STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING _____ B. WING _____	C 09/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

(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 The survey team entered the facility to conduct a complaint investigation survey on 08/29/2017 and exited on 09/01/2017. The survey team returned to the facility on 09/05/2017 to obtain additional information and exited on 09/05/2017. Therefore, the exit date was changed to 09/05/2017. When the survey team thought the survey was complete on 9/1/17, the state survey agency had not received an acceptable credible allegation. When the surveyor returned on 9/5/17 for 1 resident interview, we had not received an acceptable credible allegation. Immediate Jeopardy was identified at: CFR 483.25 at tag F223 at a scope and severity (J) CFR 483.70 at tag F490 at a scope and severity (J) The tag F223 constituted Substandard Quality of Care. Immediate Jeopardy began on 08/14/2017 and it is ongoing. An Partial extended survey was conducted.	F 000		
F 223 SS=J	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 223		9/6/17

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

Electronically Signed | 09/12/2017

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F 223	Continued From page 1 treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff, Licensed Clinical Social Worker (LCSW) and psychiatrist interviews, the facility failed to protect 1 (Resident # 2) of 3 sampled residents from abuse. Resident #1, who was exhibiting behaviors of paranoia assaulted Resident #2, who was cognitively impaired. Resident #2, was admitted to the hospital on 8/14/17 and died on 8/24/17. On 8/11/17, Resident #1 was moved to reside in the same room with Resident #2. Immediate jeopardy began on 8/14/17 at 7:20 PM when Resident #1 assaulted Resident #2. Resident #2 was discovered on the floor with blood on his face, head, chest, pants, and floor. Resident #1 was discovered sitting in the room in his wheelchair with a set of keys in his hands with blood present on his hands. The immediate jeopardy is present and ongoing. Findings included: Resident #2 was admitted to the facility on 8/18/15 with admission diagnoses which included: stroke, heart failure, and dementia. Resident #2's last Minimum Data Set (MDS) was a comprehensive annual assessment with an Assessment Reference Date (ARD) of 8/4/17. The resident was coded as having had severe cognitive loss. The resident had a Brief Interview	F 223	Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. On August 14, 2017 at approximately 7:20pm, per resident statements, Resident #1 and Resident #2 were involved in a physical altercation which took place in the room which the two shared. This altercation resulted in Resident #1 requiring additional medical attention beyond first aide at the facility. Both Resident #1 and Resident #2 were immediately separated by nursing staff at approximately 7:20pm on August 14, 2017. Resident #2 was placed with one to one supervision by a designated nurse aide immediately upon separation until departure from the facility. Resident #1 left the facility via EMS transport at 7:40pm on August 14, 2017. Resident #1 was admitted to the hospital	

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F 223	Continued From page 2	F 223		

for Mental Status (BIMS) score of 3. The resident had no behaviors coded. The resident was coded as requiring extensive assistance of one person for bed mobility, transfer, and toilet use. The resident was not coded as having had any swallowing difficulty. The resident was not coded as having had received psychotropic medications.

Resident #2's care plan, most recently updated on 8/12/17, revealed the resident needed monitoring for inappropriate actions (yelling at spouse, threatening to hit/strike spouse, being argumentative with spouse, etc ...) towards spouse and having periods of confusion. Interventions included: removing the resident from his spouse's surroundings when she appeared to be upsetting or agitating him for her safety. The resident's spouse was moved out of the resident's room to another room on 7/12/17. Per an interview conducted on 8/29/17 at 3:52 PM with the unit manager the resident's spouse was moved out of the resident's room due to an altercation between Resident #2 and his spouse.

Resident #1 was admitted to the facility on 7/15/15 with admission diagnoses which included: depression, schizophrenia, and anxiety. Resident #1's most recent Minimum Data Set (MDS) was an annual comprehensive assessment with an Assessment Reference Date (ARD) of 7/5/17. The resident was coded as being cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. The resident's behaviors included feeling depressed and feeling bad about himself for 2-6 days of the 7 day assessment period. The resident was coded as having had delusions and verbal behavioral symptoms directed toward others during 1-3 days of the 7 day assessment

on August 14, 2017 and expired in the hospital on August 24, 2017.

Resident #2 left the facility via Police Escort at 8:30pm on August 14, 2017. Resident #2 was incarcerated and remains incarcerated at this time.

The facility notified the local police of the suspected crime at approximately 7:30pm on August 14, 2017. A 24-Hour report was filed within two hours of the incident per regulation for reporting suspicion of a crime. In addition to the 24-hour report, a 5-Day investigation and report was submitted on Friday, August 18, 2017.

