Health Care Registry by Director of Nurses. 5 day investigation report completed on 5/24/11 and sent to Health Care Personnel Registry by Director of Nurses. CNA, (NA#1), was terminated post investigation on 5/24/11. Nursing Management completed a center wide full body skin assessment on all residents in house on 8/3/11 and identified no injuries of unknown origin. Appropriate reporting of bruising was included in all stated in-servicing related to abuse and neglect reporting. This in-service included all staff and as of 8/3/11 126 staff members have been in-serviced. Re-education of the staff was completed following the abuse allegation of Resident (#2) on 5/31/2011 and 6/1/2011 by the Director of Nursing Services. Re-education of all facility staff included types of abuse, who abuse is reported to, timeline for reporting, how to care for residents that resist care and how to let an agitated resident have time to calm and then re-approach in an appropriate timeline.	F 225		

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F 225	Continued From page 27 CNA (NA#2) received a final written warning regarding failure to report alleged abuse immediately on 5/21/11 and was re-educated on reporting and abuse policy and procedures. The RD was suspended on 8/2/11 pending further investigation. Licensed nurse, (SN#1) was suspended on 8/3/11 pending further investigation. CNA (NA#9) was suspended pending further investigation. All nurses will be re-educated on doing weekly skin assessments as assigned. The Director of Nursing Service or designee will validate weekly skin assessments by completing random skin assessments on residents who were identified to have no skin integrity concerns by the licensed nurse. These validations will be completed on all shifts for 2 residents per shift per day for total of 6 residents per day x 4 weeks. The Credible allegation was validated via interviews with 3 licensed nurses, Director of Social Work, housekeeping staff and 8 nursing assistants that were on duty on 8/4/11 during the second shifts. 2) Record review of the in-services on types of abuse; who the abuse is reported to; timeline for reporting abuse; how to care for residents that resist care; were reviewed for all employees (not just nursing employees, all other disciplines as well - 126 signatures were recorded on the in-service records), 3) Staff abuse interviews including staff verification of recent abuse in-service on 8/3/11. 4) Record review of the facility ' s QI committee meeting dates and members attending. Validation was also accomplished via review of the records of all residents who received full body assessment on 8/3/11.	F 225		

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F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, record review, and facility policy review, the facility failed to implement their policies and procedures to report, investigate, and protect 2 of 2 residents from alleged physical and verbal abuse. (Resident #2 and #8). Immediate jeopardy began on 5/11/11 with Resident #2 and was identified on 8/3/11, at 10:56 a.m. for Residents #2 and #8. Immediate Jeopardy was removed on 8/4/11 at 7 p.m when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems is put in place and completion of employee training. Findings include: The facility policy dated January 2008, page 2 of 5, titled, "Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, " reads in part: POLICY STATEMENT It is the center policy that every reasonable effort	F 226	F226 1. Resident # 2 was assessed by the Director of Nursing Services (DNS) on 5/17/11 a bruise on the chest was noted with no other findings and documented on skin assessment sheet. CNA, (NA #1), was suspended on 5/18/11 pending investigation. A 24 hour report was completed on 5/17/11 and sent to Health Care Personnel Registry by Director of Nursing Services. 5 day investigation report was completed on 5/24/11 and sent to Health Care Personnel Registry by Director of Nursing Services. CNA, (NA #1) was terminated post investigation on 5/24/11. Resident's physician was notified on 5/17/11 with no change in orders. Family was notified on 5/17/11 by Director of Nursing Services. CNA (NA#2) received a final written warning regarding failure to report alleged abuse immediately on 5/21/11 and was re-educated on reporting and abuse policy and procedures by the Director of Nursing Services. The Registered Dietician was suspended on 8/2/11 pending further	

