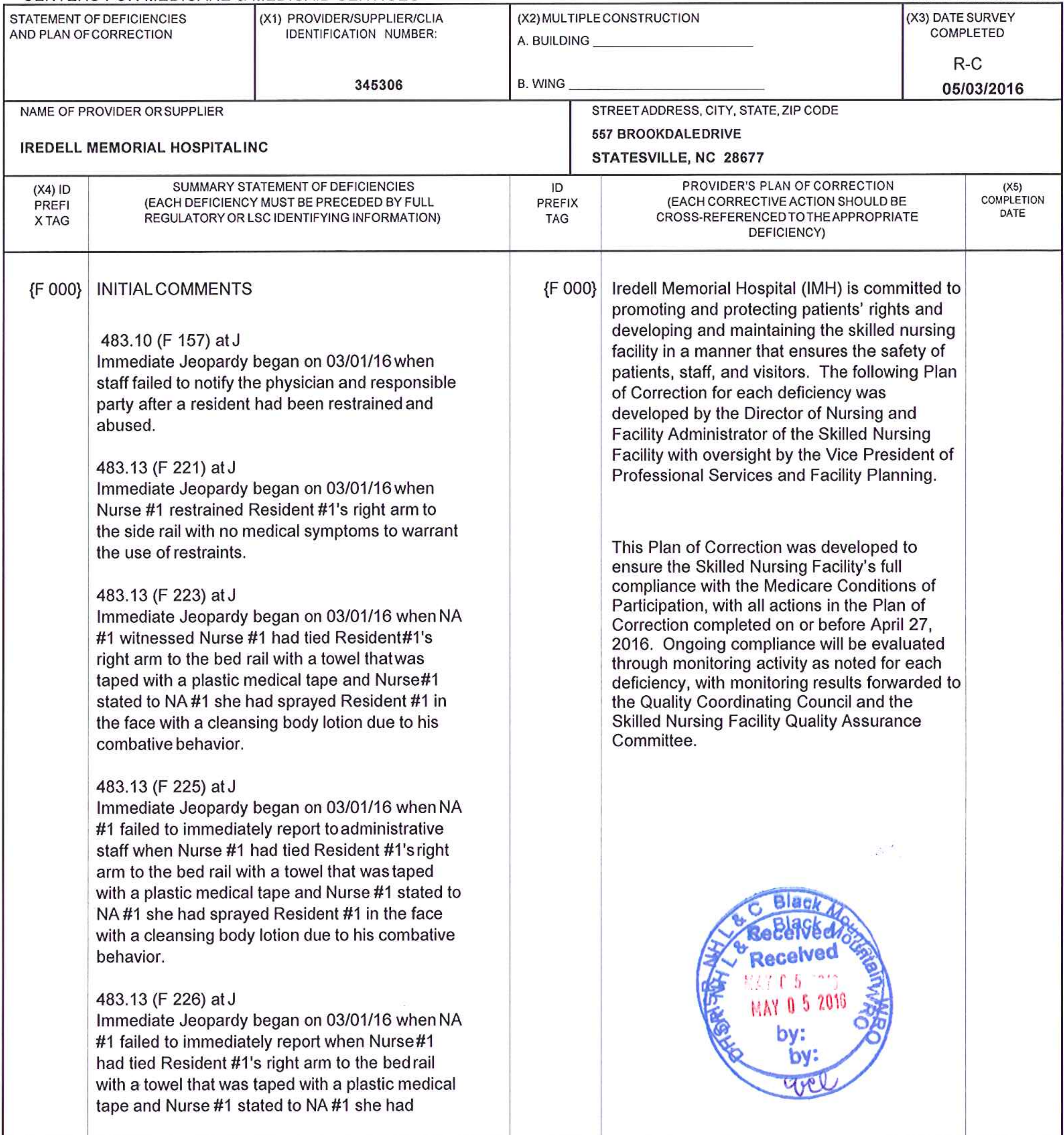
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING ______ B. WING ______	R-C 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DRIVE STATESVILLE, NC 28677

(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 000}	INITIAL COMMENTS 483.10 (F 157) at J Immediate Jeopardy began on 03/01/16 when staff failed to notify the physician and responsible party after a resident had been restrained and abused. 483.13 (F 221) at J Immediate Jeopardy began on 03/01/16 when Nurse #1 restrained Resident #1's right arm to the side rail with no medical symptoms to warrant the use of restraints. 483.13 (F 223) at J Immediate Jeopardy began on 03/01/16 when NA #1 witnessed Nurse #1 had tied Resident#1's right arm to the bed rail with a towel that was taped with a plastic medical tape and Nurse#1 stated to NA #1 she had sprayed Resident #1 in the face with a cleansing body lotion due to his combative behavior. 483.13 (F 225) at J Immediate Jeopardy began on 03/01/16 when NA #1 failed to immediately report to administrative staff when Nurse #1 had tied Resident #1's right arm to the bed rail with a towel that was taped with a plastic medical tape and Nurse #1 stated to NA #1 she had sprayed Resident #1 in the face with a cleansing body lotion due to his combative behavior. 483.13 (F 226) at J Immediate Jeopardy began on 03/01/16 when NA #1 failed to immediately report when Nurse #1 had tied Resident #1's right arm to the bed rail with a towel that was taped with a plastic medical tape and Nurse #1 stated to NA #1 she had	{F 000}	Iredell Memorial Hospital (IMH) is committed to promoting and protecting patients' rights and developing and maintaining the skilled nursing facility in a manner that ensures the safety of patients, staff, and visitors. The following Plan of Correction for each deficiency was developed by the Director of Nursing and Facility Administrator of the Skilled Nursing Facility with oversight by the Vice President of Professional Services and Facility Planning. This Plan of Correction was developed to ensure the Skilled Nursing Facility's full compliance with the Medicare Conditions of Participation, with all actions in the Plan of Correction completed on or before April 27, 2016. Ongoing compliance will be evaluated through monitoring activity as noted for each deficiency, with monitoring results forwarded to the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurance Committee. Received MAY 05 2016 by:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lindsay B. Smith	Administrator	05/05/2016

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 000}	Continued From page 1 sprayed Resident #1 in the face with a cleansing body lotion due to his combative behavior. 483. 20 (F 279) at J Immediate Jeopardy began on 03/01/16 when Nurse #1 tied Resident #1's right arm to the bed rail with a towel and taped it with a plastic medical tape to secure it and Nurse #1 stated to NA #1 she had sprayed Resident #1 in the face with a cleansing body lotion due to his combative behavior during nursing care. 483.75 (F 490) at J Immediate Jeopardy began on 03/01/16 when NA #1 witnessed Nurse #1 had tied Resident #1's right arm to the bed rail with a towel that was taped with a plastic medical tape and Nurse #1 stated to NA #1 she had sprayed Resident #1 in the face with a cleansing body lotion due to his combative behavior and NA #1 failed to immediately report the incident to administrative staff. The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance on 04/29/16. A revisit survey was conducted on 05/03/16 for verification of the facility's allegation of compliance and to determine the status of the ongoing Immediate Jeopardy. Immediate Jeopardy was removed on 05/03/16 at 10:45 AM. At the time of the exit on 05/03/16, the facility remained out of compliance at F 157, F 221, F 223, F 225, F 226, F 279 and F 490 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the	{F 000}		

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{F 000}	Continued From page 2 implementation of their correction actions.	{F 000}		
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by:	{F 157}	**CORRECTIVE ACTION FOR AFFECTED RESIDENT**	
			1. Upon learning of restraint application and alleged abuse, Director of Nursing of the Skilled Nursing Facility (DON) assessed Resident #1 on March 25, 2016, noting no sign of injury. Review of the patient's medical record by the DON and Facility Administrator on March 25, 2016, revealed no documentation of any signs of injury to Resident #1's eyes, face, arm, or wrists during subsequent shifts following the alleged events.	03/25/16
			2. Resident's physician was notified on March 25, 2016 at 12:45 pm. by the DON of restraint of patient and alleged spraying of Remedy Cleansing Body Lotion in patient's face. No new orders were received.	03/25/16
			3. Resident #1's family member was contacted by the DON on March 28, 2016, to request a meeting to discuss changes in the patient's care. The family member requested to schedule the meeting with the Director of Nursing for March 29, 2016 so additional family members could attend. On March 29, 2016, three family members, including Resident #1's Healthcare Power of Attorney met with the DON and the Facility Administrator of the Skilled Nursing Facility and the Vice President of Professional Services and Facility Planning. During this meeting, the family was notified of the allegations and the complete investigation with respect to Resident #1's care. The family was provided complete details of the	03/29/16

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{F 157} Continued From page 3

Based on record reviews and staff and physician interviews the facility failed to immediately notify the physician and responsible party when a resident became combative during nursing care and a nurse restrained the resident's arm to the bed rail with a towel and secured it with a plastic tape and sprayed the resident in the face with a cleansing body lotion for 1 of 1 sampled for abuse (Resident #1).

Immediate Jeopardy began on 03/01/16 when staff failed to notify the physician and responsible party after a resident had been restrained and abused.

The immediate jeopardy is present and ongoing.

The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance (AOC) on 04/29/16.

A revisit survey was conducted on 05/03/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following:
- Evidence of staff in-servicing on abuse prohibition and use of restraints.
- Documentation of audits for abuse, use of restraints and physician notification.
- Documentation of care plans revised and developed to be individualized for residents' care areas
- There had been no additional allegations of abuse made since 04/20/16.

Observations of nursing care, interviews with cognitively intact residents and interviews with staff present in the facility on 05/03/16, review of all documentation to support the AOC and

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incidents of March 1, 2016 and March 4, 2016. Family members had multiple questions, which were answered as fully as possible. Discussion ensued regarding resident's ongoing care and status. Family did note that Resident #1's behavior and status had improved over the past month and wished to have Resident #1 remain in the Skilled Nursing Facility for ongoing care. The meeting was concluded with an offer for additional meetings and/or discussions should other questions or concerns arise after the family members present discussed the events with another family member.

4. Resident's physician was again contacted on April 1, 2016 by the Vice President of Professional Services and Facility Planning to update him on the status of the investigation and the actions taken in response to the event. The Resident's Physician expressed that he was comfortable with the care of the residents on the Skilled Nursing Facility and he had no further suggestions for actions needed in response to the event. — 04/01/16

CORRECTIVE ACTION FOR OTHER RESIDENTS

1. On March 29, 2016, interviews were conducted by the DON with all alert and oriented long-term residents who were residents of the facility during the time of the alleged events. All residents reported no instances of abuse or neglect and verbalized that they had no complaints about the care they had received. — 03/29/16
2. Review of resident weekly skin assessments on March 2, 2016, March 9 — 03/23/16

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interviews with the facility's Administrator and Director of Nursing provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F- 157 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action.

The findings included:

Resident #1 was admitted to the facility on 09/24/15 with diagnoses which included heart failure, chronic obstructive lung disease, stroke, dementia, psychosis and schizophrenia.

A review of the admission Minimum Data Set (MDS) dated 10/01/15 indicated Resident #1 was severely impaired in cognition and exhibited no behaviors. The MDS further indicated Resident #1 required extensive assistance for transfers, bathing and hygiene but was totally dependent on staff for bed mobility and toileting and had upper extremity impairment on one side.

A review of the most recent quarterly Minimum Data Set (MDS) dated 03/27/16 indicated Resident #1 was severely impaired in cognition and exhibited physical and verbal behaviors directed toward others and was totally dependent on staff for activities of daily living and had upper extremity impairment on one side.

A review of a nurse's note dated 03/01/16 at 6:50 AM by Nurse #1 revealed Resident #1 was combative during attempt to give scheduled medications and spit out most of applesauce toward staff. The notes further revealed Resident

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2016, March 16, 2016, and March 23, 2016 by the DON revealed no documentation or reports of any injuries or wounds potentially secondary to abuse or application of restraints.

3. Interviews were conducted with 18 Skilled Nursing Facility clinical staff members by the DON and the Facility Administrator from March 24, 2016 – March 29, 2016 to inquire whether any other instances of abuse or restraint application or suspicious injury had been witnessed or observed with any other residents. No concerns were identified. — 03/29/16

4. Additionally, the DON or Facility Administrator interviewed 3 physicians who have the majority of the residents on the Skilled Nursing Facility, including the SNF Medical Director, to inquire whether they had any concerns about the care rendered or potential instances of abuse or restraint application for any of their residents. No concerns were identified. — 03/29/16

5. Following resident, staff, and physician interviews and medical record reviews, it was determined that no other residents were affected by these events and no new events were identified. — 03/29/16

SYSTEMIC CHANGES

1. During the Root Cause Analysis, the "Chain of Command" policy was reviewed by the Director of Nursing and Facility Administrator and determined to be appropriate. The Chain of Command policy specifies that staff may bypass their immediate supervisor when reporting an event if their supervisor is unresponsive or unavailable. Because the Chain of Command was not enacted at the time of the March 1, 2016 and March 4, 2016 events, it was determined that additional — 03/30/16

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{F 157}	Continued From page 5 #1 threatened to go home and get his pistol and shoot staff and attempts to redirect and reason with the resident were unsuccessful. There was no documentation in the nurse's notes that the physician or responsible party were notified. A review of a typed statement dated 03/28/16 by Nurse #1 revealed in part that taking care of Resident #1 was difficult because he was very aggressive and combative. The document further revealed on one night (no date was indicated) while discussing Resident #1 with the night shift nursing supervisor she suggested we might want to secure Resident #1's wrists while cleaning him and release them when we were finished. The document indicated later that night or the next night (no dates indicated) Resident #1 was cursing and combative and Nurse #1 called the supervisor who said to call security but we did not have time for that so in an effort to provide a safe situation for staff and resident she took a soft pillowcase and some tape and secured Resident #1's left wrist to the side rail. The document revealed Resident #1 could still move his arm but he was not able to swing his arm at them. The document indicated they cleaned and repositioned him, then Nurse #1 released the pillowcase, all taking less than 5 minutes. The document indicated Nurse #1 stated she was always in the room during this incident and accepted full responsibility for her judgment. An attempt was made to contact Nurse #1 on 04/19/16 at 2:00 PM by phone but there was no answer and no option to leave a message. During a phone interview on 04/19/16 at 4:36 PM with the night shift Nursing Supervisor she stated she had not instructed Nurse #1 to tie Resident	{F 157}	staff education was indicated. 2. To prevent delays in notification of changes to Resident's physician and Resident's legal representative, effective March 24, 2016, working staff was provided education prior to the start of shift on the policy of immediate notification of management staff of any suspected or witnessed abuse or neglect or any restraint application. Upon notification, management staff notifies the resident's responsible party and attending physician. Any changes in the resident's behavior or physical condition must be reported promptly to the resident's physician and responsible party. No Skilled Nursing Facility staff members are allowed to work until they have received this education. 3. On April 21, 2016, the Skilled Nursing Facility clinical and non-clinical staff annual competencies and the orientation checklists were expanded to include specific education on Proper Notification of Witnessed / Suspected Abuse or Restraint Application and Chain of Command. New employees will receive this education during departmental orientation to the Skilled Nursing Facility. Current employees will receive this education annually during staff competencies. 4. Education was provided to all Skilled Nursing Facility clinical and non-clinical staff and ancillary staff that provide care, treatment, or services to residents of the Skilled Nursing Facility via a computer-based learning module from April 22 – 24, 2016 on Proper Notification of Witnessed / Suspected Abuse or Restraint Application and Chain of Command. After April 24, 2016, no staff will be allowed to work on	 03/26/16 04/21/16 04/24/16

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{F 157} Continued From page 6

#1's arm to the bed rail. She stated she made rounds during the shift and was available for staff to call her when a resident was out of control and she would have expected Nurse #1 to immediately notify the physician and responsible party after Resident #1's right arm was tied to the bed rail.

A review of a facility document completed by the Administrator titled Allegation of Resident Abuse/Restraint dated 03/30/16 revealed a brief summary of interviews of staff. The document indicated on 03/01/16 NA #1 assisted Nurse#1 when they provided morning care to Resident #1. NA #1 assisted with providing peri care then left the room for a short period of time to do other duties. When she finished she noticed the door of Resident #1's room was closed so she went inside the room. When she entered the room she noticed Resident #1's right hand was tied to the bed with a towel and was taped. Nurse #1 was present in the room. NA #1 immediately began to remove the tape and towel to free his hand but Nurse #1 asked what she was doing. Resident #1 had applesauce on his face and a substance on his face that was dripping down the front of him. Nurse #1 stated she was trying to give Resident #1 his meds but he was not listening. On 03/24/16 the DON met with NA #1 and she reported the incident that had occurred on 03/01/16 and reported Nurse #1 briefly restrained Resident #1's right hand to his bed rail with a pillowcase/towel and tape to protect herself and resident while providing peri care due to combative behavior. On 03/04/16 Nurse #1 and NA #2 were attempting to get Resident #1 up out of bed with a sit to stand lift and over to a chair. Resident #1 became agitated and began hitting and spitting continuously and after he was

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the Skilled Nursing Facility until this education has been completed.