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F 226	Continued From page 29 within its control is taken to prevent the mistreatment, neglect, and abuse of residents and misappropriation of resident property. Staff must not engage in nor permit anyone else to engage in verbal, mental or physical abuse, neglect, mistreatment, or misappropriation of resident property. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members, visitors, legal guardian, friends, or other individuals. PROTECTION The administrator or his/her designee investigates allegations of abuse, takes action to protect the resident during the investigation, and implements corrective action depending on the results of the investigation. The administrator/designee shall suspend all employees suspected of abuse pending the outcome of the investigation. PREVENTION The department Heads/designee educates staff on strategies to identify, corrects, and intervenes in situations in which abuse, neglect, or misappropriation of resident property is more likely to occur. IDENTIFICATION The administrator/designee identifies events such as suspicious bruising of resident, occurrences, pattern, and trends that may constitute abuse; and to determine the direction of the investigation.	F 226	investigation. Registered Dietician returned to work on 8/09/11 post re-education on abuse policy and procedure by Regional Director of Clinical Operations. Licensed nurse, (SN #1), was suspended on 8/3/11 pending further investigation. SN #1 was terminated on 8/16 /11. CNA (NA#9) was suspended on 8/4/11 pending further investigation. NA#9 returned to work on 8/13/11. On 7/19/11 an allegation of abuse was found on a written note under the Director of Nurse's door at approximately 3:15 pm by the Director of Nursing Services. The actual event allegedly occurred on 7/17/11 which resulted in the center submitting a late report of alleged abuse. The alleged abuse of Resident (#8) was assessed for injuries with no finding of physical injury on 7/19/11 by Director of Nursing Services. CNA, (NA#7), was suspended on 7/20/11 pending investigation. The 24 hour report was sent to Health Care Personnel Registry on 7/20/11 by the Director of Nursing Services. CNA, (NA#7), was terminated post investigation on 7/25/11 for abuse. The 5 day report investigation report	

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F 226	Continued From page 30 REPORTING The administrator or his/her designee reports alleged violations and substantiates incidents to the state agency and to all other agencies as required. INVESTIGATION The administrator or his/her designee investigates allegations of abuse, neglect, misappropriation of resident property, identifies staff member responsible for initial reporting, investigation of alleged violation and reporting of results to the proper authorities. 1. Resident #2 was admitted to the facility on 4/11/2011. The resident's diagnoses included, but were not limited to, Alzheimer ' s disease, dementia with behavioral disturbances, muscle weakness; and altered mental status. Resident #2 ' s Admission Minimum Data Set (MDS) dated 4/18/11, revealed he had short/long-term memory problems. The resident ' s decision-making skills were moderately impaired. He had noted signs and symptoms of delirium present, which fluctuates, delusions, and other behavioral symptoms not directed to others. Review of the Healthcare Personnel Registry 24-hour initial report dated 5/17/11 read in part, " [resident ' s initial] incident date: 5/11/11allegation description: allegation made that employee (NA #1) forced resident to sit down forcefully pushing resident in chest with hands. " Review of the Healthcare Personnel Registry 5-day report dated 5/24/11, read in part, "	F 226	was completed and sent to Health Care Personnel Registry on 7/27/11 by the Director of Nursing Services substantiating the abuse. CNA (NA#8), was suspended on 7/19/11 pending investigation and was terminated on 7/25/11 for not reporting abuse timely. 2. Nursing Management completed a center wide skin re-assessment on residents in-house on 8/3/11 and no identified injuries of unknown origin were found. Residents were interviewed for any allegation of abuse beginning 8/4/11 using the ambassador rounds by department heads. 3. Re-education of the staff was completed following the abuse allegation of Resident (#2) on 5/26/11, 5/31/11, and 6/1/11 by the Director of Nursing Services. 109 staff members attended. Re-education included types of abuse, who abuse is reported to, timeline for reporting, how to care for residents that resist care and how to let an agitated resident have time to calm and then re-approach in a timely manner. Re-education of all facility staff was started on 8/3/11 and included types of	

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F 226	Continued From page 31 Witness stated that on 5/11/11, she witnessed CNA (NA #1) in resident ' s face hollering at him, and then she jerked him down by pulling on his upper arm. When the resident stood back up, she pushed him down with both hands on his chest. On 5/12/11, the CNA (NA #1) taking care of the resident reported to the nurse that the resident had a bruise on his chest from sternum to breast line. After speaking with the witness, the accused C.NA (NA#1) on the hall, and hall nurses, it was determined that the allegation was substantiated and the accused CNA was terminated. The resident had a bruise to chest and no other injuries. Resident has advanced dementia and does not recall incident. The accused CNA (NA #1) was suspended during the investigation, and after completion she was the terminated. " During a phone interview on 8/2/11 at 12:30 p.m., NA #2 (the aide who witnessed the alleged abuse) she stated " On 5/11/11 while breakfast was going on, I heard fussing in his room. I pushed the door and saw (NA #1) in the resident ' s face hollering and telling him to sit down. The resident stood up and she pulled him down by his upper arm. The resident immediately stands back up and she pushed him down forcefully with the palm of both hands. She pushed him hard enough that the wheelchair rolled back against the wall. NA #1 [name of the aide who allegedly abused the resident] saw me and shoved the door in my face. I went to [the Director of Nursing ' s DON] office crying. I attempted to tell her, but SN #1 came into the DON ' s office and started to accuse me of not giving care to my residents. I left the office and I saw the registered dietitian and I told her about the abuse that I saw. She told me that I should tell my supervisor. I was afraid to	F 226	abuse, who abuse is reported to, timeline for reporting, how to care for residents that resist care and how to let an agitated resident have time to calm and then re-approach in a timely manner, re-education included assessing injuries of unknown cause. This re-education was conducted by the Director of Nursing Services or designee; employees who were not scheduled will complete re-education prior to returning to work. 126 employees were re-educated on the abuse, neglect and misappropriation policy and procedure as of 8/3/11. The re-education also includes where the phone numbers are posted for the Administrator, Director of Nursing Services, the Sun Quality Compliance number and the contact information for the Regional Human Resources for immediate reporting of the abuse should the caller want to remain anonymous. The contacts are available 24/7. Re- education is on-going and staff must attend prior to being allowed to return to work. Re-education of staff on the abuse policy that addressed residents that resist care was completed on 8/10/11 to staff by Regional Director of	

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F 226	Continued From page 32 tell my supervisor, because my supervisor and NA #1 are very good friends ,and I was afraid she would have me fired. " NA #2 added, " I told [name of the family member], and she took pictures of the bruise. " During an interview on 8/2/11 at 10:00 a.m. with SN #1, who was assigned to the resident the day of the alleged abuse and who worked on the hall and was the first staff nurse the bruise was reported to, stated NA #1 went to do care on Resident #2 and she came and got me immediately and showed me the bruise on Resident #2 ' s chest. It was a large black and purplish bruise covering one nipple to another nipple. I reported it to the nurse supervisor. I do not normally document until the end of the shift and I forgot to document what I saw. I never assessed [name of the resident], because that is not my job; that is my supervisor ' s job. " During an phone interview on 8/2/11 at 12:00 noon with NA #1, who allegedly caused the bruising to Resident #2's chest, she stated that " the director of nursing called me at home on 5/17/11 and told me that I should make an appointment to come and see her at 3:30 p.m. on 5/18/11, because someone made an allegation about me on 5/11/11. I told her that I did not do care on the resident on 5/11/11. On 5/12/11 at 11:00 a.m., I took the resident ' s shirt off to do a.m. care, and I saw a large, black-purplish bruise all over his chest, from one nipple to another, going down into his upper stomach. I went and got my supervisor [Staff Nurse (SN) #1], and she came and look[ed] at it, and she got the nursing supervisor I worked with him until about May 17th. I gave him care because I work all the	F 226	Clinical Operations and on 8/17/11 by the Staff Development Coordinator. Re-education on abuse will be conducted 2 more times weekly with the Ombudsman of Chatham County conducting re-education on 08/24/11. Abuse re-education will continue monthly times 3 months. Nurses were re-educated on doing weekly skin assessments by Director of Nurses on 8/10/11. New employees will be educated on the first day of employment by the Director of Nursing Services or designee on abuse, neglect and misappropriation policy prior to contact with residents. Staff burn out will be managed thru schedule management that limits overtime. The Director of Nursing Services will review the overtime report. Beginning September 9, 2011 a new schedule will be implemented that follows a 4 days on 2 days off cycle. Director of Nursing Services will make daily rounds on halls to monitor for any signs of burn out by speaking to staff and observing for burn out behavior. Burn out behavior could be identified as but not limited to: frustration with peers, increased complaints by individuals, short	