5. Proper Notification of Witnessed / Suspected Abuse or Restraint Application and Chain of Command was added to the list of annual competencies required for any staff providing care, treatment, or services to residents of the Skilled Nursing Facility. — 04/21/16

MONITORING

1. 100% of working Skilled Nursing Facility clinical and non-clinical staff will complete education on the policy of immediate notification of management staff of any suspected or witnessed abuse or neglect or any restraint application and Chain of Command. — 03/26/16
2. 100% of employees hired to the Skilled Nursing Facility after 04/21/16 will receive education on Proper Notification of Witnessed / Suspected Abuse or Restraint Application and Chain of Command. Orientation records for 100% of new hires to the Skilled Nursing Facility will be audited by the Facility Administrator for 3 months to ensure all employees received training on proper notification. Audit results will be reported to the Quality Coordinating Council and the Skilled Nursing Quality Assurance Committee. — 04/21/16
3. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete education on proper notification of witnessed / suspected abuse or restraint application and Chain of Command. — 04/24/16
4. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff — 04/24/16

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{F 157}	Continued From page 7 transferred to his chair NA #2 turned and observed Nurse #1 as she sprayed Resident #1 in the face with cleansing body lotion due to his spitting at her. NA #2 got a wet wash cloth and wiped Resident #1's face to get the lotion off. On 03/24/16 the DON met with NA #1 and she reported the incident that had occurred on 03/01/16. NA #1 reported Nurse #1 briefly restrained Resident #1's right hand to his bed rail with a pillowcase/towel and tape to protect herself and resident while providing peri care due to combative behavior. On 03/25/16 the DON met with NA #2 and she reported the incident that had occurred on 03/04/16 when Nurse #1 sprayed Resident #1 in the face with cleansing body lotion. On 03/25/16 Resident #1's physician was notified of the incidents. On 03/28/16 at 5:30 PM Resident #1's family was contacted and a meeting was requested to discuss the incident and on 03/29/16 at 10:30 AM administration met with Resident #1's family to inform them of the incidents. A review of facility investigation dated 03/30/16 completed by the Administrator titled Final Summary of Investigation revealed Nurse #1 was consistent with the fact she restrained Resident #1's hand with a pillowcase and tape to avoid being hit. The report also revealed NA #1 provided further clarification and remembered Nurse #1 had spray a bottle of cleansing body lotion in her hand when NA #1 entered Resident #1's room on 03/01/16 and Nurse #1 told NA#1 she had sprayed Resident #1 in the face because he did not listen. The report indicated therefore, it was concluded Nurse #1 intentionally restrained Resident #1 and intentionally sprayed him in or around the face on 03/01/16 and intentionally sprayed Resident #1 in or around the face on	{F 157}	will complete the 2016 competency on proper notification of witnessed / suspected abuse or restraint application and Chain of Command.	

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{F 157}	Continued From page 8	{F 157}		

03/04/16 to serve as punishment for hitting, kicking or spitting at her and/or not following her direction during medication administration.

During an interview on 04/19/16 at 11:08 AM the Director of Nursing (DON) confirmed NA #1 had witnessed Resident #1's arm tied to the bed rail early in the morning before the end of the shift on 03/01/16. The DON explained on 03/04/16 there was no restraint used but NA #2 observed Nurse #1 spraying a cleansing body lotion in Resident's #1's face. She further verified Nurse #1 was no longer employed by the facility.

An attempt was made on 04/20/16 at 11:15 AM to contact Resident #1's physician by phone but was unsuccessful.

During an interview on 04/20/16 at 2:24 PM with the facility Medical Director he stated he thought there was a better way to have handled the situation instead of tying the resident's arm to the bed rail. He explained physicians were available and on call 24 hours a day 7 days a week and it was his expectation nursing staff should call the physician if a resident had a change in condition or exhibited behaviors and were out of control. He further stated he would want to be notified about the incidents as soon as possible and why they had occurred.

An attempt was made on 04/20/16 at 2:35 PM to contact Resident #1's responsible party but was unsuccessful.

During a follow up interview on 04/20/16 at 2:58 PM the DON verified after review of the nurse's notes there was no documentation Resident #1's physician or responsible party were notified after

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{F 157}	Continued From page 9 the incidents. She confirmed Resident #1's physician was unaware of the incidents until he was notified during the investigation on 03/25/16 and the family was unaware of the incidents until the administrative staff met with them on 03/29/16. She stated it was her expectation when a resident had a change in status she expected nursing staff to notify the physician and they should notify the responsible party. She stated if she had known the morning of 03/01/16 that Resident #1's arm had been tied to the bed rail and he had been sprayed in the face with the cleansing body lotion she would have notified the physician and responsible party immediately. During an interview on 04/20/16 at 4:23 PM the Administrator stated it was her expectation that nursing staff should have reported immediately to the physician and responsible party when Resident #1's arm was restrained to the bed rail and when Resident #1 was sprayed in the face with the cleansing body lotion. The facility Administrator, DON, hospital Administrator and hospital Vice President were notified of immediate jeopardy on 04/19/16 at 4:02 PM.	{F 157}		
{F 221} SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	{F 221}	**CORRECTIVE ACTION FOR AFFECTED RESIDENT** 1. On March 1, 2016, NA #1 reported that she promptly removed the restraint. 2. The Facility Administrator recalled that on March 4, 2016, Nurse #1 had requested to meet with her and during that meeting expressed frustration with Resident #1's behavior. Nurse #1 reported being upset	03/01/16 03/04/16

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Based on observations, staff and physician interviews, police interview and record reviews the facility failed to protect a resident's right to be free of physical restraint when staff restrained a resident without medical symptoms. As a result a nurse restrained the resident's arm to the bed rail with a towel and secured the towel with a plastic medical tape when he became combative during care for 1 of 1 resident sampled for abuse (Resident #1).

Immediate Jeopardy began on 03/01/16 when Nurse #1 restrained Resident #1's right arm to the side rail with no medical symptoms to warrant the use of restraints.

The immediate jeopardy is present and ongoing.

The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance (AOC) on 04/29/16.

A revisit survey was conducted on 05/03/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following:
- Evidence of staff in-servicing on abuse prohibition and use of restraints.
- Documentation of audits for abuse, use of restraints and physician notification.
- Documentation of care plans revised and developed to be individualized for residents' care areas
- There had been no additional allegations of abuse made since 04/20/16.

Observations of nursing care, interviews with cognitively intact residents and interviews with staff present in the facility on 05/03/16, review of

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and crying during her shift the evening before. When questioned, Nurse #1 denied anything further happening. The Facility Administrator asked Nurse #1 if she felt she needed to take some time off work, and Nurse #1 responded that she had only one more shift to work, and then was going to be on vacation from March 5 – March 13. The Facility Administrator felt Nurse #1 was experiencing burn-out, and decided to immediately remove Nurse #1 from Resident #1's care. Nurse #1 was not assigned to provide care for Resident #1 after this meeting and throughout the duration of her employment.

3. Since the facility is committed to being restraint-free and use of restraints is not tolerated, Nurse #1 was suspended on March 24, 2016 at 4:45 p.m. — 03/24/16

4. Upon learning of restraint application and alleged abuse, Director of Nursing of the Skilled Nursing Facility (DON) assessed Resident #1 on March 25, 2016, noting no sign of injury. Review of the patient's medical record by the DON and Facility Administrator on March 25, 2016, revealed no documentation of any signs of injury to Resident #1's eyes, face, arm, or wrists during subsequent shifts following the alleged events. — 03/25/16

5. Suspension of Nurse #1 continued pending full investigation with termination of the nurse's employment on March 30, 2016 for application of restraint. The nurse did not return to work or provide any resident care from March 24, 2016 – March 30, 2016. — 03/30/16

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all documentation to support the AOC and interviews with the facility's Administrator and Director of Nursing provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F- 221 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action.

The findings included:

Resident #1 was admitted to the facility on 09/24/15 with diagnoses which included heart failure, chronic obstructive lung disease, stroke, dementia, psychosis and schizophrenia.

A review of the most recent quarterly Minimum Data Set (MDS) dated 03/27/16 indicated Resident #1 was severely impaired in cognition and exhibited physical and verbal behaviors directed toward others and was totally dependent on staff for activities of daily living and had upper extremity impairment on one side. The MDS further revealed restraints were not used.

A review of a care plan dated 02/15/16 titled psychotropic's revealed Resident #1 was receiving Prozac and Risperdal for behavior disinhibitions. The goal indicated resident's behavior will be managed by lowest possible dose of medications. The interventions were listed to observe for side effects of Prozac such as anxiety, somnolence (drowsiness), dizziness or headaches and observe for side effects of Risperdal such as nausea, constipation, sedation and dizziness.

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CORRECTIVE ACTION FOR OTHER RESIDENTS

1. Review of weekly skin assessments on March 2, 2016, March 9, 2016, March 16, 2016, and March 23, 2016 by the DON revealed no documentation or reports of any injuries or wounds potentially secondary to application of restraints. — 03/23/16

2. Staff interviews and a root cause analysis were immediately initiated upon receiving NA #1's report of restraint application. — 03/24/16

3. NA #1 was suspended on March 25, 2016 at 1:25 p.m. for failure to immediately notify management staff of the observed application of restraint. — 03/25/16

4. Education on the Statement of Restraint-Free Facility and the importance of Immediately following the Chain of Command if application of restraint is observed was provided to NA #1 at the time of suspension and prior to her return to work on April 2, 2016. — 04/02/16

5. As of Friday, March 25, 2016, the DON and Facility Administrator have been rounding separately on all three shifts at least three times per week to confirm the understanding of the restraint-free policy and to meet with staff regarding any questions or concerns. — Ongoing

6. On March 29, 2016, interviews were conducted by the DON with all alert and oriented long-term residents who were residents of the facility during the time of the alleged events. All residents verbalized that they had no complaints about the care they had received. — 03/29/16

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A review of a care plan with a revised date of 02/17/16 tiled psychotropic's indicated Risperdal was discontinued and Resident #1 was started on Zyprexa and to continue goal that resident's behavior will be managed by lowest possible dose of medications. The interventions were listed to observe for side effects of Zyprexa such dry mouth, sedation and somnolence.

A review of a care plan with a revised date of 02/22/16 titled psychotropic's indicated Prozac and Zyprexa were discontinued.

A review of a care plan with a revised date of 02/29/16 titled psychotropic's indicated Seroquel 25 milligrams was started for schizoaffective disorder and the goal indicated that resident's behavior will be managed by lowest possible dose of medications. The interventions were listed to observe for side effects of Seroquel such as agitation, dizziness, dry mouth and constipation.

A review of a staff schedule for the 11:00 PM - 7:00 AM shift from 02/29/16 through 03/01/16 revealed Nurse #1 and Nurse Aide (NA) #1 were assigned to care for Resident#1.

A review of a nurse's note dated 03/01/16 at 4:49 AM by Nurse #1 revealed Resident #1 had slept quietly off and on all night and no complaints or requests were verbalized.

A review of a nurse's note dated 03/01/16 at 6:50 AM by Nurse #1 revealed Resident #1 was combative during attempt to give scheduled medications and spit out most of applesauce toward staff. The notes further revealed Resident #1 threatened to go home and get his pistol and

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7. Interviews were conducted with 18 Skilled Nursing Facility clinical staff members by the DON and the Facility Administrator from March 24, 2016 – March 29, 2016 to inquire whether any other instances of restraint application or suspicious injury had been witnessed or observed with any other residents. No concerns were identified. — 03/29/16

8. Additionally, on March 25, 2016 and March 29, 2016, the DON or Facility Administrator interviewed 3 physicians who have the majority of the residents on the Skilled Nursing Facility, including the SNF Medical Director, to inquire whether they had any concerns about the care rendered or restraint application for any of their residents. No concerns were identified. — 03/29/16

SYSTEMIC CHANGES

1. To mitigate this type of event from reoccurring, on March 24, 2016, March 25, 2016, and March 26, 2016, all Skilled Nursing Facility clinical and non-clinical staff was provided education by the DON prior to the start of shift on the policy of immediate notification of management staff of any suspected or witnessed restraint application. Specific discussion points included the facility's commitment to maintaining a restraint-free environment and the use of restraints for medical symptoms or convenience are not tolerated. Education included a discussion of restraint alternatives to utilize in response to aggressive or combative residents, to include notification of Nursing Supervisor, Resident's physician, and Responsible Party and calling Security or transferring resident to ED as indicated. — 03/26/16

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shoot staff and attempts to redirect and reason with the resident were unsuccessful.

A review of a nurse's notes dated 03/01/16 at 9:57 PM revealed Resident #1 resting in bed with no complaints and took his PM medication with no complications.

A review of nursing assessments dated 03/01/16 through 03/31/16 revealed there were no medical symptoms documented for use of restraints.

A review of a handwritten statement by NA#1 revealed on Monday night 02/29/16 she worked with Nurse #1 and Resident #1 was very combative. The statement further revealed Nurse #1 helped NA #1 change Resident #1 and after he was changed NA #1 left the room to check on other residents and after she finished with other residents, NA #1 noticed Nurse #1 was still in Resident #1's room so she went to see if Nurse #1 needed any help. The document indicated when NA #1 opened the door she witnessed Nurse #1 fighting with Resident #1 and had his arm tied to the bed with a bath towel and tape wrapped around it. The document further revealed NA #1 immediately removed the tape and towel from Resident #1's arm and straightened him up in bed because he was lying sideways in the bed.

During an interview on 04/19/16 at 2:08 PM with NA #1 she confirmed she had written the hand written statement and dated it 02/29/15 because she started her shift at 11:00 PM on that day and worked until the end of her shift at 7:00 AM on 03/01/16. She explained around 6:00 AM on 03/01/16 Nurse #1 helped her change Resident #1. She stated she gathered up the dirty linens

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No Skilled Nursing Facility staff members are allowed to work until they have received this education.

2. On 3/29/16 and 3/31/16, Skilled Nursing Facility staff was provided education by the DON on managing challenging behaviors and resident rights. — 03/31/16

3. During the Root Cause Analysis, the "Chain of Command" policy was reviewed by the Director of Nursing and Facility Administrator and determined to be appropriate. The Chain of Command policy specifies that staff may bypass their immediate supervisor when reporting an event if their supervisor is unresponsive or unavailable. Because the Chain of Command was not enacted at the time of the March 1, 2016 and March 4, 2016 events, it was determined that additional staff education was indicated. — 03/30/16

4. The root cause analysis was completed on April 1, 2016. The investigation revealed that Nurse #1 felt frustrated and at her "wit's end" with resident's combativeness and she willfully violated the facility's Restraint-Free policy. NA #1 recognized that the restraint application should have been immediately reported, but opted to withhold the report due to personal reasons. It was determined that additional education needed to be provided to Skilled Nursing Facility staff on the facility's Restraint-Free policy, examples of restraints, the importance of immediate notification of restraint application, and methods of dealing with frustration or burn-out. — 04/01/16

5. On 4/09/16, the Director of Nursing implemented "Daily Reminders" for all — Ongoing

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{F 221}	Continued From page 14 and trash and left the room and when she had finished disposing of the linen and trash she noticed Resident #1's door was closed and it concerned her because they did not usually leave his door closed. NA #1 explained when she opened the door Nurse #1 was standing on the left side of the bed and told her to close the door. NA #1 stated she then observed Resident #1's right arm near his wrist was tied to the bed rail with a towel. She explained the towel was wrapped around the bedrail then around Resident #1's wrist and then the ends of the towel were twisted together and plastic medical tape was wrapped multiple times around the towel to secure it. She verified she observed Resident #1's arm was restrained with a white towel and stated she was sure it was a towel and it was not a pillow case. She stated she immediately went to the resident and he was lying across the bed from one side to the other instead of his head toward the head of the bed and his feet toward the foot of the bed. She explained the towel was wrapped pretty tight around his arm and he had limited movement of his right arm. She further explained Resident #1 was unable to use his left arm because of left sided weakness from a stroke so he could not have removed the towel from his right arm. She stated she immediately grabbed the towel and started pulling the tape off and released his arm and she noticed he had applesauce with particles of medication in it and a solution that looked like body cleanser on his face. She explained Nurse #1 told her she had tried to give Resident #1 his morning medications but he was combative and was spitting them at her. NA #1 stated she thought when Nurse #1 tied Resident #1's arm to the bed rail it agitated him more. She described his behaviors as sporadic and she was never sure when he was	{F 221}	clinical staff. These reminders are a printed document on a topic related to resident care selected by the Director of Nursing. Topics include challenging behaviors, care of the resident with dementia, resident rights, and other pertinent topics. The reminders are posted for all staff members to review daily seven days/ week. 6. On April 12, 2016, the Regional Ombudsman provided mandatory education to Skilled Nursing Facility clinical and non-clinical staff regarding resident rights, including the right to be free from restraints. A second training session with the Regional Ombudsman is scheduled for April 27, 2016. 7. On April 21, 2016, the Skilled Nursing Facility clinical and non-clinical staff annual competencies and the orientation checklists were expanded to include Specific education on: • Restraint-free Environment • Managing Challenging Behaviors • Chain of Command • Proper Notification of Restraint Application • Caregiver Fatigue New employees will receive this education during departmental orientation to the Skilled Nursing Facility. Current employees will receive this education annually during staff competencies. 8. On April 22, 2016, these same topics were added to the list of annual competencies	 04/27/16 04/21/16 04/22/16

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going to be combative. She explained Resident #1 sometimes made inappropriate verbal remarks and sometimes would hit and kick at staff during care but she redirected him or stopped what she was doing and went back later to provide his care and then he usually was cooperative.

During an observation on 04/19/16 at 2:30 PM NA #1 provided a demonstration of how Resident #1's arm was tied to the bedrail in an empty resident room and the DON and Administrator were present for the demonstration. NA #1 turned the bed diagonally so that it was no longer parallel with the wall and the side rails were in the up position on the right side of the bed. NA#1 requested the DON to lie across the bed from side to side with her back resting on the side rail and NA #1 wrapped the towel around the side rail then around the DON's right wrist and twisted the ends of the towel together and taped it to secure it with Transpore medical tape (a latex-free, hypoallergenic, transparent and perforated plastic tape that offers strong adhesion). NA #1 verified the tape was the same plastic medical tape that had been used to tape the towel on Resident #1's arm.

A review of a typed statement dated 03/28/16 by Nurse #1 revealed in part that taking care of Resident #1 was difficult because he was very aggressive and combative. The document further revealed on one night (no date was indicated) while discussing Resident #1 with the night shift nursing supervisor she suggested we might want to secure Resident #1's wrists while cleaning him and release them when we were finished. The document indicated later that night or the next night (no dates indicated) Resident #1 was

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required for any staff providing care, treatment, or services to residents of the Skilled Nursing Facility.

9. Education was provided to all Skilled Nursing Facility clinical and non-clinical staff and ancillary staff that provide care, treatment, or services to residents of the Skilled Nursing Facility via a computer-based learning module from April 22 – 24, 2016 on the following topics: — 04/24/16
   - Resident's Rights
   - Restraint-Free Environment
   - Proper Notification of Restraint Application
   - Managing Challenging Behaviors
   - Chain of Command
   - Caregiver Fatigue

   After April 24, 2016, no staff will be allowed to work on the Skilled Nursing Facility until this education has been completed.