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F 226	Continued From page 33 halls. " She further stated, " They call me back on May 24th and substantiated the investigation and let me go. " When asked by the surveyor what happened on 5/11/11, she stated that nothing happened. During an interview on 8/2/11 at 10:30 a.m. with the nurse supervisor, she stated that about the first week in May-I do not know the date-[name of the resident] had the large bruise on his chest. I waited to document it because he had multiple falls. We [everyone in the facility] thought the bruise was from one of his falls. I did not look at the bruise. I did not assess him. A week later, the aide [NA #2] came forward and told us that [NA #1] pushed the resident in his chest. During the investigation, we found out that when SN #1 found the bruise, she did not put any nursing notes in the chart and she did not assess the resident. " She further stated that injuries from unknown origin must be investigated immediately, or when a staff member notes a new injury such as bruising to the resident, the supervisor should be notified. An incident report is filled out and the resident is assessed. The floor supervisor also documents the incident in the chart. The nurse notifies the medical doctor and the family. She further added that this reporting procedure was not followed for the resident. During an interview on 8/2/11 at 11:00 a.m. with the Director of Nursing (DON), she stated that " it was reported to me on 5/17/11 by [NA #2] [the aide who witnessed the alleged abuse] that [NA #1] abused Resident #2. " She further stated that on 5/11/11 while NA #1 was providing care to Resident #2, NA #2 heard " fussing " in Resident #2 ' s room; NA #2 entered the room and saw NA	F 226	abrupt answers to peers, increased call outs, and reporting late to work. If burn out is identified the staff member will be removed from that assignment, encourage to take time off or may be referred to Human Resources for additional support. The Department heads are assigned specific rooms to make rounds and complete interviews to insure residents are monitored for safety and well-being. Non-interviewable residents' family members will be interviewed as they are in the center and alert/oriented room-mates will be interviewed as well. The ambassador rounds questions include: have you been mistreated by staff and do you have concerns regarding missing property. Director of Nursing Services or designee will validate weekly skin assessments by completing random skin assessments on residents who were identified to have no skin integrity concerns by the licensed nurse. These validations will be completed on each shift for 2 residents per shift per day for a total of 6 residents per day x 4 weeks. Any concerns/allegations will be reported	

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F 226	Continued From page 34 #1 forcefully push the resident down in the wheelchair by pulling on his upper arm. The DON further stated that NA #2 reported that when the resident stood back up, the aide pushed him down in his wheelchair with both hands and the wheelchair rolled into the wall. The DON further stated that on 5/17/11, " I assessed the resident and he had a purplish-yellowish large bruise at the center of his chest from one nipple to another nipple; no other bruises or redness was noted. The resident denied pain. I immediately completed a 24-hr report, faxed it to the healthcare registry, and started the investigation. " The DON further stated that, NA #1 was a team leader for the CNAs and she did not have to be assigned to Resident #2 ' s hall in order to have contact with him. She may just answer the resident ' s light or assist another aide giving care. DON added that NA#1 worked several days after 5/11/11. A review of the facility ' s daily staffing revealed NA #1 and NA #2 worked on the 300 Hall on 5/11/11 during the 7-3 shift. A review of the facility ' s daily staffing revealed NA #1 worked on the 300 Hall on 5/12/11 during the 7-3 shift. A review of the facility ' s daily staffing revealed NA #1 worked on the 300 Hall on 5/16/11 during the 7-3 shift A review of the facility ' s daily staffing revealed that NA #1 worked on the 300 Hall on 5/17/11 during the 7-3 shift. The DON further stated that " on Wednesday (5/11/11), I was present in the building and NA #2	F 226	immediately to the Administrator/designee with investigation starting immediately. 4. Ambassador rounds findings will be reviewed at the morning meeting with the department heads and Administrator present. Administrator will assure that concerns have been delegated to the appropriate staff for interventions and solutions. Findings will be monitored monthly at the Performance Improvement Committee meeting for 3 months. The Director of Social Services and the Director of Nursing will complete random interviews with 5 staff members on each shifts weekly x 4 weeks, questions will include types of abuse, where phone numbers are posted, who is the abuse coordinator and reporting of abuse immediately.. . A report will be submitted to the Performance Improvement Committee monthly for 3 months. Date of Compliance: August 26, 2011	

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came into my office upset and crying. I asked what was wrong, and she stated, ' those people on the 300 Hall are mean. ' I asked her what she meant by that. At the same time, SN #1 opened my office door and walked in. I asked her what was going on, on the hall. [SN #1] stated that ' all she did was to tell [NA #2] that a resident said she had not received her bath yet. ' [NA #2] stated the resident was given her bath before breakfast, and she left the office. " The DON stated that she had a discussion with SN #1 concerning the manner in which she speaks to the staff.

During an interview on 8/4/11 at 11:30 a.m. with the DON, she stated that " I felt NA #1 had hit the resident willfully and put him in the chair. " She further added, " The nurse who did not report it [SN #1] was given a final warning. All decisions go through corporate HR [Human Resources]. " The DON stated that the staff completed abuse in-service online after 5/17/11.