10. Education was provided to all Skilled Nursing Facility clinical and non-clinical staff and ancillary staff that provide care to residents of the Skilled Nursing Facility via a computer-based learning module on the facility's commitment to remain restraint-free and examples of restraints from April 22 – 24, 2016. — 04/24/16

MONITORING

1. 100% of working Skilled Nursing Facility clinical and non-clinical staff will complete education on the policy of immediate notification of management staff of any suspected or witnessed abuse or neglect or any restraint application, restraint-free environment, & restraint alternatives. — 03/26/16

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{F 221}	Continued From page 16 cursing and combative and Nurse #1 called the supervisor who said to call security but we did not have time for that so in an effort to provide a safe situation for staff and resident Nurse #1 took a soft pillowcase and some tape and secured Resident #1's left wrist to the side rail. The document revealed Resident #1 could still move his arm but was not able to swing his arm at them. The document indicated we cleaned and repositioned him, then Nurse #1 released the pillowcase, all taking less than 5 minutes. The document indicated Nurse #1 stated she was always in the room during this incident and accepted full responsibility for her judgment. An attempt was made to contact Nurse #1 on 04/19/16 at 2:00 PM by phone but there was no answer and no option to leave a message. During a phone interview on 04/19/16 at 4:36 PM with the night shift Nursing Supervisor she stated she had not instructed Nurse #1 to tie Resident #1's arm to the bed rail. She stated she made rounds during the shift and was available for staff to call her when a resident was out of control. She further stated it was her expectation Nurse #1 should have called her and should not have tied Resident #1's arm to the bed rail. She explained staff should have attempted to redirect Resident #1 when he was combative or should have stopped what they were doing and went back at a later time to provide care. A review of facility investigation dated 03/30/16 completed by the Administrator titled Final Summary of Investigation revealed it was determined Nurse #1 was unable to provide a consistent story. The report indicated Nurse #1 was inconsistent on the date of the incident, the	{F 221}	2. 100% of working Skilled Nursing Facility staff will complete education on managing challenging behaviors and resident rights.	04/22/16
			3. The Facility Administrator will monitor weekly to ensure that seven "Daily Reminders" were posted by the DON for the staff. Monitoring will continue for 3 months and results will be reported to the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurance Committee.	Ongoing
			4. 100% of working Skilled Nursing Facility clinical and non-clinical staff will receive training on resident rights.	04/27/16
			5. 100% of employees hired to the Skilled Nursing Facility after 04/21/16 will receive education during orientation on restraint-free environment, managing challenging behaviors, chain of command, proper notification of restraint application, and caregiver fatigue. Orientation records for 100% of new hires to the Skilled Nursing Facility will be audited by the Facility Administrator for 3 months to ensure all employees received training on these items. Audit results will be reported to the Quality Coordinating Council and the Skilled Nursing Quality Assurance Committee.	Ongoing
			6. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete the 2016 competency on proper notification of witnessed / suspected abuse or restraint application.	04/24/16
			7. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete education on resident's rights, restraint-free environment, proper	04/24/16

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{F 221}	Continued From page 17 hand that was restrained, the NA present in the room, when the restraint was actually applied or if a Nurse Supervisor was notified. The report further indicated Nurse #1 was consistent with the fact she restrained Resident #1's hand with a pillowcase and tape to avoid being hit so therefore, it was concluded Nurse #1 intentionally restrained Resident #1. A review of a facility document completed by the Administrator titled Allegation of Resident Abuse/Restraint dated 03/30/16 revealed a brief summary of interviews of staff. The document indicated on 03/01/16 NA #1 assisted Nurse#1 when they provided morning care to Resident #1. NA #1 assisted with providing peri care then left the room for a short period of time to do other duties. When she finished she noticed the door of Resident #1's room was closed so she went inside the room. When she entered the room she noticed Resident #1's right hand was tied to the bed with a towel and was taped. Nurse #1 was present in the room. NA #1 immediately began to remove the tape and towel to free his hand but Nurse #1 asked what she was doing. Nurse #1 stated she was trying to give Resident #1 his medications but he was not listening. On 03/24/16 the DON met with NA #1 and she reported the incident that had occurred on 03/01/16. NA #1 reported Nurse #1 briefly restrained Resident #1's right hand to his bed rail with a pillowcase/towel and tape to protect herself and resident while providing peri care due to combative behavior. During an interview on 04/19/16 at 11:08 AM with the Director of Nursing (DON) she confirmed Nurse #1 and NA #1 were assigned to care for Resident #1 on the night shift from 02/29/16	{F 221}	notification of restraint application, managing challenging behaviors, chain of command, and caregiver fatigue. 8. During rounding 3 times per week for six months, the DON and Facility Administrator will ensure that all residents are free from restraints. Audit results will be reported to the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurance Committee.	 Ongoing

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through 03/01/16. She also confirmed NA #1 had witnessed Resident #1's arm tied to the bed rail early in the morning before the end of the shift on 03/01/16. She further verified Nurse #1 was no longer employed by the facility.

During an observation on 04/19/16 at 1:00 PM the door of Resident #1's room was open and he was sitting calmly in a chair in his room facing the door. An over bed table was in front of him and he was moving items on top of the table around with his right hand and there were no restraints observed.

During an observation on 04/20/16 at 10:35 AM the door of Resident #1's room was open and Resident #1 sitting up in a chair in his room with the over bed table in front of him. He was sitting quietly and as staff spoke to him he replied in a calm voice and raised his right hand to wave when staff walked by his door and there were no restraints observed.

During an interview on 04/19/16 at 1:15 with the Assistant Chief of Police he verified Resident #1's family reported the incident of tying Resident #1's arm to the bedrail to the police at the police department. He explained they conducted an investigation and issued a warrant for Nurse #1's arrest. He further explained Nurse #1 came to the police station and was taken into custody and she confessed to tying Resident #1's arm to the bed rail. He explained after being processed she was taken to jail on 2 counts of assault on a handicapped person and 1 count of false imprisonment. He further explained she had been released from jail on bond.

During an interview on 04/20/16 at 2:24 PM with

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{F 221}	Continued From page 19 the facility Medical Director he confirmed the facility was a restraint free facility. He stated he thought there was a better way to have handled the situation instead of tying the resident's arm to the bed rail. He explained usually when a resident exhibited behaviors someone sat with them to monitor them. During a follow up interview on 04/20/16 at 2:58 PM the DON stated they were a restraint-free facility and there should be absolutely no reason for use of physical restraints or restraints used for convenience and there were no medical reasons for restraints to be used for Resident #1. She further stated it was her expectation that staff should have used other least restrictive interventions to handle Resident #1's combative behaviors. She explained Resident #1 should have had a care plan for behaviors with specific interventions for staff to use when he exhibited behaviors. She stated interventions should have included for staff to step away or reach out for help from coworkers or supervisors when a resident exhibited behaviors or redirect residents when they exhibited behaviors or change staff members because sometimes different staff would calm the resident. During an interview on 04/20/16 at 4:23 PM the Administrator stated it was her expectation that no resident in the facility should be restrained because they were a restraint-free facility. She further stated it was her expectation that nursing staff should have reported immediately when Resident #1's arm was restrained to the bed rail. The facility Administrator, DON, hospital Administrator and hospital Vice President were notified of immediate jeopardy on 04/19/16 at	{F 221}		

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{F 221} Continued From page 20
4:02 PM.

{F 223} SS=D 483.13(b), 483.13(c)(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 observations, staff and physician interviews, police interview and record reviews the facility failed to protect a resident's right to be free from physical abuse when a resident became combative during nursing care and a nurse restrained the resident's arm to the bed rail with a towel and secured it with a plastic tape and sprayed the resident in the face on 2 occasions with a cleansing body lotion for 1 of 1 resident sampled for abuse (Resident #1).

Immediate Jeopardy began on 03/01/16 when NA #1 witnessed Nurse #1 had tied Resident #1's right arm to the bed rail with a towel that was taped with a plastic medical tape and Nurse #1 stated to NA #1 she had sprayed Resident #1 in the face with a cleansing body lotion due to his combative behavior.

The immediate jeopardy is present and ongoing.

The facility provided the State Agency and the Centers for Medicare and Medicaid with an

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{F 223} **CORRECTIVE ACTION FOR AFFECTED RESIDENT**

1. On March 1, 2016, NA #1 reported that she promptly removed the restraint, cleaned Resident #1's face and repositioned him in bed. — 03/01/16

2. On March 4, 2016, NA #2 reported she immediately cleaned Resident #1's face to remove the lotion. — 03/04/16

3. The Facility Administrator recalled that on March 4, 2016, Nurse #1 had requested to meet with her and during that meeting expressed frustration with Resident #1's behavior. Nurse #1 reported being upset and crying during her shift the evening before. When questioned, Nurse #1 denied anything further happening. The Facility Administrator asked Nurse #1 if she felt she needed to take some time off work, and Nurse #1 responded that she had only one more shift to work, and then was going to be on vacation from March 5 – March 13. The Facility Administrator felt Nurse #1 was experiencing burn-out, and decided to immediately remove Nurse #1 from Resident #1's care. Nurse #1 was not assigned to provide care for Resident #1 after this meeting and throughout the duration of her employment. — 03/04/16

4. Since the facility is committed to being restraint-free and use of restraints is not tolerated, Nurse #1 was suspended on March 24, 2016 at 4:45 p.m. pending investigation of the alleged abuse. — 03/24/16

5. Upon learning of restraint application and alleged abuse, the Director of Nursing of — 03/25/16

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acceptable allegation of compliance (AOC) on 04/29/16.

A revisit survey was conducted on 05/03/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following:

- Evidence of staff in-servicing on abuse prohibition and use of restraints.
- Documentation of audits for abuse, use of restraints and physician notification.
- Documentation of care plans revised and developed to be individualized for residents' care areas
- There had been no additional allegations of abuse made since 04/20/16.

Observations of nursing care, interviews with cognitively intact residents and interviews with staff present in the facility on 05/03/16, review of all documentation to support the AOC and interviews with the facility's Administrator and Director of Nursing provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F-223 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action.

The findings included:

A review of a Material Safety Data Sheet (MSDS) dated 02/26/08 indicated the body cleanser used by the facility was labeled Remedy, 4-in-1 body cleanser and described the appearance as a thin yellow liquid. The MSDS sheet further indicated it was not considered to be a skin irritant but with eye contact to flush with adequate amount of cool

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the Skilled Nursing Facility (DON) assessed Resident #1 on March 25, 2016, noting no sign of injury. Review of the patient's medical record by the DON and Facility Administrator on March 25, 2016, revealed no documentation of any signs of injury to Resident #1's eyes, face, arm, or wrists during subsequent shifts following the alleged events.

6. Nurse #1 was terminated by the Director of Nursing for allegation of abuse and improper application of restraint. — 03/30/16

CORRECTIVE ACTION FOR OTHER RESIDENTS

1. Review of resident weekly skin assessments on March 2, 2016, March 9, 2016. March 16, 2016, and March 23, 2016 by the DON revealed no documentation or reports of any injuries or wounds potentially secondary to abuse. — 03/23/16
2. Staff interviews and a root cause analysis were immediately initiated on March 24, 2016 by the Director of Nursing and Facility Administrator. — 03/24/16
3. As of Friday, March 25, 2016, the DON and Facility Administrator have been rounding separately on all three shifts at least three times per week to confirm understanding that there is no tolerance of abuse in the facility and to meet with staff regarding any questions or concerns. — Ongoing
4. Interviews were conducted with 18 Skilled Nursing Facility clinical staff members by the DON and the Facility Administrator from March 24, 2016 – March 29, 2016 to — 03/29/16

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water for at least 15 minutes and seek medical attention if irritation persists.

Resident #1 was admitted to the facility on 09/24/15 with diagnoses which included heart failure, chronic obstructive lung disease, stroke, dementia, psychosis and schizophrenia.

A review of the admission Minimum Data Set (MDS) dated 10/01/15 indicated Resident #1 was severely impaired in cognition and exhibited no behaviors. The MDS further indicated Resident #1 required extensive assistance for transfers, bathing and hygiene but was totally dependent on staff for bed mobility and toileting and had upper extremity impairment on one side.

A review of the most recent quarterly Minimum Data Set (MDS) dated 03/27/16 indicated Resident #1 was severely impaired in cognition and exhibited physical and verbal behaviors directed toward others and was totally dependent on staff for activities of daily living and had upper extremity impairment on one side. The MDS further revealed restraints were not used.

A review of a staff schedule for the 11:00 PM - 7:00 AM shift from 02/29/16 through 03/01/16 revealed Nurse #1 and Nurse Aide (NA) #1 were assigned to care for Resident#1.

A review of a handwritten statement by NA#1 revealed on Monday night 02/29/16 she worked with Nurse #1 and Resident #1 was very combative. The statement further revealed Nurse #1 helped NA #1 change Resident #1 and after he was changed NA #1 left the room to check on other residents and after she finished with other residents, NA #1 noticed Nurse #1 was still in

inquire whether any other instances of restraint application or suspicious injury had been witnessed or observed with any other residents. No concerns were identified.

5. On March 29, 2016, interviews were conducted by the DON with all alert and oriented long-term residents who were residents of the facility during the time of the alleged events. All residents verbalized that they had no complaints about the care they had received. — 03/29/16

6. Additionally, on March 25, 2016 and March 29, 2016, the DON or Facility Administrator interviewed 3 physicians who have the majority of the residents on the Skilled Nursing Facility, including the SNF Medical Director, to inquire whether they had any concerns about the care rendered for any of their residents. No concerns were identified. — 03/29/16

SYSTEMIC CHANGES

1. To mitigate this type of event from reoccurring, on March 24, 2016, March 25, 2016, and March 26, 2016, all Skilled Nursing Facility clinical and non-clinical staff was provided education by the DON prior to the start of shift on what is considered abuse and types of abuse. No Skilled Nursing Facility staff members are allowed to work until they have received this education. — 03/26/16

2. On 3/29/16 and 3/31/16, Skilled Nursing Facility staff was provided education on resident abuse by the Director of Nursing. — 03/31/16

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{F 223}	Continued From page 23 Resident #1's room so she went to see if Nurse #1 needed any help. The document indicated when NA #1 opened the door she witnessed Nurse #1 fighting with Resident #1 and had his arm tied to the bed with a bath towel and tape wrapped around it. The document further revealed NA #1 immediately removed the tape and towel from Resident #1's arm and straightened him up in bed because he was lying sideways in the bed. During an interview on 04/19/16 at 2:08 PM with NA #1 she confirmed she worked the night shift from 11:00 PM on 02/29/16 until 7:00 AM on 03/01/16. She explained around 6:00 AM on 03/01/16 Nurse #1 helped her change Resident #1. She stated she gathered up the dirty linens and trash and left the room and when she had finished disposing of the linen and trash she noticed Resident #1's door was closed and it concerned her because they did not usually leave his door closed. NA #1 explained when she opened the door Nurse #1 was standing on the left side of the bed and told her to close the door. NA #1 stated she then observed Resident #1's right arm near his wrist was tied to the bed rail with a towel. She explained the towel was wrapped around the bedrail then around Resident #1's wrist and then the ends of the towel were twisted together and plastic medical tape was wrapped multiple times around the towel to secure it. She verified she observed Resident #1's arm was restrained with a white towel and stated she was sure it was a towel and it was not a pillow case. She stated she immediately went to the resident and he was lying across the bed from one side to the other instead of his head toward the head of the bed and his feet toward the foot of the bed. She explained the towel was wrapped	{F 223}	3. During the Root Cause Analysis, the "Chain of Command" policy was reviewed by the Director of Nursing and Facility Administrator and determined to be appropriate. The Chain of Command policy specifies that staff may bypass their immediate supervisor when reporting an event if their supervisor is unresponsive or unavailable. Because the Chain of Command was not enacted at the time of the March 1, 2016 and March 4, 2016 events, it was determined that additional staff education was indicated. 4. The root cause analysis was completed on April 1, 2016 by the Director of Nursing and Facility Administrator. Following resident, staff, and physician interviews and medical record reviews, it was determined that no other residents were affected by these events and no new events were identified. The investigation revealed that Nurse #1 felt frustrated and at her "wit's end" with resident's combativeness and she willfully violated the facility's Restraint-Free policy. NA #2 did not recognize that spraying Resident #1 in the face with cleansing lotion was a form of abuse even if it was immediately addressed and did not result in harm. It was determined that additional education needed to be provided to Skilled Nursing Facility staff on the definition of abuse and examples of abusive behavior, managing challenging behaviors, and methods of dealing with frustration or burn-out. 5. On 4/09/16, the Director of Nursing implemented "Daily Reminders" for all clinical staff. These reminders are a printed document on a topic related to	03/30/16 04/01/16 Ongoing

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pretty tight around his arm and he had limited movement of his right arm. She further explained Resident #1 was unable to use his left arm because of left sided weakness from a stroke so he could not have removed the towel from his right arm. She stated she immediately grabbed the towel and started pulling the tape off and released his arm. She explained after she removed the towel from his arm she noticed he had applesauce with pieces of medication in it and a solution was all over his face and on the front of his gown. She stated the solution on his face was yellow in color and looked like body cleanser they used as a lotion/cleanser during peri care. She explained she did not witness Nurse #1 spray Resident #1 in the face but that Nurse #1 had told her she sprayed him in the face with the body cleanser. She stated Resident #1 was not able to rub the lotion off his face because his right hand was tied to the bed rail.

During an observation on 04/19/16 at 2:30 PM NA #1 provided a demonstration of how Resident #1's arm was tied to the bedrail in an empty resident room and the DON and Administrator were present for the demonstration. NA #1 turned the bed diagonally so that it was no longer parallel with the wall and the side rails were in the up position on the right side of the bed. NA#1 requested the DON to lie across the bed from side to side with her back resting on the side rail and NA #1 wrapped the towel around the side rail then around the DON's right wrist and twisted the ends of the towel together and taped it to secure it with Transpore medical tape (a latex-free, hypoallergenic, transparent and perforated plastic tape that offers strong adhesion). NA #1 verified the tape was the same plastic medical tape that had been used to tape the towel on Resident #1's

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resident care selected by the Director of Nursing. Topics include challenging behaviors, care of the resident with dementia, resident rights, and other pertinent topics. The reminders are posted for all staff members to review daily seven days/ week.