During an interview on 8/4/11 at 12:20 p.m. with SN #3, she stated that " the day after Resident #2 came back to Hall 500 [5/13/11], at about 8:00 a.m. during my medication pass; I reported to the DON that Resident #2 had a large bruise on his chest. SN #3 added that NA #6 [the aide who was assigned to Resident #2] called me to the resident ' s room and showed the bruise on the resident ' s chest." It was brought to SN #3 ' s attention that the DON was not in the building on May 13. SN #3 insisted that the DON accompanied her to the resident ' s room and looked at the bruise and that NA #6 [the aide assigned to the resident] witnessed the DON ' s observation.

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During an interview on 8/4/11 at 5:13 p.m., the DON stated that her expections are that the nurse on the hall immediately inform her or the charge nurse of any allegations. The nurse should call the doctor and document the allegation in the nurse's notes. If the nurse is busy, she can tell the supervisor, administrator, or DON. An incident report should be filled out. If the allegation is made after an employee has gone home, the employee should be called and suspended. If the allegation is made during the employee's working hours, the employee is called into the office, where the employee is to write a statement. The employee is subsequently suspended with pay pending the outcome of an investigation. The facility has 24 hours to send in the initital report to the state agency and 5 days to complete the investigation.

2. Resident #8 was admitted to the facility on 9/18/07. The resident's diagnoses included, but were not limited to, Parkinson ' s disease, osteoarthritis, glaucoma, history of muscular disorder, psychosis, and diabetes.

Resident #8 ' s minimum data set (MDS) dated 6/28/11 revealed she had short/long-term memory problems. The resident ' s decision-making skills were moderately impaired. She had noted signs and symptoms of delirium present, which fluctuates, and physical and verbal behavioral symptoms directed towards others, and other behavioral symptoms not directed to others.

A review of the note that NA # 8 (the witness of

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the abuse) left under the Director of Nursing ' s (DON) door dated 7/17/11 read, " on July 17, 2011, I worked on the 100 Hall with [name of the aide]. We were in [Resident #8 ' s] room. [Resident #8] became combative and hit [name of the aide], then [name of the aide] grabbed [Resident #8 ' s] arm and punched her left upper arm and held her hands down."

A review of the healthcare personnel registry 24-hour Initial report dated 7/20/11 read in part, " allegation description: CNA (NA# 8) reported that on Sunday 7/17/11 she worked with the accused CNA (NA# 7). She stated the accused CNA hit a resident in the shoulder while providing care. She also states that the accused CNA told the resident she did not belong in this facility, that she belongs in mental institution. "

A review of the healthcare personnel registry 5-day report dated 7/27/11 read in part, " the CNA who was in the room with the accused CNA at the time of the incident stated that while putting the resident to bed, the resident became combative. When this happened, the CNA stated that the accused CNA hit the resident in the arm and grabbed her hand. The accused CNA stated that while putting the resident to bed, she [the resident] became combative. She states the resident swung at her, and then she grabbed the resident arm to keep her from hitting her. The resident has dementia and is confused. She was unable to answer questions about the injury. The investigation determined that the allegations were substantiated and the CNA was terminated. "

During a phone interview on 8/4/11 at 10:40 a.m., with NA #7, she stated, " I went to help (NA #8)

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put (Resident #8) to bed. " NA #7 further stated, " I started to put on [Resident #8 ' s] night gown, and the resident hit me. I caught her hand and held it for while, and I told her not to hit me. I was not verbally abusive to her. I did not tell my supervisor because I do not think it was important. " NA #7 further stated that, she worked 7/18/11 and 7/19/11, but Resident #8 was not assigned to her. She added, " I only had her that night because I went to help [NA #8]. "

During an interview on 8/4/11 at 11:00 a.m., with the DON, she stated that the alleged abuse occurred on 7/17/11. The aide put a note under her office door. The DON further stated that " the note stated that one aide was assisting another aide with getting a resident to bed. The resident became combative, and the accused aide became physically and verbally abusive to the resident. I suspended the aide on 7/20/11 because she was off on [7/19/11] pending the investigation, but she worked that Monday (7/18/11). I immediately suspended the other aide for not reporting the verbal and physical abuse immediately. "

The DON added that on 7/19/11, " I assessed the resident for any bruising secondary to alleged abuse. I completed a full-body assessment: no bruising was found. I assessed the left upper shoulder, both arms, no bruising or redness was noted. I immediately completed a 24-hr report and faxed it to the healthcare registry, and started the investigation. I faxed the 5-day investigation. I knew according to policy they were late, but we did not know of the abuse allegation because we [she and the administrator] were in Raleigh that Monday, and we encouraged the staff to report

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alleged abuse immediately to their supervisors."

The DON further stated that " I substantiated the allegation because the aide who allegedly physically and verbally abused Resident #8 told me that when the resident became combative she held the resident ' s hand for a while and she also made a statement that ' that type of resident does not belong in this facility. ' " That statement was consistent with the witness ' s statement.

During an interview on 8/11/11 at 10:05 a.m., with the NA #8 who witnessed the abuse, she stated that on 7/17/11, " a little after dinner I requested help from [NA #7, the aide who allegedly physically and verbally abused the resident].We lifted (Resident #8) from her chair to the bed with the Hoyer lift. The resident became combative. The resident hit [NA #7], and [NA#7] grabbed the resident ' s shoulder and punched her in the shoulder and held the resident ' s arm in a restrained position. She looked at the resident and told her that she ' does not belong in the facility ' ; she ' belongs to a mental institution. ' I went outside and I did not see the supervisor; someone said she went to get meds [medications]. "

On 8/2/11 at 10:56 a.m., the facility Interim Administrator and the Director of Nursing were notified of the Immediate Jeopardy. An allegation of compliance was provided by the facility on 8/4/11 at 5:45p.m.

Credible Allegation of Compliance

Re-education on reporting abuse, assessing injuries of unknown cause, and care for residents

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who resist care for all facility staff was started on 8/3/11; all employees must complete re-education prior to returning to work. 126 employees were re-educated as of 8/3/11 and education is on-going.

At time of re-education employees are being instructed where the phone numbers are posted for Administrator, Director of Nurses, the Sun Quality Compliance number and the contact information for the Regional Human Resource for immediate reporting of abuse in case the reported would like to remain anonymous. The contacts are available 24/7.
All new employees will be educated on the first day of employment by the Director of Nursing Services or designee on abuse, neglect and misappropriation policy prior to contact with residents.

The Director of Social Work and the Director of Nursing will do random interviews with 5 staff members on all shifts weekly x 4 weeks, questions will include, types of abuse, where phone numbers are posted, who is the abuse coordinator and reporting abuse immediately. Re-education of staff on the abuse, neglect and misappropriation policy will completed weekly x 4 then monthly x 3 months.

Staff burn out will be managed thru schedule management that limits overtime. The Director of Nurses will review the overtime report daily. Beginning September 9, 2011 a new schedule will be implemented that follows a 4 days on 2 days off cycle. Director of Nursing/Supervisors will make daily rounds on all halls to monitor for any signs of burn out by speaking to staff and

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observing for burn out behavior. Burn out behavior could be identified as, but not limited to: frustration with peers, increased complains by individuals, short abrupt answers to peers, increased call outs, and reporting late to work. If burn out is identified the staff member will be removed from that assignment, encouraged to take time off or may be referred to Human Resources for additional support.

Quality Assurance Measures

The Center held on Ad hoc Performance Improvement Committee meeting on 8/3/11 at 2:00pm including the Medical Director to discuss the Plan of Correction. Discussion included steps taken to re-educate all staff on the abuse policy, immediate reporting of any allegations of abuse or suspected abuse, and assessment of injuries of unknown origins reported immediately. The Abuse policy and procedure was reviewed with no changes made.

The allegation was validated via interviews with 3 licensed nurses, Director of Social Work, housekeeping staff and 8 nursing assistants that were on duty on 8/4/11 during the second shifts. 2) Record review of the in-services on types of abuse; who the abuse is reported to; timeline for reporting abuse; how to care for residents that resist care; were reviewed for all employees (not just nursing employees, all other disciplines as well - 126 signatures were recorded on the in-service records), 3) Staff abuse interviews including staff verification of recent abuse in-service on 8/3/11. 4) Record review of the facility ' s QI committee meeting dates and members attending. Validation was also