6. On 4/12/16, the Regional Ombudsman provided mandatory education to clinical and non-clinical Skilled Nursing Facility staff regarding resident rights, including the right to be free from abuse. This training session will be repeated by the Regional Ombudsman on 4/27/16. — 04/27/16

7. On April 21, 2016, the Skilled Nursing Facility staff annual competencies and the orientation checklist were expanded to include specific education on: — 04/21/16
   - Managing Challenging Behaviors
   - Caregiver Fatigue
   - Chain of Command

   New employees will receive this education during departmental orientation to the Skilled Nursing Facility. Current employees will receive this education annually during staff competencies.

8. On April 22, 2016, these same topics were added to the list of annual competencies required for any staff providing care, treatment, or services to residents of the Skilled Nursing Facility. — 04/22/16

9. Education was provided to all Skilled Nursing Facility clinical and non-clinical staff and ancillary staff that provide care, treatment, or services to residents of the Skilled Nursing Facility via a computer- — 04/24/16

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arm.

A review of a facility document completed by the Administrator titled Allegation of Resident Abuse/Restraint dated 03/24/16-03/30/16 revealed a brief summary of interviews of staff. The document indicated on 03/01/16 NA #1 assisted Nurse #1 when they provided morning care to Resident #1. NA #1 assisted with providing peri care then left the room for a short period of time to do other duties. When she finished she noticed the door of Resident #1's room was closed so she went inside the room. When she entered the room she noticed Resident #1's right hand was tied to the bed with a towel and was taped and Nurse #1 was present in the room. NA #1 immediately began to remove the tape and towel to free his hand but Nurse #1 asked what she was doing. The document further revealed Resident #1 had applesauce on his face and a substance on his face that was dripping down the front of him. Nurse #1 stated she was trying to give Resident #1 his medications but he was not listening. On 03/24/16 the DON met with NA #1 and she reported the incident that had occurred on 03/01/16. NA #1 reported Nurse #1 briefly restrained Resident #1's right hand to his bed rail with a pillowcase/towel and tape to protect herself and resident while providing peri care due to combative behavior. The document indicated on 03/04/16 Nurse #1 and NA #2 were attempting to get Resident #1 up out of bed with a sit to stand lift and over to a chair. Resident #1 became agitated and began hitting and spitting continuously and after he was transferred to his chair NA #2 turned and observed Nurse #1 as she sprayed Resident #1 in the face with cleansing lotion due to his spitting at her. NA #2 got a wet wash cloth and wiped Resident #1's

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based learning module from April 22 – 24, 2016 on the following topics:

- Resident's Rights
- Managing Challenging Behaviors
- Caregiver Fatigue, including access to EAP Program
- Chain of Command

10. Additionally all clinical and non-clinical Skilled Nursing Facility staff were provided education from April 22 -24, 2016 on actions to be taken in response to a safety event where resident or staff safety are in jeopardy ("5 Rights of Duty To Report"). These actions include providing a safe environment for the resident, speaking up about the event, documenting the event, enlisting help from co-workers, and ensuring staff safety. After April 24, 2016 no staff will be allowed to work on the Skilled Nursing Facility until this education has been completed. — 04/24/16

MONITORING

1. 100% of working Skilled Nursing Facility clinical and non-clinical staff will complete education on what is considered abuse and types of abuse. — 03/26/16
2. 100% of working Skilled Nursing Facility staff will complete education on resident abuse. — 04/22/16
3. The Facility Administrator will monitor weekly to ensure that seven "Daily Reminders" were posted by the DON for the staff. Monitoring will continue for 3 months and results will be reported to the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurance Committee. — Ongoing

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{F 223}	Continued From page 26 face to get the lotion off. On 03/24/16 the DON met with NA #1 and she reported the incident that had occurred on 03/01/16. NA #1 reported Nurse #1 briefly restrained Resident #1's right hand to his bed rail with a pillowcase/towel and tape to protect herself and resident while providing peri care due to combative behavior. On 03/25/16 the DON met with NA #2 and she reported the incident that had occurred on 03/04/16 when Nurse #1 sprayed Resident #1 in the face with cleansing lotion. A review of a typed statement dated 03/26/16 at 1:15 AM by NA #2 revealed she was in Resident #1's room on 03/04/16 with Nurse #1 to get Resident #1 out of bed. The document indicated Resident #1 was combative (hitting, kicking and trying to spit on staff) and after Resident #1 was transferred to a chair NA #2 asked Nurse #1 several times to assist her to get Resident back in the chair so he wouldn't slide off the edge but instead Nurse #1 proceeded to spray Resident #1 in the face with some lotion base cleansing spray which made Resident #1 more aggressive. The document further indicated NA #2 immediately got a washcloth and washed the resident's face. During a phone interview on 04/19/16 at 3:02 PM with NA #2 she explained Nurse #1 wanted to get Resident #1 up to a chair on 03/04/16 between 6:00 AM and 6:30 AM and they transferred him with a sit to stand lift from his bed to the chair. She stated Resident #1 was trying to hit them and kick them and he was spitting at them. NA #2 stated she kept asking Nurse #1 to help her position Resident #1 in the chair because he was sliding forward but Nurse #1 ignored her and grabbed a spray bottle of cleansing lotion and sprayed him multiple times in the face. She	{F 223}	4. 100% of working Skilled Nursing Facility clinical and non-clinical staff will receive training on resident rights.	04/27/16
			5. 100% of employees hired to the Skilled Nursing Facility after 04/21/16 will receive education during orientation on managing challenging behaviors, caregiver fatigue, and chain of command. Orientation records for 100% of new hires to the Skilled Nursing Facility will be audited by the Facility Administrator for 3 months to ensure all employees received training on these items. Audit results will be reported to the Quality Coordinating Council and the Skilled Nursing Quality Assurance Committee.	Ongoing
			6. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete the 2016 competency on managing challenging behaviors, caregiver fatigue, and chain of command.	04/24/16
			7. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete education on resident's rights, managing challenging behaviors, caregiver fatigue, and chain of command.	04/24/16
			8. 100% of working clinical and non-clinical Skilled Nursing Facility staff will complete education on actions to be taken in response to a safety event where resident or staff safety are in jeopardy ("5 Rights of Duty to Report").	04/24/16
			9. During rounding 3 times per week for six months, the DON and Facility Administrator will ensure that all residents are free from abuse. Audit results will be reported to the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurance Committee.	Ongoing

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stated the lotion was on his face at his cheekbones and was running down his face so she got a washcloth and wiped the lotion off. She explained when Nurse #1 sprayed him in the face it startled him and made his agitation worse. She stated she felt she had taken care of it by washing the lotion off Resident #1's face and at the time did not think it was abuse.

A review of a typed statement dated 03/28/16 by Nurse #1 revealed in part that taking care of Resident #1 was difficult because he was very aggressive and combative. The document further revealed on one night (no date was indicated) while discussing Resident #1 with the night shift nursing supervisor she suggested we might want to secure Resident #1's wrists while cleaning him and release them when we were finished. The document indicated later that night or the next night (no dates indicated) Resident #1 was cursing and combative and Nurse #1 called the supervisor who said to call security but we did not have time for that so in an effort to provide a safe situation for staff and resident, Nurse #1 took a soft pillowcase and some tape and secured Resident #1's left wrist to the side rail. The document revealed Resident #1 could still move his arm but was not able to swing his arm at them. The document indicated we cleaned and repositioned him, then Nurse #1 released the pillowcase, all taking less than 5 minutes. The document indicated Nurse #1 stated she was always in the room during this incident and accepted full responsibility for her judgment.

An attempt was made to contact Nurse #1 on 04/19/16 at 2:00 PM by phone but there was no answer and no option to leave a message.

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During a phone interview on 04/19/16 at 4:36 PM with the night shift Nursing Supervisor she stated she had not instructed Nurse #1 to tie Resident #1's arm to the bed rail. She stated she made rounds during the shift and was available for staff to call her when a resident was out of control. She further stated it was her expectation Nurse #1 should have called her and should not have tied Resident #1's arm to the bed rail and should not have spayed the cleansing body lotion in his face.

During an interview on 04/19/16 at 1:15 with the Assistant Chief of Police he verified Resident #1's family reported the incident of tying Resident #1's arm to the bedrail to the police at the police department. He explained they conducted an investigation and issued a warrant for Nurse #1's arrest. He further explained Nurse #1 came to the police station and was taken into custody and she confessed to tying Resident #1's arm to the bed rail. He explained after being processed she was taken to jail on 2 counts of assault on a handicapped person and 1 count of false imprisonment. He further explained she had been released from jail on bond.

During an observation on 04/19/16 at 1:00 PM the door of Resident #1's room was open and he was sitting calmly in a chair in his room facing the door. An over bed table was in front of him and he was moving items on top of the table around with his right hand.

During an observation on 04/20/16 at 10:35 AM the door of Resident #1's room was open and Resident #1 sitting up in a chair in his room with the over bed table in front of him. He was sitting quietly and as staff spoke to him he replied in a

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{F 223}	Continued From page 29 calm voice and raised his right hand to wave when staff walked by his door. During an interview on 04/20/16 at 2:24 PM with the facility Medical Director he confirmed the DON had informed him during the investigation of the incidents that had occurred on 03/01/16 and 03/04/16. He stated he thought there was a better way to have handled the situation instead of tying the resident's arm to the bed rail. During a follow up interview on 04/20/16 at 2:58 PM the DON stated she considered the incidents of tying Resident #1's arm to the bed rail and spraying him in the face with the cleansing lotion as abuse. The DON explained there was a zero tolerance for abuse in the facility. During an interview on 04/20/16 at 4:23 PM the Administrator stated it was her expectation of staff to treat residents respectfully and abuse of residents was not tolerated in the facility. The facility Administrator, DON, hospital Administrator and hospital Vice President were notified of immediate jeopardy on 04/19/16 at 4:02 PM.	{F 223}		
{F 225} SS=D	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	{F 225}	**CORRECTIVE ACTION FOR AFFECTED RESIDENT** 1. On March 1, 2016, NA #1 reported that she promptly removed the restraint, cleaned the Resident #1's face, and repositioned him in bed. 2. On March 4, 2016, NA #2 reported she immediately cleaned Resident #1's face to remove the lotion.	 03/01/16 03/04/16

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{F 225}	Continued From page 30 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 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 staff interviews and record reviews the facility staff failed to immediately report witnessed incidents of physical abuse and the failure to report placed other residents at risk for abuse. The facility staff failed to immediately report when a resident became combative during nursing care and a nurse restrained the resident's arm to the bed rail with a towel and secured it with a plastic	{F 225}	3. The Facility Administrator recalled that on March 4, 2016, Nurse #1 had requested to meet with her and during that meeting expressed frustration with Resident #1's behavior. Nurse #1 reported being upset and crying during her shift the evening before. When questioned, Nurse #1 denied anything further happening. The Facility Administrator asked Nurse #1 if she felt she needed to take some time off work, and Nurse #1 responded that she had only one more shift to work, and then was going to be on vacation from March 5 – March 13, 2016. The Facility Administrator felt Nurse #1 was experiencing burn-out, and decided to immediately remove Nurse #1 from Resident #1's care. Nurse #1 was not assigned to provide care for Resident #1 after this meeting and throughout the duration of her employment. 4. Since the facility is committed to being restraint-free and use of restraints is not tolerated, Nurse #1 was suspended on March 24, 2016 at 4:45 p.m. pending investigation of the alleged abuse. 5. Upon learning of restraint application and alleged abuse, Director of Nursing of the Skilled Nursing Facility (DON) assessed Resident #1 on March 25, 2016, noting no sign of injury. Review of the patient's medical record by the DON and Facility Administrator on March 25, 2016, revealed no documentation of any signs of injury to Resident #1's eyes, face, arm, or wrists during subsequent shifts following the alleged events. 6. Suspension of Nurse #1 continued pending full investigation with termination of the nurse's employment on March 30, 2016 for alleged abuse and restraint	03/04/16 03/24/16 03/25/16 03/30/16

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tape and sprayed the resident in the face with a cleansing body lotion on 2 occasions for 1 of 1 resident sampled for abuse (Resident #1).

Immediate Jeopardy began on 03/01/16 when NA #1 failed to immediately report to administrative staff when Nurse #1 had tied Resident #1's right arm to the bed rail with a towel that was taped with a plastic medical tape and Nurse #1 stated to NA #1 she had sprayed Resident #1 in the face with a cleansing body lotion due to his combative behavior.

The immediate jeopardy is present and ongoing.

The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance (AOC) on 04/29/16.

A revisit survey was conducted on 05/03/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following:
- Evidence of staff in-servicing on abuse prohibition and use of restraints.
- Documentation of audits for abuse, use of restraints and physician notification.
- Documentation of care plans revised and developed to be individualized for residents' care areas
- There had been no additional allegations of abuse made since 04/20/16.

Observations of nursing care, interviews with cognitively intact residents and interviews with staff present in the facility on 05/03/16, review of all documentation to support the AOC and interviews with the facility's Administrator and Director of Nursing provided sufficient evidence to

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application. The nurse did not return to work or provide any resident care from March 24, 2016 – March 30, 2016.

CORRECTIVE ACTION FOR OTHER RESIDENTS

1. Review of resident weekly skin assessments on March 2, 2016, March 9, 2016. March 16, 2016, and March 23, 2016 by the DON revealed no documentation or reports of any injuries or wounds potentially secondary to abuse. — 03/23/16
2. Staff interviews and a root cause analysis were immediately initiated on March 24, 2016 by the Director of Nursing and Facility Administrator. — 03/24/16
3. NA #1 and NA #2 were suspended on March 25, 2016 for failure to immediately notify management staff of the suspected abuse and application of restraint. — 03/25/16
4. As of Friday, March 25, 2016, the DON and Facility Administrator have been rounding separately on all three shifts at least three times per week to confirm understanding that there is no tolerance of abuse in the facility and to meet with staff regarding any questions or concerns. — Ongoing
5. Interviews were conducted with 18 Skilled Nursing Facility clinical staff members by the DON and the Facility Administrator from March 24, 2016 – March 29, 2016 to inquire whether any other instances of suspicious injury or abuse had been witnessed or observed with any other residents. No concerns were identified. — 03/29/16

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support corrective action by the facility to remove the immediate jeopardy at F- 225 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action.

The findings included:

Resident #1 was admitted to the facility on 09/24/15 with diagnoses which included heart failure, chronic obstructive lung disease, stroke, dementia, psychosis and schizophrenia.

A review of the most recent quarterly Minimum Data Set (MDS) dated 03/27/16 indicated Resident #1 was severely impaired in cognition and exhibited physical and verbal behaviors directed toward others and was totally dependent on staff for activities of daily living and had upper extremity impairment on one side. The MDS further revealed restraints were not used.

A review of a staff schedule for the 11:00 PM - 7:00 AM shift from 02/29/16 through 03/01/16 revealed Nurse #1 and Nurse Aide (NA) #1 were assigned to care for Resident #1.

A review of a handwritten statement by NA#1 revealed on Monday night 02/29/16 she worked with Nurse #1 and Resident #1 was very combative. The statement further revealed Nurse #1 helped NA #1 change Resident #1 and after he was changed NA #1 left the room to check on other residents and after she finished with other residents, NA #1 noticed Nurse #1 was still in Resident #1's room so she went to see if Nurse #1 needed any help. The document indicated

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6. On March 29, 2016, interviews were conducted by the DON with all alert and oriented long-term residents who were residents of the facility during the time of the alleged events. All residents verbalized that they had no complaints about the care they had received — 03/29/16

7. Additionally, on March 25, 2016 and March 29, 2016, the DON or Facility Administrator interviewed 3 physicians who have the majority of the residents on the Skilled Nursing Facility, including the SNF Medical Director, to inquire whether they had any concerns about the care rendered for any of their residents. No concerns were identified. — 03/29/16

SYSTEMIC CHANGES

1. To mitigate this type of event from reoccurring, on March 24, 2016, March 25, 2016, and March 26, 2016, all Skilled Nursing Facility clinical and non-clinical staff was provided education by the DON prior to the start of shift on the need to immediately notify management staff of any suspected or witnessed abuse or restraint application. Any changes in the resident's behavior or physical condition must be reported promptly to the resident's physician and responsible party. No Skilled Nursing Facility staff members are allowed to work until they have received this education. — 03/26/16

2. During the Root Cause Analysis, the "Chain of Command" policy was reviewed by the Director of Nursing and Facility Administrator and determined to be — 03/30/16

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when NA #1 opened the door she witnessed Nurse #1 fighting with Resident #1 and had his arm tied to the bed with a bath towel and tape wrapped around it. The document further revealed NA #1 immediately removed the tape and towel from Resident #1's arm and straightened him up in bed because he was lying sideways in the bed.

During an interview on 04/19/16 at 2:08 PM with NA #1 she confirmed she worked the night shift from 11:00 PM on 02/29/16 until 7:00 AM on 03/01/16. She explained around 6:00 AM on 03/01/16 Nurse #1 helped her change Resident #1. She stated she gathered up the dirty linens and trash and left the room and when she had finished disposing of the linen and trash she noticed Resident #1's door was closed and it concerned her because they did not usually leave his door closed. NA #1 explained when she opened the door Nurse #1 was standing on the left side of the bed and Resident #1's right arm near his wrist was tied to the bed rail with a towel. She explained the towel was wrapped around the bedrail then around Resident #1's wrist and then the ends of the towel were twisted together and plastic medical tape was wrapped multiple times around the towel to secure it. She verified she observed Resident #1's arm was restrained with a white towel and stated she was sure it was a towel and it was not a pillow case. She stated she immediately went to the resident and he was lying across the bed from one side to the other instead of his head toward the head of the bed and his feet toward the foot of the bed. She explained the towel was wrapped pretty tight around his arm and he had limited movement of his right arm. She further explained Resident #1 was unable to use his left arm because of left sided weakness

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appropriate. The Chain of Command policy specifies that staff may bypass their immediate supervisor when reporting an event if their supervisor is unresponsive or unavailable. Because the Chain of Command was not enacted at the time of the March 1, 2016 and March 4, 2016 events, it was determined that additional staff education was indicated.

3. The root cause analysis was completed on April 1, 2016. This investigation revealed that Nurse #1 felt frustrated and at her "wit's end" with Resident #1's combativeness, and she independently chose to inappropriately restrain Resident #1. NA #1 recognized that the restraint application should have been immediately reported, but opted to withhold the report due to personal reasons. NA #2 did not recognize that spraying Resident #1 in the face with cleansing lotion was a form of abuse even if it was immediately addressed and did not result in harm. It was determined that additional education needed to be provided to Skilled Nursing Facility staff on the definition of abuse and examples of abusive behavior, the importance of immediate notification of any restraint application or suspected or witnessed abuse, managing challenging behaviors, and methods of dealing with frustration or burn-out. — 04/01/16

4. On 4/12/16, the Regional Ombudsman provided mandatory education to clinical and non-clinical Skilled Nursing Facility staff regarding resident rights, including the right to be free from abuse and the North Carolina Elder Abuse Act. This training session will be repeated by the Regional Ombudsman on 4/27/16. — 04/27/16

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from a stroke so he could not have removed the towel from his right arm. She stated she immediately grabbed the towel and started pulling the tape off and released his arm and she noticed he had applesauce with particles of medication in it and a solution that looked like body cleanser on his face. She explained the solution looked like the cleanser they used on a resident's skin while cleaning them and it was all over his face and on the front of his gown and stated the cleanser was yellow in color. She stated Resident #1 was not able to rub the lotion off his face because his right hand was tied to the bed rail. She explained she did not observe Nurse #1 spray the body cleanser on Resident #1's face but Nurse #1 told her she had sprayed Resident #1's face with the cleanser. She confirmed she gave report to the day shift NA on 03/01/16 who was assigned to Resident #1 but she did not report that Resident #1's arm had been tied to the bed rail with a towel. She stated she knew Resident #1's arm should not have been tied to the bed rail but she did not report the incident at the time because she did not want to get anyone in trouble. She further stated she was concerned she would be treated differently by her co-workers if she reported it. She explained she worked with Nurse #1 after the incident on 03/01/16 but they worked on different halls. She explained when the DON called her in on 03/23/16 to talk about some things she saw it as an opportunity to show her the handwritten statement she had written dated 02/29/16.

A review of a typed statement dated 03/26/16 at 1:15 AM by NA #2 revealed she was in Resident #1's room on 03/04/16 with Nurse #1 to get Resident #1 out of bed. The document indicated Resident #1 was combative (hitting, kicking and trying to spit on staff) and after Resident #1 was

5. On April 21, 2016, the Skilled Nursing Facility staff annual competencies and the orientation checklist were expanded to include specific education on Proper Notification of Witnessed / Suspected Abuse or Restraint Application, Caregiver Fatigue, and Chain of Command. New employees will receive this education during departmental orientation to the Skilled Nursing Facility. Current employees will receive this education annually during staff competencies. — 04/21/16

6. On April 22, 2016, these same topics were added to the list of annual competencies required for any staff providing care, treatment, or services to residents of the Skilled Nursing Facility. — 04/22/16

7. Education was provided to all Skilled Nursing Facility clinical and non-clinical staff and ancillary staff that provide care, treatment, or services to residents of the Skilled Nursing Facility via a computer-based learning module from April 22 – 24, 2016 on the Proper Notification of Witnessed / Suspected Abuse or Restraint Application, Caregiver Fatigue, and Chain of Command. After April 24, 2016, no staff will be allowed to work on the Skilled Nursing Facility until this education has been completed. — 04/24/16

8. Additionally all clinical and non-clinical Skilled Nursing Facility staff were provided education from April 22 -24, 2016 on actions to be taken in response to a safety event where resident or staff safety are in jeopardy ("5 Rights of Duty To Report"). These actions include providing a safe environment for the resident, speaking up about the event, documenting the event, enlisting help from co-workers, and — 04/24/16

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transferred to a chair NA #2 asked Nurse #1 several times to assist her to get Resident #1 back in the chair so he wouldn't slide off the edge but instead Nurse #1 proceeded to spray Resident #1 in the face with some lotion base cleansing spray which made Resident #1 more aggressive. The document further indicated NA #2 immediately got a washcloth and washed the resident's face.

During a phone interview on 04/19/16 at 3:02 PM with NA #2 she explained Nurse #1 wanted to get Resident #1 up to a chair on 03/04/16 between 6:00 AM and 6:30 AM and they transferred him with a sit to stand lift from his bed to the chair. She stated Resident #1 was trying to hit them and kick them and he was spitting at them. NA #2 stated she kept asking Nurse #1 to help her position Resident #1 in the chair because he was sliding forward but Nurse #1 ignored her and Nurse #1 grabbed a spray bottle of cleansing lotion and sprayed him multiple times in the face. She stated the lotion was on his face at his cheekbones and was running down his face so she got a washcloth and wiped the lotion off. She explained when Nurse #1 sprayed him in the face it startled him and made his agitation worse. She stated after they got him positioned in his chair she left the room and gave report to the first shift NA but did not report to her that Nurse #1 had sprayed Resident #1 in the face with the body cleansing lotion. She stated she left the facility and didn't report the incident to anyone. She further stated she felt she had taken care of it by washing the lotion off Resident #1's face and at the time did not think it was abuse but now she realized she should have reported the incident immediately. She confirmed she met with the DON on 03/25/16 and reported the incident that

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ensuring staff safety. After April 24, 2016, no staff will be allowed to work on the Skilled Nursing Facility until this education has been completed.

MONITORING

1. 100% of working Skilled Nursing Facility clinical and non-clinical staff will complete education on the need to notify management staff of any suspected or witnessed abuse or restraint application. — 03/26/16

2. 100% of working Skilled Nursing Facility clinical and non-clinical staff will receive training on resident rights and North Carolina Elder Abuse Act. — 04/27/16

3. 100% of employees hired to the Skilled Nursing Facility after 04/21/16 will receive education during orientation on proper notification of witnessed/suspected abuse or restraint application, caregiver fatigue, and chain of command. Orientation records for 100% of new hires to the Skilled Nursing Facility will be audited by the Facility Administrator for 3 months to ensure all employees received training on these items. Audit results will be reported to the Quality Coordinating Council and the Skilled Nursing Quality Assurance Committee. — Ongoing

4. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete the 2016 competency on proper notification of witnessed/suspected abuse or restraint application, caregiver fatigue, and chain of command. — 04/24/16

5. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete education on proper — 04/24/16

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had occurred on 03/04/16. She explained the DON requested she write a statement about the incident that occurred on 03/04/16 so that night she wrote the statement that was dated 03/26/16 and emailed it to the DON.

A review of a typed statement dated 03/28/16 by Nurse #1 revealed in part that taking care of Resident #1 was difficult because he was very aggressive and combative. The document further revealed on one night (no date was indicated) while discussing Resident #1 with the night shift nursing supervisor she suggested we might want to secure Resident #1's wrists while cleaning him and release them when we were finished. The document indicated later that night or the next night (no dates indicated) Resident #1 was cursing and combative and Nurse #1 called the supervisor who said to call security but we did not have time for that so in an effort to provide a safe situation for staff and resident, Nurse #1 took a soft pillowcase and some tape and secured Resident #1's left wrist to the side rail. The document revealed Resident #1 could still move his arm but was not able to swing his arm at them. The document indicated we cleaned and repositioned him, then Nurse #1 released the pillowcase, all taking less than 5 minutes. The document indicated Nurse #1 stated she was always in the room during this incident and accepted full responsibility for her judgment.

An attempt was made to contact Nurse #1 on 04/19/16 at 2:00 PM by phone but there was no answer and no option to leave a message.

During a phone interview on 04/19/16 at 4:36 PM with the night shift Nursing Supervisor she stated she had not instructed Nurse #1 to tie Resident

Provider's Plan of Correction (continued):

notification of witnessed/suspected abuse or restraint application, caregiver fatigue, and chain of command.

6. 100% of working clinical and non-clinical Skilled Nursing Facility staff will complete education on actions to be taken in response to a safety event where resident or staff safety are in jeopardy ("5 Rights of Duty to Report"). — Completion date: 04/24/16

7. During rounding 3 times per week for six months, the DON and Facility Administrator will ensure that all residents are free from abuse. Audit results will be reported to the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurance Committee. — Completion date: Ongoing

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IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DRIVE STATESVILLE, NC 28677

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#1's arm to the bed rail. She stated she made rounds during the shift and was available for staff to call her when a resident was out of control. She further stated it was her expectation Nurse #1 should have called her and should not have tied Resident #1's arm to the bed rail or sprayed him in the face and Nurse #1, NA #1 and NA #2 should have reported the incidents immediately so an investigation could have been completed.

A review of the initial 24 hour report that was sent to the North Carolina Health Care Personnel Registry by facsimile (fax) was dated 03/24/16 at 6:05 PM. The report revealed it was completed by the DON and the allegation description revealed it was reported to the DON on 03/24/16 at 11:00 AM that Nurse #1 had briefly restrained Resident #1's right hand to the bed rail with a pillow case and tape to protect herself and Resident #1 during peri care due to combative behavior.

A review of the 5 working day report that was sent to the North Carolina Health Care Personnel Registry by fax was dated 03/30/16 at 1:00 PM. The report revealed it was completed by the DON and the allegation description revealed Nurse #1 restrained Resident #1's right hand to the bottom side rail in order to administer medication and care. The description further revealed Resident #1's hand was restrained with a towel/pillowcase with tape wrapped around the restraint to avoid Resident #1 from hitting Nurse #1. The description indicated NA #1 entered the room, found Resident #1 restrained by Nurse #1 and immediately approached Resident #1 and began removing tape to release restraint. The description also indicated NA #1 noticed Resident #1 had medicine, applesauce and some form of

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{F 225}	Continued From page 38 substance on his face and she cleaned it up. The description further indicated NA #1 later stated when she entered the room that Nurse #1 had a spray bottle of cleansing lotion in her hand and admitted she had sprayed it in Resident #1's face when he did not cooperate. A review of a facility document dated 03/30/16 titled Allegation of Resident Abuse/Restraint completed by the Administrator and DON revealed a brief summary of interviews of staff. The document indicated on 03/01/16 NA #1 assisted Nurse #1 when they provided morning care to Resident #1. The document revealed NA #1 assisted with providing peri care then left the room for a short period of time to do other duties and when she finished she noticed the door of Resident #1's room was closed so she went inside the room. The documents further revealed when she entered the room she noticed Resident #1's right hand was tied to the bed with a towel and was taped and Nurse #1 was present in the room. The document indicated NA #1 immediately began to remove the tape and towel to free his hand and Resident #1 had applesauce on his face and a substance on his face that was dripping down from his face onto the front of him. The document revealed Nurse #1 stated she was trying to give Resident #1 his medications but he was not listening. The document further revealed on 03/24/16 the DON met with NA #1 and she reported the incident that had occurred on 03/01/16. The document indicated NA #1 reported Nurse #1 briefly restrained Resident #1's right hand to his bed rail with a pillowcase/towel and tape to protect herself and resident while providing peri care due to combative behavior. The document further indicated on 03/04/16 Nurse #1 and NA #2 were attempting to get	{F 225}		

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{F 225}	Continued From page 39	{F 225}		

Resident #1 up out of bed with a sit to stand lift and over to a chair. The document revealed Resident #1 became agitated and began hitting and spitting continuously and after he was transferred to his chair NA #2 turned and observed Nurse #1 as she sprayed Resident #1 in the face with cleansing lotion due to his spitting at her. The document indicated NA #2 got a wet wash cloth and wiped Resident #1's face to get the lotion off. The document further indicated on 03/24/16 the DON met with NA #1 and she reported the incident that had occurred on 03/01/16. The document revealed NA #1 reported Nurse #1 briefly restrained Resident #1's right hand to his bed rail with a pillowcase/towel and tape to protect herself and resident while providing peri care due to combative behavior. The document further indicated on 03/25/16 the DON met with NA #2 and she reported the incident that had occurred on 03/04/16 when Nurse #1 sprayed Resident #1 in the face with cleansing lotion.

A review of a facility investigation report dated 03/30/16 completed by the Administrator titled Final Summary of Investigation revealed it was determined Nurse #1 was unable to provide a consistent story. The report indicated Nurse #1 was inconsistent on the date of the incident, the hand that was restrained, the NA present in the room, when the restraint was actually applied or if a Nurse Supervisor was notified. The report further indicated Nurse #1 was consistent with the fact she restrained Resident #1's hand with a pillowcase and tape to avoid being hit. The report also revealed NA #1 provided further clarification and remembered Nurse #1 had spray bottle of cleansing lotion in her hand when NA #1 entered Resident #1's room on 03/01/16 and Nurse #1

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{F 225}	Continued From page 40 told NA #1 she had sprayed Resident #1 in the face because he did not listen. The report indicated therefore, it was concluded Nurse #1 intentionally restrained Resident #1 and intentionally sprayed him in or around the face on 03/01/16 and intentionally sprayed Resident #1 in or around the face on 03/04/16 to serve as punishment for hitting, kicking or spitting at her and/or not following her direction during medication administration. During an interview on 04/19/16 at 11:08 AM with the Director of Nursing (DON) she confirmed Nurse #1 and NA #1 were assigned to care for Resident #1 on the night shift from 02/29/16 through 03/01/16. She also confirmed NA #1 had witnessed Resident #1's arm tied to the bed rail early in the morning before the end of the shift on 03/01/16 but NA #1 did not immediately report the incident. She explained the handwritten document by NA #1 dated 02/29/16 was given to her on 03/24/16 when she had called NA #1 to come in and meet with her and at the end of the meeting NA #1 showed her the handwritten document and stated she needed to discuss it. The DON stated she asked NA #1 why she had not reported the incident immediately after she observed Nurse #1 had tied Resident #1's arm to the bed rail and NA #1 stated she had not reported the incident to anyone because of personal reasons and she had been processing what she was going to do about it. The DON explained on 03/04/16 NA #2 observed Nurse #1 spraying a cleansing lotion in Resident's #1's face but did not report the incident immediately. She stated she met with NA #2 on 03/25/16 and asked her why she had not reported it immediately and NA #2 stated at the time she didn't think it was something that should be reported. The DON	{F 225}		

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verified Resident #1 was still present in the facility. She further verified Nurse #1 was no longer employed by the facility.

During an interview on 04/19/16 at 3:00 PM the Adminsitrator explained Nurse #1 had requested to meet with her on the morning of 03/04/16 after she had finished working the night shift. She explained she came in and met with Nurse #1 and she was crying and upset and told her Resident #1 had been hitting, kicking and spitting at her. She stated she asked Nurse #1 numerous times if anything else had happened and Nurse #1 told her nothing else had happened. The Administrator stated she felt Nurse #1 was experiencing burnout and but was completely unaware at that point the incidents of abuse had occurred on 03/01/16 and 03/04/16.

During a follow up interview on 04/20/16 at 2:58 PM the DON stated it was her expectation that Nurse #1 and NA #1 should have immediately reported the incident on 03/01/16 so an investigation could have been started immediately. The DON further stated it was her expectation NA #2 should have immediately reported the incident on 03/04/16 when NA #2 witnessed Nurse #1 spray the body cleansing lotion in Resident #1's face.

During a follow up interview on 04/20/16 at 4:23 PM the Administrator stated it was her expectation that nursing staff should have reported immediately when Resident #1's arm was restrained to the bed rail and when Resident #1 was sprayed in the face with the body cleansing lotion.

The facility Administrator, DON, hospital

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{F 225}	Continued From page 42 Administrator and hospital Vice President were notified of immediate jeopardy on 04/19/16 at 4:02 PM.	{F 225}		
{F 226} SS=D	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 staff interviews and record reviews the facility staff failed to operationalize policy and procedure when staff failed to immediately notify administrative staff of 2 witnessed incidents of physical abuse when a resident became combative during nursing care and a nurse restrained the resident's arm to the bed rail with a towel and secured it with a plastic tape and sprayed the resident in the face with a cleansing body lotion on 2 occasions. The facility staff also failed to assess the resident for physical injury after both of these instances of staff abuse for 1 of 1 resident sampled for abuse (Resident#1). Immediate Jeopardy began on 03/01/16 when NA #1 failed to immediately report when Nurse#1 had tied Resident #1's right arm to the bed rail with a towel that was taped with a plastic medical tape and Nurse #1 stated to NA #1 she had sprayed Resident #1 in the face with a cleansing body lotion due to his combative behavior. The immediate jeopardy is present and ongoing.	{F 226}	**CORRECTIVE ACTION FOR AFFECTED RESIDENT**	
			1. On March 1, 2016, NA #1 reported that she promptly removed the restraint, cleaned Resident #1's face, and repositioned him in bed.	03/01/16
			2. On March 4, 2016, NA #2 reported she immediately cleaned Resident #1's face to remove the lotion.	03/04/16
			3. The Facility Administrator recalled that on March 4, 2016, Nurse #1 had requested to meet with her and during that meeting expressed frustration with Resident #1's behavior. Nurse #1 reported being upset and crying during her shift the evening before. When questioned, Nurse #1 denied anything further happening. The Facility Administrator asked Nurse #1 if she felt she needed to take some time off work, and Nurse #1 responded that she had only one more shift to work, and then was going to be on vacation from March 5 – March 13. The Facility Administrator felt Nurse #1 was experiencing burn-out, and decided to immediately remove Nurse #1 from Resident #1's care. Nurse #1 was not assigned to provide care for Resident #1 after this meeting and throughout the duration of her employment.	03/04/16
			4. Since the facility is committed to being restraint-free and use of restraints is not tolerated, Nurse #1 was suspended on March 24, 2016 at 4:45 p.m. pending investigation of the alleged abuse.	03/24/16

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The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance (AOC) on 04/29/16.