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F 226	Continued From page 42 accomplished via review of the records of all residents who received full body assessment on 8/3/11.	F 226		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review, staff interview the facility failed to complete an initial comprehensive assessment of fourteen (14) days of admission for one (Resident#5) of eight sampled residents. Findings included: Resident #5 was admitted on 6/28/11, cumulative diagnosis included in part subdural hematoma, seizures, and hypertension Review of the medial record revealed a fourteen day comprehensive assessment using the Minimum Data Set (MDS) was not in the medical record. On 8/1/11 at 10:00am, MDS coordinator stated there was no MDS completed for Resident # 5. She stated the department was about one (1) to two (2) weeks behind completing the assessments. While the MDS coordinator viewed the missing data in the computer she indicated the dead line for Resident #5 ' s fourteen (14) day assessment was 7/12/11.	F 273	F 273 1. Resident #5 had a comprehensive assessment completed on 7/22/11 by MDS coordinator 2. A medical records audit was completed on 08/24/11 by Nursing Management and MDS nurses to assure that residents have a comprehensive assessment completed as required. 3. Re-education was completed with the Interdisciplinary team by Director of Nursing Services on 8/24/11 regarding the timeline for completing comprehensive assessments. 4. A validation of completion of comprehensive assessments will be completed by Nursing Management and MDS nurses weekly x 3 months. Validation findings will be reviewed by Performance Improvement Committee monthly for 3 months. Date of Compliance: August 26, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345143	A. BUILDING _____ B. WING _____	C 08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CARE AND REHABILITATION CENTER	900 W DOLPHIN ST SILER CITY, NC 27344

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview the facility failed to develop individualized care plan for falls for one (Resident#5) of eight (8)sampled residents. Findings included: Resident #5 was admitted on 6/28/11, cumulative diagnosis of subdural hematoma, seizures, and hypertension. Review of the physician order dated 6/29/11, " Bed and chair alarm in place check for function and placement every shift every day. Must wear helmet at while oob (out of bed) subdural	F 279	F 279 1. Resident # 5 had an individualized care plan developed and completed on 8/2/11 by MDS Coordinator. 2. A care plan audit was completed by Nursing Management, MDS, Activities, and Social Services on or before 8/26/11 with updates made as needed. 3. Nursing Supervisors and MDS staff were re-educated on completing, individualizing initial and comprehensive care plans by Director of Nursing Services on 8/24/11. 4. Residents that receive new physician orders will be reviewed in clinical meeting to assure that any care plan updates are completed. Residents that are newly admitted will have initial care plans reviewed within 24 hours of admit, then the care plans will be reviewed at the CARE meeting the second week post admission. Health Information Manager will complete an audit of newly admitted residents to assure that care plans have been completed weekly for 1 month and monthly for 2 months. A report	

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F 279	Continued From page 44 hematoma S/P(status post) evactuatuion. " (sic). · Review of the care plan dated 6/29/11, revealed Resident #5 was at risk for falls. The individualization for Resident #5 had not been completed as follows · " Mats on floor next to____side of bed " . · " Side rails up X___ while in bed as an enabler. " · " Assist resident getting in and out of bed with___ assistance using a std.(standard) walker , roll walker, quad can, Str. (straight) cane, no device, std.(standard) pivot transfer(sic), slide board. " Review of the Change of Condition documentation dated 6/29/11 revealed Resident #5 had a fall out of a wheel chair while visiting with family. Review of the physician order dated 6/30/11, " Must wear helmet at all times. " The order was transcribed by the Assistant Director of Nursing (ADON). Review of the daily nurse ' s documentation revealed Resident #5 refused to wear the protective head gear. During an interview 8/1/11 at 10:00am, aide #1 indicated Resident #5 throws her protective head gear off regularly it was a daily struggle. During an interview on 8/1/11 at 3:00pm, with the Assistant Director of Nursing (ADON) indicated she had written the interim care plan at admission, and stated she had not individualized the plan for Resident #5. ADON stated she was learning how to do the care plans and did not know how to fill in the blanks, delete or change the computerized plan. When asked should the care plan have been updated after Resident #5 was refusing to wear her helmet and fell from her	F 279	will be submitted to the Performance Improvement Committee monthly for 3 months. Date of Compliance: August 26, 2011	

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F 279	Continued From page 45 wheelchair. ADON indicated she should have updated the care plan when the new order was transcribed and once Resident #5 began to exhibit behaviors and refusing to wear the protective head gear. During an interview on 8/2/11 at 4:00pm, the director of nursing (DON) reviewed the documentation and indicated the care plan should be individualized for each resident.	F 279		