A revisit survey was conducted on 05/03/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following:
- Evidence of staff in-servicing on abuse prohibition and use of restraints.
- Documentation of audits for abuse, use of restraints and physician notification.
- Documentation of care plans revised and developed to be individualized for residents' care areas
- There had been no additional allegations of abuse made since 04/20/16.

Observations of nursing care, interviews with cognitively intact residents and interviews with staff present in the facility on 05/03/16, review of all documentation to support the AOC and interviews with the facility's Administrator and Director of Nursing provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F- 226 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action.

The findings included:

A review of a facility policy titled Abuse Prohibition Policy with a reviewed date of October 2014 revealed neglect or abuse of residents will not be tolerated. Any employee who willfully or

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5. Upon learning of restraint application and alleged abuse, Director of Nursing of the Skilled Nursing Facility (DON) assessed Resident #1 on March 25, 2016, noting no sign of injury. Review of the patient's medical record by the DON and Facility Administrator on March 25, 2016, revealed no documentation of any signs of injury to Resident #1's eyes, face, arm, or wrists during subsequent shifts following the alleged events. — 03/25/16

6. The full investigation was completed and the nurse's employment was terminated on 3/30/16 — 03/30/16

7. Resident #1's care plan was updated on April 20, 2016 to include interventions for staff to utilize to protect Resident #1 and staff from Resident #1's sexual behavior, inappropriate touching, and verbal and physical aggression. — 04/20/16

CORRECTIVE ACTION FOR OTHER RESIDENTS

1. Review of resident weekly skin assessments on March 2, 2016, March 9, 2016. March 16, 2016, and March 23, 2016 by the DON revealed no documentation or reports of any injuries or wounds potentially secondary to abuse. — 03/23/16

2. Staff interviews and a root cause analysis were immediately initiated on 3/24/16 by the Director of Nursing and Facility Administrator. — 03/24/16

3. The Skilled Nursing Facility policies on "Statement on Restraint-Free Facility", "Abuse Prohibition Policy", and "Resident Rights" were reviewed by the DON and Facility Administrator on March 24, 2016, — 03/24/16

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{F 226}	Continued From page 44 unintentionally abuses or neglects a resident will be suspended immediately and ultimately terminated after completion of investigation. Residents shall be examined by the Director of Nursing (DON) or by supervisory personnel as designated by the DON to determine if evidence of abuse or neglect exists. Any incident which appears to have resulted from abuse shall be thoroughly investigated and reported to the appropriate authorities, including but not limited to, the police, the Division of Facility Services, the Nurse Aide Registry and the Board of Nursing. The Director of Nursing and/or Administrator shall investigate all complaints of abuse immediately by speaking with the resident and/or complainant and any staff member involved or having knowledge of the occurrence. Any staff member suspected of being abusive shall be suspended from work until the investigation is complete. Residents are assessed, care planned and monitored to identify needs and behaviors that might lead to abuse, neglect or misappropriation. This may include those with dementia, abnormal behavior, aggressiveness, mental illness etc. Resident #1 was admitted to the facility on 09/24/15 with diagnoses listed on a diagnosis list in the electronic medical record which included heart failure, chronic obstructive lung disease, stroke, dementia, psychosis and schizophrenia. A review of the most recent quarterly Minimum Data Set (MDS) dated 03/27/16 indicated Resident #1 was severely impaired in cognition and exhibited physical and verbal behaviors directed toward others and was totally dependent on staff for activities of daily living and had upper extremity impairment on one side. The MDS further revealed restraints were not used.	{F 226}	and it was determined that had these policies been followed, Resident #1 would have been protected.	
			4. NA #1 and NA #2, who failed to immediately report either witnessed application of restraint or resident abuse, were suspended on 3/25/16.	03/25/16
			5. To ensure ongoing reinforcement of policies, as of Friday, 3/25/16, the Director of Nursing and Facility Administrator have been rounding separately on all 3 shifts at least three times per week to monitor the well-being and safety of each resident, to confirm staff understanding of the facility's restraint-free policy and to meet with staff regarding any questions or concerns.	Ongoing
			6. The Director of Nursing was counseled on 3/25/16 by the Facility Administrator on the importance of immediately assessing the resident for potential injury or harm regardless of timing of report.	03/25/16
			7. On March 29, 2016, interviews were conducted by the DON with all alert and oriented long-term residents who were residents of the facility during the time of the alleged events. All residents verbalized that they had no complaints about the care they had received.	03/29/16
			8. Interviews were conducted with 18 Skilled Nursing Facility clinical staff members by the DON and the Facility Administrator from March 24, 2016 – March 29, 2016 to inquire whether any other instances of suspicious injury or abuse had been witnessed or observed with any other residents. No concerns were identified.	03/29/16

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A review of a staff schedule for the 11:00 PM - 7:00 AM shift from 02/29/16 through 03/01/16 revealed Nurse #1 and Nurse Aide (NA) #1 were assigned to care for Resident#1.

A review of a handwritten statement by NA#1 revealed on Monday night 02/29/16 she worked with Nurse #1 and Resident #1 was very combative. The statement further revealed Nurse #1 helped NA #1 change Resident #1 and after he was changed NA #1 left the room to check on other residents and after she finished with other residents, NA #1 noticed Nurse #1 was still in Resident #1's room so she went to see if Nurse #1 needed any help. The document indicated when NA #1 opened the door she witnessed Nurse #1 fighting with Resident #1 and had his arm tied to the bed with a bath towel and tape wrapped around it. The document further revealed NA #1 immediately removed the tape and towel from Resident #1's arm and straightened him up in bed because he was lying sideways in the bed.

During an interview on 04/19/16 at 2:08 PM with NA #1 she confirmed she worked the night shift from 11:00 PM on 02/29/16 until 7:00 AM on 03/01/16 and wrote the hand written statement. She explained around 6:00 AM on 03/01/16 Nurse #1 helped her change Resident #1. She stated she gathered up the dirty linens and trash and left the room and when she had finished disposing of the linen and trash she noticed Resident #1's door was closed and it concerned her because they did not usually leave his door closed. NA #1 explained when she opened the door Nurse #1 was standing on the left side of the bed and Resident #1's right arm near his wrist

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9. Additionally, on March 25, 2016 and March 29, 2016, the DON or Facility Administrator interviewed 3 physicians who have the majority of the residents on the Skilled Nursing Facility, including the SNF Medical Director, to inquire whether they had any concerns about the care rendered for any of their residents. No concerns were identified. — 03/29/16

10. As a component of the root cause analysis, the process for screening staff upon hire was reviewed and felt to be appropriate. No staff is employed to the Skilled Nursing Facility without first having an in-person interview, reference checks, drug screen, and a national criminal record background check. Additionally, licensed or certified clinical staff is primary source verified prior to employment — 03/30/16

SYSTEMIC CHANGES

1. To mitigate this type of event from reoccurring, on March 24, 2016, March 25, 2016, and March 26, 2016, all Skilled Nursing Facility clinical and non-clinical staff was provided education by the DON prior to the start of shift on facility policies related to a restraint-free environment, resident abuse, and resident rights. Education included strategies for dealing with residents when frustrated, including removing oneself from the resident's care with appropriate notification of supervisory staff. Skilled Nursing Facility staff was counseled to immediately intervene in the event of witnessed abuse to ensure the safety of the resident. This action must be followed by prompt notification of management staff of any suspected or witnessed abuse, neglect, — 03/26/16

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was tied to the bed rail with a towel. She explained the towel was wrapped around the bedrail then around Resident #1's wrist and then the ends of the towel were twisted together and plastic medical tape was wrapped multiple times around the towel to secure it. She verified she observed Resident #1's arm was restrained with a white towel and stated she was sure it was a towel and it was not a pillow case. She stated she immediately went to the resident and he was lying across the bed from one side to the other instead of his head toward the head of the bed and his feet toward the foot of the bed. She explained the towel was wrapped pretty tight around his arm and he had limited movement of his right arm. She further explained Resident #1 was unable to use his left arm because of left sided weakness from a stroke so he could not have removed the towel from his right arm. She stated she immediately grabbed the towel and started pulling the tape off and released his arm and she noticed he had applesauce with particles of medication in it and a solution that looked like body cleanser on his face. She explained the solution looked like the cleanser they used on a resident skin while cleaning them and it was all over his face and on the front of his gown and stated the cleanser was yellow in color. She stated Resident #1 was not able to rub the lotion off his face because his right hand was tied to the bed rail. She explained she did not observe Nurse #1 spray the body cleanser on Resident #1's face but Nurse #1 told her she had sprayed Resident #1's face with the cleanser. She confirmed she gave report to the day shift NA on 03/01/16 who was assigned to Resident #1 but she did not report that Resident #1's arm had been tied to the bed rail with a towel. She stated she knew Resident #1's arm should not have been tied to the bed rail but she did not report the

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or restraint application. Any changes in the resident's behavior or physical condition must be reported promptly to the resident's physician and responsible party. No Skilled Nursing Facility staff members are allowed to work until they have received this education.

2. On 3/29/16 and 3/31/16, clinical and non-clinical Skilled Nursing Facility staff was provided additional education on managing challenging behaviors, resident rights, and resident abuse by the DON. — 03/31/16

3. During the Root Cause Analysis, the “Chain of Command” policy was reviewed by the Director of Nursing and Facility Administrator and determined to be appropriate. The Chain of Command policy specifies that staff may bypass their immediate supervisor when reporting an event if their supervisor is unresponsive or unavailable. Because the Chain of Command was not enacted at the time of the March 1, 2016 and March 4, 2016 events, it was determined that additional staff education was indicated. — 03/30/16

4. The root cause analysis was completed on April 1, 2016. This investigation revealed that Nurse #1 felt frustrated and at her “wit's end” with resident's combativeness and she willfully violated the facility's Restraint-Free policy. NA #1 recognized that the restraint application should have been immediately reported, but opted to withhold the report due to personal reasons. NA #2 did not recognize that spraying Resident #1 in the face with cleansing lotion was a form of abuse even if it was immediately addressed and did not result in harm. It was determined by the Facility Administrator and the Director of Nursing — 04/01/16

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IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DRIVE STATESVILLE, NC 28677

(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 226}	Continued From page 47 incident at the time because she did not want to get anyone in trouble. She further stated she was concerned she would be treated differently by her co-workers if she reported it. She explained she worked with Nurse #1 after the incident on 03/01/16 but they worked on different halls. She explained when the DON called her in on 03/23/16 to talk about some things she saw it as an opportunity to show her the handwritten statement she had written dated 02/29/16. A review of a typed statement dated 03/26/16 at 1:15 AM by NA #2 revealed she was in Resident #1's room on 03/04/16 with Nurse #1 to get Resident #1 out of bed. The document indicated Resident #1 was combative (hitting, kicking and trying to spit on staff) and after Resident #1 was transferred to a chair NA #2 asked Nurse #1 several times to assist her to get Resident #1 back in the chair so he wouldn't slide off the edge but instead Nurse #1 proceeded to spray Resident #1 in the face with some lotion base cleansing spray which made Resident #1 more aggressive. The document further indicated NA #2 immediately got a washcloth and washed the resident's face. During a phone interview on 04/19/16 at 3:02 PM with NA #2 she explained Nurse #1 wanted to get Resident #1 up to a chair on 03/04/16 between 6:00 AM and 6:30 AM and they transferred him with a sit to stand lift from his bed to the chair. She stated Resident #1 was trying to hit them and kick them and he was spitting at them. NA #2 stated she kept asking Nurse #1 to help her position Resident #1 in the chair because he was sliding forward but Nurse #1 ignored her and Nurse #1 grabbed a spray bottle of cleansing lotion and sprayed him multiple times in the face.	{F 226}	for the Skilled Nursing Facility that RN #1, NA #1, and NA #2 failed to follow policies and procedures, specifically "Statement of Restraint-Free Facility", "Abuse Prohibition Policy", and "Resident Rights". It was concluded that additional education needed to be provided to Skilled Nursing Facility staff on the definition of abuse and examples of abusive behavior, the importance of immediately reporting any restraint application or suspected or witnessed abuse, managing challenging behaviors, and methods of dealing with frustration or burn-out.	
			5. On 4/09/16, the Director of Nursing implemented "Daily Reminders" for all clinical staff. These reminders are a printed document on a topic related to resident care selected by the Director of Nursing. Topics include challenging behaviors, care of the resident with dementia, resident rights, and other pertinent topics. The reminders are posted for all staff members to review daily seven days/ week.	Ongoing
			6. On 4/12/16, the Regional Ombudsman provided mandatory education to clinical and non-clinical Skilled Nursing Facility staff regarding resident rights, including the right to be free from abuse and the North Carolina Elder Justice Act. This training session will be repeated by the Regional Ombudsman on April 27, 2016.	04/27/16
			7. Review of the Skilled Nursing Facility's process for managing challenging behaviors, specifically incorporating challenging behaviors into the Resident's care plan on April 20, 2016, resulted in the	04/20/16

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She stated the lotion was on his face at his cheekbones and was running down his face so she got a washcloth and wiped the lotion off. She explained when Nurse #1 sprayed him in the face it startled him and made his agitation worse. She stated after they got him positioned in his chair she left the room and gave report to the first shift NA but did not report to her that Nurse #1 had sprayed Resident in the face with the body cleansing lotion. She stated she left the facility and didn't report the incident to anyone. She further stated she felt she had taken care of it by washing the lotion off Resident #1's face and at the time did not think it was abuse but now she realized she should have reported the incident immediately. She confirmed she met with the DON on 03/25/16 and reported the incident that had occurred on 03/04/16. She explained the DON requested she write a statement about the incident that occurred on 03/04/16 so that night she wrote the statement that was dated 03/26/16 and emailed it to the DON.

A review of a typed statement dated 03/28/16 by Nurse #1 revealed in part that taking care of Resident #1 was difficult because he was very aggressive and combative. The document further revealed on one night (no date was indicated) while discussing Resident #1 with the night shift nursing supervisor she suggested we might want to secure Resident #1's wrists while cleaning him and release them when we were finished. The document indicated later that night or the next night (no dates indicated) Resident #1 was cursing and combative and Nurse #1 called the supervisor who said to call security but we did not have time for that so in an effort to provide a safe situation for staff and resident, Nurse #1 took a soft pillowcase and some tape and secured

{F 226}

following process revisions and staff education:

- In order to provide guidance for staff in addressing challenging behavior, any such behavior (for example aggression, sexual behavior disinhibitions) will be incorporated into the resident's care plan and appropriate parties notified if such behavior develops or exacerbates.

8. On April 21, 2016, the Abuse Prohibition Policy was revised to incorporate the timeframes for reporting suspected or witnessed abuse as specified in the Elder Justice Act. — 04/21/16

9. On April 21, 2016, the Skilled Nursing Facility clinical and non-clinical staff annual competencies and the orientation checklists were expanded to include specific education on: — 04/21/16
   - Restraint-free Environment
   - Proper Notification of Witnessed / Suspected Abuse or Restraint Application
   - Managing Challenging Behaviors
   - Abuse Prohibition policy
   - Elder Justice Act
   - Chain of Command
   - Caregiver Fatigue

   New employees will receive this education during departmental orientation to the Skilled Nursing Facility. Current employees will receive this education annually during staff competencies.

10. On April 22, 2016, these same topics were added to the list of annual competencies required for any staff providing care, treatment, or services to residents of the Skilled Nursing Facility. — 04/22/16

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{F 226} Continued From page 49

Resident #1's left wrist to the side rail. The document revealed Resident #1 could still move his arm but was not able to swing his arm at them. The document indicated we cleaned and repositioned him, then Nurse #1 released the pillowcase, all taking less than 5 minutes. The document indicated Nurse #1 stated she was always in the room during this incident and accepted full responsibility for her judgment.

An attempt was made to contact Nurse #1 on 04/19/16 at 2:00 PM by phone but there was no answer and no option to leave a message.

During a phone interview on 04/19/16 at 4:36 PM with the night shift Nursing Supervisor she stated she had not instructed Nurse #1 to tie Resident #1's arm to the bed rail. She stated she made rounds during the shift and was available for staff to call her when a resident was out of control. She further stated it was her expectation Nurse #1 should have called her and should not have tied Resident #1's arm to the bed rail or sprayed him in the face and Nurse #1, NA #1 and NA #2 should have reported the incidents immediately.

The initial 24 hour report that was sent to the North Carolina Health Care Personnel Registry by facsimile (fax) was dated 03/24/16 at 6:05 PM. The report revealed it was completed by the DON and the allegation description revealed it was reported to the DON on 03/24/16 at 11:00 AM that Nurse #1 had briefly restrained Resident #1's right hand to the bed rail with a pillow case and tape to protect herself and Resident #1 during peri care due to combative behavior.

A review of the 5 working day report that was sent to the North Carolina Health Care Personnel

{F 226}

11. Education was provided to all Skilled Nursing Facility clinical and non-clinical staff and ancillary staff that provide care, treatment, or services to residents of the Skilled Nursing Facility via a computer-based learning module from April 22 – 24, 2016 on the following topics: — 04/24/16
    - Resident's Rights
    - Elder Justice Act
    - Proper Notification of Witnessed / Suspected Abuse or Restraint Application
    - Restraint-free Environment
    - Managing Challenging Behaviors
    - Abuse Prohibition policy
    - Chain of Command
    - Caregiver Fatigue

    After April 24, 2016, no staff will be allowed to work on the Skilled Nursing Facility until this education has been completed

12. Additionally all clinical and non-clinical Skilled Nursing Facility staff were provided education from April 22 -24, 2016 on actions to be taken in response to a safety event where resident or staff safety are in jeopardy ("5 Rights of Duty To Report"). These actions include providing a safe environment for the resident, speaking up about the event, documenting the event, enlisting help from co-workers, and ensuring staff safety. After April 24, 2016, no staff will be allowed to work on the Skilled Nursing Facility until this education has been completed. — 04/24/16

13. Education was provided to all Skilled Nursing Facility clinical and non-clinical staff and ancillary staff that provide care, treatment, or services to residents of the — 04/24/16

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{F 226}	Continued From page 50 Registry by fax was dated 03/30/16 at 1:00 PM. The report revealed it was completed by the DON and the allegation description revealed Nurse #1 restrained Resident #1's right hand to the bottom side rail in order to administer medication and care. The description further revealed Resident #1's hand was restrained with a towel/pillowcase with tape wrapped around the restraint to avoid Resident #1 from hitting Nurse #1. The description indicated NA #1 entered the room, found Resident #1 restrained by Nurse #1 and immediately approached Resident #1 and began removing tape to release restraint. The description also indicated NA #1 noticed Resident #1 had medicine, applesauce and some form of substance on his face and she cleaned it up. The description further indicated NA #1 later stated when she entered the room that Nurse #1 had a spray bottle of cleansing lotion in her hand and admitted she had sprayed it in Resident #1's face when he did not cooperate. A review of a facility document dated 03/30/16 titled Allegation of Resident Abuse/Restraint completed by the Administrator and DON revealed a brief summary of interviews of staff. The document indicated on 03/01/16 NA #1 assisted Nurse #1 when they provided morning care to Resident #1. The document revealed NA #1 assisted with providing peri care then left the room for a short period of time to do other duties and when she finished she noticed the door of Resident #1's room was closed so she went inside the room. The documents further revealed when she entered the room she noticed Resident #1's right hand was tied to the bed with a towel and was taped and Nurse #1 was present in the room. The document indicated NA #1 immediately began to remove the tape and towel	{F 226}	Skilled Nursing Facility via a computer-based learning module from April 22 – 24, 2016 that if abuse to a resident occurs, law enforcement must be notified within 2 hours if there is serious bodily injury or within 24 hours if there is no serious bodily injury. In accordance with the Elder Justice Act, staff may notify law enforcement directly if abuse occurs.	
			14. All unlicensed and non-nursing clinical staff will be provided education via a computer-based learning module on the importance of reporting challenging or aberrant behavior promptly to licensed nursing staff. Education will be completed by April 24, 2016. No staff will be allowed to work beginning April 25, 2016 unless they have completed this education.	04/24/16
			15. All licensed nursing staff will be provided education on the importance of reporting challenging or aberrant behavior to the Skilled Nursing Facility Charge Nurse. The Charge Nurse will report the behavior to management staff on the 24 hour report and notify the Director of Nursing if behavior is severe. Education will be completed by April 24, 2016. No staff will be allowed to work beginning April 25, 2016 unless they have completed this education.	04/24/16
			MONITORING	
			1. 100% of working Skilled Nursing Facility clinical and non-clinical staff will complete education on facility policies related to a restraint-free environment, resident abuse, and resident rights.	03/26/16
			2. 100% of working Skilled Nursing Facility	04/22/16

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{F 226}	Continued From page 51 to free his hand and Resident #1 had applesauce on his face and a substance on his face that was dripping down from his face onto the front of him. The document revealed Nurse #1 stated she was trying to give Resident #1 his medications but he was not listening. The document further revealed on 03/24/16 the DON met with NA #1 and she reported the incident that had occurred on 03/01/16. The document indicated NA #1 reported Nurse #1 briefly restrained Resident #1's right hand to his bed rail with a pillowcase/towel and tape to protect herself and resident while providing peri care due to combative behavior. The document further indicated on 03/04/16 Nurse #1 and NA #2 were attempting to get Resident #1 up out of bed with a sit to stand lift and over to a chair. The document revealed Resident #1 became agitated and began hitting and spitting continuously and after he was transferred to his chair NA #2 turned and observed Nurse #1 as she sprayed Resident #1 in the face with cleansing lotion due to his spitting at her. The document indicated NA #2 got a wet wash cloth and wiped Resident #1's face to get the lotion off. The document further indicated on 03/24/16 the DON met with NA #1 and she reported the incident that had occurred on 03/01/16. The document revealed NA #1 reported Nurse #1 briefly restrained Resident #1's right hand to his bed rail with a pillowcase/towel and tape to protect herself and resident while providing peri care due to combative behavior. The document further indicated on 03/25/16 the DON met with NA #2 and she reported the incident that had occurred on 03/04/16 when Nurse #1 sprayed Resident #1 in the face with cleansing lotion. A review of a fax documents revealed a report of	{F 226}	clinical and non-clinical staff will receive education on managing challenging behaviors, resident rights, and resident abuse.	
			3. The Facility Administrator will monitor weekly to ensure that seven "Daily Reminders" were posted by the DON for the staff. Monitoring will continue for 3 months and results will be reported to the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurance Committee.	Ongoing
			4. 100% of working Skilled Nursing Facility clinical and non-clinical staff will receive training on resident rights and the North Carolina Elder Abuse Act.	04/27/16
			5. 100% of employees hired to the Skilled Nursing Facility after 04/21/16 will receive education during orientation on restraint-free environment, proper notification of witnessed/suspected abuse or restraint application, managing challenging behaviors, Abuse Prohibition policy, Elder Justice Act, caregiver fatigue, and chain of command. Orientation records for 100% of new hires to the Skilled Nursing Facility will be audited by the Facility Administrator for 3 months to ensure all employees received training on these items. Audit results will be reported to the Quality Coordinating Council and the Skilled Nursing Quality Assurance Committee.	Ongoing
			6. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete the 2016 competency on proper notification of witnessed/suspected abuse or restraint application, caregiver fatigue, and chain of command.	04/24/16

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{F 226}	Continued From page 52	{F 226}		

the investigation was submitted to the North Carolina Board of Nursing on 03/31/16.

A review of facility investigation dated 03/30/16 completed by the Administrator titled Final Summary of Investigation revealed it was determined Nurse #1 was unable to provide a consistent story. The report indicated Nurse #1 was inconsistent on the date of the incident, the hand that was restrained, the NA present in the room, when the restraint was actually applied or if a Nurse Supervisor was notified. The report further indicated Nurse #1 was consistent with the fact she restrained Resident #1's hand with a pillowcase and tape to avoid being hit. The report also revealed NA #1 provided further clarification and remembered Nurse #1 had spray bottle of cleansing lotion in her hand when NA #1 entered Resident #1's room on 03/01/16 and Nurse #1 told NA #1 she had sprayed Resident #1 in the face because he did not listen. The report indicated therefore, it was concluded Nurse #1 intentionally restrained Resident #1 and intentionally sprayed him in or around the face on 03/01/16 and intentionally sprayed Resident #1 in or around the face on 03/04/16 to serve as punishment for hitting, kicking or spitting at her and/or not following her direction during medication administration.

During an interview on 04/19/16 at 11:08 AM with the Director of Nursing (DON) she confirmed Nurse #1 and NA #1 were assigned to care for Resident #1 on the night shift from 02/29/16 through 03/01/16. She also confirmed NA #1 had witnessed Resident #1's arm tied to the bed rail early in the morning before the end of the shift on 03/01/16 but NA #1 did not immediately report the incident. She explained the handwritten

7. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete education on Resident's Rights, Elder Justice Act, proper notification of witnessed/suspected abuse or restraint application, restraint-free environment, managing challenging behaviors, Abuse Prohibition policy, caregiver fatigue, and chain of command. — 04/24/16

8. 100% of working clinical and non-clinical Skilled Nursing Facility staff will complete education on actions to be taken in response to a safety event where resident or staff safety are in jeopardy ("5 Rights of Duty to Report"). — 04/24/16

9. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete education on abuse reporting requirements according to the Elder Justice Act. — 04/24/16

10. 100% of working unlicensed and non-nursing Skilled Nursing Facility clinical staff will complete education on the importance of reporting challenging or aberrant behavior promptly to licensed nursing staff. — 04/24/16

11. 100% of working licensed nursing staff will complete education on the importance of reporting challenging or aberrant behavior according to the Chain of Command. — 04/24/16

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{F 226}	Continued From page 53 document by NA #1 dated 02/29/16 was given to her on 03/24/16 when she had called NA #1 to come in and meet with her and at the end of the meeting NA #1 showed her the handwritten document and stated she needed to discuss it. The DON stated she asked NA #1 why she had not reported the incident immediately after she observed Nurse #1 had tied Resident #1's arm to the bed rail and NA #1 stated she had not reported the incident to anyone because of personal reasons and she had been processing what she was going to do about it. The DON explained on 03/04/16 NA #2 observed Nurse #1 spraying a cleansing lotion in Resident #1's face but did not report the incident immediately. She stated she met with NA #2 on 03/25/16 and asked her why she had not reported it immediately and NA #2 stated at the time she didn't think it was something that should be reported. The DON verified Resident #1 was still present in the facility. She further verified Nurse #1 was no longer employed by the facility. During an interview on 04/19/16 at 3:00 PM the Administrator explained Nurse #1 had requested to meet with her on the morning of 03/04/16 after she had finished working the night shift. She explained she came in and met with Nurse #1 and she was crying and upset and told her Resident #1 had been hitting, kicking and spitting at her. She stated she asked Nurse #1 numerous times if anything else had happened and Nurse #1 told her nothing else had happened. The Administrator stated she felt Nurse #1 was experiencing burnout and but was completely unaware at that point the incidents of abuse had occurred on 03/01/16 and 03/04/16. During a follow up interview on 04/20/16 at 2:58	{F 226}		

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{F 226}	Continued From page 54	{F 226}		

PM the DON stated facility staff received training regarding abuse and neglect when hired at the facility during orientation and it was repeated annually and more often as needed. She further stated during the training the facility policies for abuse and neglect were reviewed with staff. She stated it was her expectation for all staff to abide by the facility policies to prevent abuse and neglect and Nurse #1 and NA #1 should have immediately reported the incident on 03/01/16 so an investigation could have been started immediately. The DON further stated Nurse #1 and NA #2 should have reported the incident on 03/04/16 immediately and an investigation would have been done. The DON explained she did not have any evidence Nurse #1 had assessed Resident #1 after the incidents because there was no documentation in Resident #1's medical record that he was assessed for injuries after his arm was tied to the bed rail on 03/01/16 or was assessed for any irritation on his face or in his eyes when the body lotion was sprayed in his face on 03/01/16 or 03/04/16. She stated she would have expected for Nurse #1 to have assessed Resident #1 immediately after the incidents and should have documented her assessments in the nurse's notes. The DON explained she was notified on 03/24/16 of the incidents that had occurred on 03/01/16 and 03/04/16 and assessed Resident #1 on 03/25/16 as part of her investigation and did not see any physical signs of injury to Resident #1's right arm or irritation to his eyes.

During a follow up interview on 04/20/16 at 4:23 PM the Administrator stated it was her expectation that all staff would be knowledgeable of the abuse and neglect policies in the facility and abide by them. She further stated nursing

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{F 226}	Continued From page 55 staff should have reported immediately when Resident #1's arm was restrained to the bed rail and when Resident #1 was sprayed in the face with the cleansing body lotion so it could have been investigated immediately. The facility Administrator, DON, hospital Administrator and hospital Vice President were notified of immediate jeopardy on 04/19/16 at 4:02 PM.	{F 226}		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	{F 279}	**CORRECTIVE ACTION FOR AFFECTED RESIDENT**	
	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.		1. On April 20, 2016, review of Resident #1's care plan revealed that the Resident's psychotropic medications were reflected on the care plan on February 29, 2016 with an intervention to observe for side effects of the medications. On March 11, 2016, an intervention was added to monitor Resident #1's behavior for effectiveness of medication and to notify the resident's physician for escalations or changes in behavior.	04/20/16
	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).		2. It was determined that Resident #1's care plan should be updated to address his aggressive behavior and sexual behavior disinhibitions. The care plan was updated on April 20, 2016, to include interventions for staff to utilize to protect Resident #1 and staff from Resident #1's sexual behavior, inappropriate touching, and verbal and physical aggression. **CORRECTIVE ACTION FOR OTHER RESIDENTS**	04/20/16
	This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the		1. Additionally, on April 20, 2016, all resident care plans were reviewed by the MDS Nurse to ensure that there were no other	04/20/16

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facility failed to develop a care plan with interventions to guide staff for handling a resident with inappropriate and combative behaviors during nursing care. As a result of the lack of care plan interventions the resident's arm was tied to the bed rail with a towel and secured with a plastic medical tape and he was sprayed in the face with a cleansing body lotion on 2 occasions for 1 of 1 resident sampled for abuse (Resident #1).

Immediate Jeopardy began on 03/01/16 when Nurse #1 tied Resident #1's right arm to the bed rail with a towel and taped it with a plastic medical tape to secure it and Nurse #1 stated to NA #1 she had sprayed Resident #1 in the face with a cleansing body lotion due to his combative behavior during nursing care.

The immediate jeopardy is present and ongoing.

The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance (AOC) on 04/29/16.

A revisit survey was conducted on 05/03/16 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following:
- Evidence of staff in-servicing on abuse prohibition and use of restraints.
- Documentation of audits for abuse, use of restraints and physician notification.
- Documentation of care plans revised and developed to be individualized for residents' care areas
- There had been no additional allegations of abuse made since 04/20/16.

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residents within the facility at risk due to challenging behaviors not being addressed in their care plan. There were no other residents with challenging behaviors in the Skilled Nursing Facility at the time of this review; therefore, it was determined that there were no other residents at risk.

SYSTEMIC CHANGES

1. The Skilled Nursing Facility's process for developing resident-specific care plans was evaluated on April 20, 2016. A review of all resident care plans revealed that each care plan included resident-specific problems, interventions, and measurable goals with a specific timeframe for measurement. Care plans for all residents are reviewed and updated on an ongoing basis with a formal review weekly during Interdisciplinary Team Meeting. — 04/20/16

2. As a result of the review of Resident #1's care plan, the Skilled Nursing Facility's process for managing challenging behaviors, specifically incorporating challenging behaviors into the Resident's care plan, resulted in the following process revisions and staff education — 04/24/16
   - In order to provide guidance for staff in addressing challenging behavior, any such behavior (for example aggression, sexual behavior disinhibitions) will be incorporated into the resident's care plan and appropriate parties notified if such behavior develops or exacerbates.
   - All unlicensed and non-nursing clinical staff will be provided education via a computer-based

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Observations of nursing care, interviews with cognitively intact residents and interviews with staff present in the facility on 05/03/16, review of all documentation to support the AOC and interviews with the facility's Administrator and Director of Nursing provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F- 279 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action.

The findings included:

Resident #1 was admitted to the facility on 09/24/15 with diagnoses which included heart failure, chronic obstructive lung disease, stroke, dementia, psychosis and schizophrenia.

A review of the admission Minimum Data Set (MDS) dated 10/01/15 indicated Resident #1 was severely impaired in cognition and exhibited no behaviors. The MDS further indicated Resident #1 required extensive assistance for transfers, bathing and hygiene but was totally dependent on staff for bed mobility and toileting and had upper extremity impairment on one side. A review of the Care Area Assessments revealed behaviors did not trigger.

A review of a quarterly MDS dated 12/29/15 indicated Resident #1 was severely impaired in cognition and exhibited no behaviors. The MDS further indicated Resident #1 was totally dependent on staff for activities of daily living and had upper extremity impairment on one side.

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learning module on the importance of reporting challenging or aberrant behavior promptly to licensed nursing staff. Education will be completed by April 24, 2016. No staff will be allowed to work beginning April 25, 2016 unless they have completed this education.

- All licensed nursing staff will be provided education via a computer-based learning module on the appropriate process for reporting challenging or aberrant behavior and documenting the behavior in the plan of care. This education will be provided to all licensed staff by April 24, 2016. No staff will be allowed to work beginning April 25, 2016 unless they have completed this education.

MONITORING

1. 100% of 24-hour reports will be audited by the Director of Nursing for six months to ensure that any challenging behaviors or changes in the resident's condition are reflected in the Resident's care plan and reported to appropriate parties. Audit results will be reported to the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurance Committee. — Ongoing

2. 100% of working unlicensed and non-nursing Skilled Nursing Facility clinical staff will complete education on the importance of reporting challenging or aberrant behavior promptly to licensed nursing staff. — 04/24/16

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{F 279}	Continued From page 58 A review of a care plan dated 02/15/15 titled psychotropic's revealed Resident #1 was receiving Prozac and Risperdal for behavior disinhibitions. The goal indicated resident's behavior will be managed by lowest possible dose of medications. The interventions were listed to observe for side effects of Prozac such as anxiety, somnolence (drowsiness), dizziness or headaches and observe for side effects of Risperdal such as nausea, constipation, sedation and dizziness. The resident's care plan did not contain any interventions on what staff should do if the resident exhibited inappropriate or combative behaviors. A review of a care plan with a revised date of 02/17/16 tiled psychotropic's indicated Risperdal was discontinued and Resident #1 was started on Zyprexa and to continue goal that resident's behavior will be managed by lowest possible dose of medications. The interventions were listed to observe for side effects of Zyprexa such dry mouth, sedation and somnolence. The resident's care plan did not contain any interventions on what staff should do if the resident exhibited inappropriate or combative behaviors. A review of a care plan with a revised date of 02/22/16 titled psychotropic's indicated Prozac and Zyprexa were discontinued. A review of a care plan with a revised date of 02/29/16 titled psychotropic's indicated Seroquel 25 milligrams was started for schizoaffective disorder and the goal indicated that resident's behavior will be managed by lowest possible dose of medications. The interventions were listed to observe for side effects of Seroquel such	{F 279}	3. 100% of working licensed nursing staff will complete education on the importance of reporting challenging or aberrant behavior according to the Chain of Command.	04/24/16

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as agitation, dizziness, dry mouth and constipation. The resident's care plan did not contain any interventions on what staff should do if the resident exhibited inappropriate or combative behaviors.

A review of a facility document dated 03/30/16 titled Allegation of Resident Abuse/Restraint by the Administrator revealed a brief summary of interviews of staff. The document indicated on 03/01/16 NA #1 assisted Nurse #1 when they provided morning care to Resident #1. NA #1 assisted with providing peri care then left the room for a short period of time to do other duties. When she finished she noticed the door of Resident #1's room was closed so she went inside the room. When she entered the room she noticed Resident #1's right hand was tied to the bed with a towel and was taped and Nurse #1 was present in the room. NA #1 immediately began to remove the tape and towel to free his hand but Nurse #1 asked what she was doing. The document further revealed Resident #1 had applesauce on his face and a substance on his face that was dripping down the front of him. Nurse #1 stated she was trying to give Resident #1 his medications but he was not listening and restrained Resident #1's right hand to his bed rail with a pillowcase/towel and tape to protect herself and resident due to combative behavior. On 03/24/16 the DON met with NA #1 and she reported the incident that had occurred on 03/01/16. The document indicated on 03/04/16 Nurse #1 and NA #2 were attempting to get Resident #1 up out of bed with a sit to stand lift and over to a chair. Resident #1 became agitated and began hitting and spitting continuously and after he was transferred to his chair NA #2 turned and observed Nurse #1 as

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she sprayed Resident #1 in the face with cleansing lotion due to his spitting at her. NA#2 got a wet wash cloth and wiped Resident#1's face to get the lotion off. On 03/25/16 the DON met with NA #2 and she reported the incident that had occurred on 03/04/16 when Nurse #1 sprayed Resident #1 in the face with cleansing lotion.

An attempt was made to contact Nurse #1 on 04/19/16 at 2:00 PM by phone but there was no answer and no option to leave a message.

During an interview on 04/20/16 at 4:17 PM with the MDS nurse, who developed Resident #1's care plan for psychotropic medications on 2/15/16, she described herself as being new to the role of MDS and in the learning process of care plans. She explained she tried to combine care plans to cover individual areas for residents because otherwise a resident might have numerous care plans. The MDS nurse explained when psychotropic medications were added for Resident #1 a care plan for the use of psychotropic medications was developed on 02/15/16 and her goal with the interventions was to monitor the resident to determine if the medications were effective. She stated she didn't think about implementing interventions for nursing staff to deal with the behaviors and was unable to describe how a staff member would know or be able to handle Resident #1's behaviors from the care plan she had developed. She stated Resident #1 was not coded with behaviors on the admission MDS dated 10/01/15 and as a result no care plan for behaviors was developed at that time. She explained she developed the care plan on 02/15/16 for psychotropic medications when he was started on

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{F 279}	Continued From page 61 medications for the behaviors. During an interview on 04/20/16 at 2:58 PM the DON explained the MDS nurse created care plans and Resident #1 should have had a care plan for behaviors with interventions for staff to use when he exhibited behaviors. She stated interventions should have included for staff to step away or reach out for help from coworkers or supervisors when a resident exhibited behaviors or redirect residents when they exhibited behaviors or change staff members because sometimes different staff would calm the resident. The facility Administrator, DON, hospital Administrator and hospital Vice President were notified of immediate jeopardy on 04/20/16 at 5:11 PM.	{F 279}		
{F 490} SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of facility records, the facility administrative staff failed to create and impose a culture that all residents would be protected from extreme resident restraint and abuse and that staff would implement the facility's abuse policy and procedures to intervene, protect and immediately report abuse when witnessed. The facility failed	{F 490}	**CORRECTIVE ACTION FOR AFFECTED RESIDENT** 1. The DON immediately notified the Facility Administrator when NA #1 reported the restraint application and suspected abuse of Resident #1.	03/24/16
			2. NA #1 was interviewed by the Facility Administrator and the hospital Administrator-on-Call and Patient Safety Officer were notified of NA #1's allegations.	03/24/16
			3. The Facility Administrator instructed the Director of Nursing to assess the resident for injury on March 24, 2016. The resident wasn't assessed on March 24, 2016, as the Director of Nursing knew that she had been in Resident #1's room and assisted in his care on March 1, 2015 and March 4, 2015. On both of	03/24/16

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to immediately notify the physician and responsible party when a resident became combative during nursing care and a nurse restrained the resident's arm to the bed rail, failed to protect a resident's right to be free of physical restraint, failed to immediately report witnessed incidents of physical abuse and the failure to report placed other residents at risk for abuse. The facility also failed to operationalize policy and procedure when staff failed to immediately notify administrative staff of 2 witnessed incidents of physical abuse and failed to develop a care plan with interventions to guide staff for handling a resident with inappropriate and combative behaviors during nursing care for a combative resident who experienced 2 episodes of physical abuse without immediate facility intervention, protection and implementation of abuse policies and procedures for 1 of 1 sampled residents reviewed for abuse (Resident #1).

Immediate Jeopardy began on 03/01/16 when NA #1 witnessed Nurse #1 had tied Resident #1's right arm to the bed rail with a towel that was taped with a plastic medical tape and Nurse #1 stated to NA #1 she had sprayed Resident #1 in the face with a cleansing body lotion due to his combative behavior and NA #1 failed to immediately report the incident to administrative staff.

Immediate jeopardy is present and ongoing.

The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance (AOC) on 04/29/16.

A revisit survey was conducted on 05/03/16 to

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these dates, the Director of Nursing did not identify any injury to Resident #1's eyes, wrists, or arms. The DON's presence in Resident #1's room on both of these dates was documented in the nursing notes in the electronic medical record. Throughout the month of March, the DON frequently participated in Resident #1's care with no injuries identified.

4. Nurse #1 was interviewed and admitted to application of restraint, The DON notified the Director of Human Resources and Assistant VP of Quality and Clinical Outcomes of Nurse #1's statements. The DON also updated the Administrator-on-Call and Patient Safety Officer on Nurse #1's interview. — 03/24/16

5. Nurse #1 was suspended on March 24, 2016 at 4:45 p.m. pending investigation of the alleged abuse. — 03/24/16

6. The Vice President of Professional Services and Facility Planning was notified by the Facility Administrator of the allegations and actions taken on March 24, 2016. — 03/24/16

7. On 3/24/16, the Vice President of Professional Services and Facility Planning notified the President/Chief Executive Officer of the allegations and actions taken. — 03/24/16

8. Suspension of Nurse #1 continued pending full investigation with termination of the nurse's employment on March 30, 2016 for restraint application and alleged abuse. — 03/30/16

9. Resident #1's care plan was reviewed by — 04/20/16

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{F 490}	Continued From page 63 determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following: - Evidence of staff in-servicing on abuse prohibition and use of restraints. - Documentation of audits for abuse, use of restraints and physician notification. - Documentation of care plans revised and developed to be individualized for residents' care areas - There had been no additional allegations of abuse made since 04/20/16. Observations of nursing care, interviews with cognitively intact residents and interviews with staff present in the facility on 05/03/16, review of all documentation to support the AOC and interviews with the facility's Administrator and Director of Nursing provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F- 490 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action. The findings included: Cross refer to F 157 - Based on record reviews and staff and physician interviews the facility failed to immediately notify the physician and responsible party when a resident became combative during nursing care and a nurse restrained the resident's arm to the bed rail with a towel and secured it with a plastic tape and sprayed the resident in the face with a cleansing body lotion for 1 of 1 sampled for abuse (Resident #1).	{F 490}	the MDS nurse, and it was determined that the care plan should be updated to address his aggressive behavior and sexual behavior disinhibitions. **CORRECTIVE ACTION FOR OTHER RESIDENTS** 1. Review of resident weekly skin assessments on March 2, 2016, March 9, 2016. March 16, 2016, and March 23, 2016 by the DON revealed no documentation or reports of any injuries or wounds potentially secondary to abuse. 2. The Director of Nursing was counseled on March 25, 2016 on the need for immediate assessment of a resident in the event of alleged abuse. 3. NA #1 and NA #2 were suspended on March 25, 2016 for failure to immediately notify management staff of the restraint application and /or suspected abuse. 4. On March 29, 2016, interviews were conducted by the DON with all alert and oriented long-term residents who were residents of the facility during the time of the alleged events. All residents verbalized that they had no complaints about the care they had received. 5. Interviews were conducted with 18 Skilled Nursing Facility clinical staff members by the DON and the Facility Administrator from March 24, 2016 – March 29, 2016 to inquire whether any other instances of suspicious injury or abuse had been witnessed or observed with any other residents. No concerns were identified.	 03/23/16 03/25/16 03/25/16 03/29/16 03/29/16

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Cross refer to F 221 - Based on observations, staff and physician interviews, police interview and record reviews the facility failed to protect a resident's right to be free of physical restraint when staff restrained a resident without medical symptoms. As a result a nurse restrained the resident's arm to the bed rail with a towel and secured the towel with a plastic medical tape when he became combative during care for 1 of 1 resident sampled for abuse (Resident #1).

Cross refer to F 223 - Based on observations, staff and physician interviews, police interview and record reviews the facility failed to protect a resident's right to be free from physical abuse when a resident became combative during nursing care and a nurse restrained the resident's arm to the bed rail with a towel and secured it with a plastic tape and sprayed the resident in the face on 2 occasions with a cleansing body lotion for 1 of 1 resident sampled for abuse (Resident #1).

Cross refer to F 225 - Based on staff interviews and record reviews the facility staff failed to immediately report witnessed incidents of physical abuse and the failure to report placed other residents at risk for abuse. The facility staff failed to immediately report when a resident became combative during nursing care and a nurse restrained the resident's arm to the bed rail with a towel and secured it with a plastic tape and sprayed the resident in the face with a cleansing body lotion on 2 occasions for 1 of 1 resident sampled for abuse (Resident #1).

Cross refer to F 226 - Based on staff interviews and record reviews the facility staff failed to operationalize policy and procedure when staff

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6. The DON or Facility Administrator interviewed 3 physicians, who have the majority of the residents on the Skilled Nursing Facility, including the SNF Medical Director, to inquire whether they had any concerns about the care rendered for any of their residents. No concerns were identified. — 03/29/16

7. Education on the facility's Abuse Prohibition Policy was provided to NA #1 and NA #2 before their return to work. — 04/02/16

SYSTEMIC CHANGES

1. To mitigate this type of event from reoccurring, on March 24, 2016, March 25, 2016, and March 26, 2016, all Skilled Nursing Facility clinical and non-clinical staff was provided education by the DON prior to the start of shift on facility policies related to resident abuse, maintaining a restraint-free environment, and prompt notification of appropriate parties for any change in resident behavior or physical condition. — 03/26/16

2. On 3/29/16 and 3/31/16, education was again provided to all Skilled Nursing Facility staff regarding immediate notification of management staff of any suspected or witnessed abuse or neglect, including content regarding managing challenging behaviors, resident rights, and resident abuse. — 04/22/16

3. During the Root Cause Analysis, the "Chain of Command" policy was reviewed by the Director of Nursing and Facility Administrator and determined to be appropriate. The Chain of Command policy specifies that staff may bypass their immediate supervisor when — 03/30/16

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{F 490}	Continued From page 65 failed to immediately notify administrative staff of 2 witnessed incidents of physical abuse when a resident became combative during nursing care and a nurse restrained the resident's arm to the bed rail with a towel and secured it with a plastic tape and sprayed the resident in the face with a cleansing body lotion on 2 occasions. The facility staff also failed to assess the resident for physical injury after both of these instances of staff abuse for 1 of 1 resident sampled for abuse (Resident #1). Cross refer to F 279 - Based on record reviews and staff interviews the facility failed to develop a care plan with interventions to guide staff for handling a resident with inappropriate and combative behaviors during nursing care. As a result of the lack of care plan interventions the resident's arm was tied to the bed rail with a towel and secured with a plastic medical tape and he was sprayed in the face with a cleansing body lotion on 2 occasions for 1 of 1 resident sampled for abuse (Resident #1).	{F 490}	reporting an event if their supervisor is unresponsive or unavailable. Because the Chain of Command was not enacted at the time of the March 1, 2016 and March 4, 2016 events, it was determined that additional staff education was indicated.	
			4. The root cause analysis was completed on April 1, 2016. This investigation revealed that Nurse #1 felt frustrated and at her "wit's end" with resident's combativeness. It was noted that Nurse #1 closed Resident #1's door during the restraint application on March 1, 2016 and instructed NA #1 to close the door when she re-entered Resident #1's room. It was concluded that Nurse #1 willfully violated the facility's Restraint-Free policy. NA #1 recognized that the restraint application should have been immediately reported, but opted to withhold the report due to personal reasons. NA #2 did not recognize that spraying Resident #1 in the face with cleansing lotion was a form of abuse even if it was immediately addressed and did not result in harm; therefore, she did not report the event as abuse. It was determined that additional education needed to be provided to Skilled Nursing Facility staff on the definition of abuse and examples of abusive behavior, restraint-free environment, the importance of immediately reporting any restraint application or suspected or witnessed abuse, managing challenging behaviors, and methods of dealing with frustration or burn-out.	04/01/16
			5. On 4/09/16, the Director of Nursing implemented "Daily Reminders" for all clinical staff. These reminders are a	Ongoing

{F 490}		{F 490}	printed document on a topic related to resident care selected by the Director of Nursing. Topics include challenging behaviors, care of the resident with dementia, resident rights, and other pertinent topics. The reminders are posted for all staff members to review daily seven days/ week.	
			6. On 4/12/16, the Regional Ombudsman provided education to clinical and non-clinical Skilled Nursing Facility staff regarding resident rights, including the right to be free from abuse and the North Carolina Elder Abuse Law. A second training session with the Regional Ombudsman is scheduled for 4/27/16.	04/27/16
			7. The Skilled Nursing Facility's process for developing resident-specific care plans was evaluated on April 20, 2016. A review of all resident care plans revealed that each care plan included resident-specific problems, interventions, and measurable goals with a specific timeframe for measurement. Care plans for all residents are reviewed and updated on an ongoing basis with a formal review weekly during Interdisciplinary Team Meeting. The care planning process was revised to require that challenging behavior (for example aggression, sexual behavior disinhibitions) will be incorporated into the resident's care plan and appropriate parties notified if such behavior develops or exacerbates.	04/20/16
			8. On April 21, 2016, the Abuse Prohibition Policy was revised to incorporate the timeframes for reporting suspected or witnessed abuse as specified in the Elder Justice Act.	04/21/16

{F 490}		{F 490}	9. On April 21, 2016, the Skilled Nursing Facility staff annual competencies and the orientation checklist were expanded to include specific education on: • Elder Justice Act • Proper Notification of Witnessed / Suspected Abuse or Restraint • Managing Challenging Behaviors • Abuse Prohibition policy • Chain of Command • Caregiver Fatigue	04/21/16
			10. On April 22, 2016, these same topics were added to the list of annual competencies required for any staff providing care, treatment, or services to residents of the Skilled Nursing Facility.	04/22/16
			11. Education was provided to all Skilled Nursing Facility clinical and non-clinical staff and ancillary staff that provide care, treatment, or services to residents of the Skilled Nursing Facility via a computer-based learning module from April 22 – 24, 2016 that if harm to a resident occurs, law enforcement will be notified by the Facility Administrator or the DON. Alternatively, in accordance with the Elder Justice Act, staff may notify law enforcement directly if an event occurs. Law enforcement notification of abuse or neglect must occur within 2 hours if there is serious bodily injury to a resident or within 24 hours if there is no serious bodily injury to a resident. This education also included: • Resident's Rights • Elder Justice Act • Proper Notification of Witnessed / Suspected Abuse or Restraint Application • Restraint-free Environment	04/24/16

{F 490}		{F 490}	• Managing Challenging Behaviors • Abuse Prohibition policy • Chain of Command • Caregiver Fatigue	
			12. Additionally all clinical and non-clinical Skilled Nursing Facility staff were provided education from April 22 -24, 2016 on actions to be taken in response to a safety event where resident or staff safety are in jeopardy ("5 Rights of Duty To Report"). These actions include providing a safe environment for the resident, speaking up about the event, documenting the event, enlisting help from co-workers, and ensuring staff safety. After April 24, 2016, no staff will be allowed to work on the Skilled Nursing Facility until this education has been completed.	04/24/16
			13. To promote a culture of safety and open communication, the VP will make rounds on the Skilled Nursing Facility biweekly effective 4/28/16. The VP maintains an "open door" policy for all staff to be able to communicate concerns. During biweekly rounds, the VP will communicate his open door policy and office location to the Skilled Nursing Facility staff.	Ongoing
			MONITORING	
			1. 100% of working Skilled Nursing Facility clinical and non-clinical staff will complete education on facility policies related to a resident abuse and maintaining a restraint-free environment.	03/26/16

{F 490}		{F 490}	2. 100% of working Skilled Nursing Facility clinical and non-clinical staff will receive education on managing challenging behaviors, resident rights, and resident abuse.	04/22/16
			3. The Facility Administrator will monitor weekly to ensure that seven "Daily Reminders" were posted by the DON for Monitoring will continue for 3 months and results will be reported to the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurance Committee.	Ongoing
			4. 100% of working Skilled Nursing Facility clinical and non-clinical staff will receive training on resident rights and the North Carolina Elder Abuse Law.	04/27/16
			5. 100% of 24-hour reports will be audited by the Director of Nursing for six months to ensure that any challenging behaviors are reflected in the Resident's care plan and appropriate parties were notified. Audit results will be reported to the Quality Coordinating Council and the Skilled Nursing Facility Quality Assurance Committee.	Ongoing
			6. 100% of employees hired to the Skilled Nursing Facility after 04/21/16 will receive education during orientation on proper notification of witnessed/suspected abuse or restraint application, managing challenging behaviors, Abuse Prohibition policy, Elder Justice Act, caregiver fatigue, and chain of command. Orientation records for 100% of new hires to the Skilled Nursing Facility will be audited by the Facility Administrator for 3 months to ensure all employees received training on these items. Audit results will be reported	Ongoing

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
{F 490}		{F 490}	to the Quality Coordinating Council and the Skilled Nursing Quality Assurance Committee.	
			7. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete the 2016 competency on proper notification of witnessed/suspected abuse or restraint application, managing challenging behaviors, Abuse Prohibition policy, Elder Justice Act, caregiver fatigue, and chain of command.	04/24/16
			8. 100% of working Skilled Nursing Facility clinical and non-clinical and ancillary staff will complete education on Resident's Rights, Elder Justice Act, proper notification of witnessed/suspected abuse or restraint application, restraint-free environment, managing challenging behaviors, Abuse Prohibition policy, caregiver fatigue, and chain of command.	04/24/16