Beginning August 15, 2017, all room changes or roommate selections, including new admissions, will be decided in a group decision amongst the Interdisciplinary Team with input from floor staff, including but not limited to, nurse aides, nurses, housekeeping, and other members of administration. Criteria included in consideration for roommate compatibility will include; similar sleeping patterns, toileting needs, ability to vocalize needs, similar routines, and examples of physical, mental, psychosocial, impairments that may cause conflicts, activity preferences, social preferences, and religious compatibility. Staff was also educated that roommate compatibility may be determined by resident□s environmental preferences such as, lighting, noise levels, temperatures, and clutter within the living space. The Administrator will make the final approval

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F 223	Continued From page 3 period. The resident's behaviors put the resident at risk for illness/injury. The resident was coded as requiring extensive assistance of one person for bed mobility and toilet use. The resident was coded as requiring extensive assistance of two people for transfers, i.e. from bed to chair. The resident was coded as requiring supervision and one person physical assist with eating. The resident was coded as having had received an antipsychotic and antidepressant for each of the 7 days of the assessment period. The resident was coded as having had received an antianxiolytic for 4 days of the 7 day assessment period. The Care Area Assessment (CAA) triggered for Cognitive Loss/Dementia. Review of the CAA revealed the following: The resident had a history of schizophrenia with delusions, anxiety, and depression that affected his cognitive status. The resident required staff redirection/reorientation during periods of confusion/disorientation and required assistance with appropriate decision making at times. The resident had delusional episodes noted July 1st and 2nd, 2017, feeling his roommate wanted to harm him, the resident fell from his wheelchair and had a subsequent emergency room visit. The visit confirmed no acute injury despite bump on head. The resident triggered a CAA for Psychosocial Well-being. Review of the CAA revealed the following: The resident had a diagnosis of depression. Per the MDS he reported feeling down or depressed and feeling bad about himself. The resident had inappropriate outbursts and delusional thinking noted at times. The resident was generally pleasant, friendly and easily directed. The Mood State triggered a CAA. Review of the CAA revealed: The resident had diagnoses of depression, hypothyroidism, and history of a stroke. The resident was being treated with	F 223	on all room changes or roommate selections beginning August 15, 2017. Staff interviews were initiated August 14, 2017 at approximately 8:00pm by the Director of Nursing and the RN Unit Manager to ensure no one had witnessed any previous resident to resident altercations, signs or symptoms of abuse and/or neglect. Staff interviewed includes; licensed nurses, nurse aides, dietary, and environmental services. Any reported resident to resident altercations or signs and symptoms of abuse were investigated by the Director of Nursing and determined to be previously addressed accordingly. One staff member was reeducated regarding proper procedures for reporting potential allegations of abuse. Staff interviews continued through August 25, 2017. Any staff not interviewed beyond August 25, 2017 did not work until an interview by the Director of Nursing, Unit Manager, or the Regional Nurse Manager was completed. A review of active residents Nursing notes for the past (90) days occurred between August 14, 2017 and August 25, 2017. This review was completed by the Director of Nursing, Regional Operations Manager, Director of Clinical Services, and two Regional Nurse Managers. The review monitored for behavior charting or other forms of documentation which may indicate signs of resident to resident altercations or signs and symptoms of abuse. The audit found no other incidents of resident to resident altercations which	

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F 223	Continued From page 4 medications and was able to go get therapy at the outpatient psychiatric center when he needed. The resident had diagnoses of depression, hypothyroidism, and history of stroke. Resident had noted use of psychotropic medications including: haloperidol (antipsychotic), quetiapine (antidepressant), and clonazepam (antianxiolytic) for anxious mood indicators. A CAA for behavioral symptoms triggered. Review of the CAA revealed: Noted episode of combativeness (hitting at staff) on 7/9/16. Noted episode of verbally aggressive/abusive behavior towards staff and escalating delusional thoughts that his roommate wanted to harm him. The resident had noted diagnoses of schizophrenia, anxiety, and depression that create the potential for fluctuations in behaviors and mood. The resident's behaviors were usually easily redirected. Inappropriate behaviors were discouraged as they occurred. Noted use of multiple psychotropic medications to help manage moods and behaviors. Care plan was developed for behaviors secondary to the need for implementation of measures to help decrease the number of episodes of inappropriate behaviors. The CAA for Psychotropic drug use triggered. The resident's psychotropic medications included citalopram, clonazepam, haloperidol, and quetiapine. Management of schizophrenia, anxiety, and depression. Noted evidence of paranoid delusional thinking and having had verbally aggressive behaviors during the assessment period. The resident presented with episodes of delusional behaviors (thought staff was stealing from him, roommate was taking his clothes, etc.) however, there was no documented episodes of delusion behavior noted during assessment period. The resident's inappropriate behaviors were monitored every	F 223	had not been addressed appropriately at the time of occurrence. All active residents with a BIMS score of 11 or higher were interviewed by the Social Worker, Director of Nursing, or the Regional Nurse Manager beginning August 14, 2017 and continuing through August 25, 2017. These interviews were conducted to ensure everyone felt safe and had not witnessed any incidents of abuse or resident to resident altercations. One resident reported an incident of another resident touching him. This resident confirmed on the date of interview that he did not report this incident to anyone nor was the incident witnessed. This incident was clarified by the Regional Operations Manager on August 25, 2017 and determined not to be an allegation of abuse. All Staff, including but not limited to, licensed nurses, nurse aides, dietary, housekeeping, administration, and clerical support, were in-serviced between August 14, 2017 and August 25, 2017. In-services were conducted by the Director of Nursing and RN Unit Manager. The in-service included recognizing signs and symptoms of abuse and neglect, preventing resident abuse, resident to resident altercations, recognizing and reporting signs or symptoms of resident to resident altercations, reporting abuse/neglect/resident to resident altercations to facility management. Any active staff determined not to receive the in-service prior to August 25, 2017 did	

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F 223	Continued From page 5 shift and potential side effects of medications were also monitored. Resident #1's care plan, most recently updated on 7/5/17, included the resident had depression, poor decision making skills, mood and behavioral problems, schizophrenia, anxiety, hallucinations, delusions, paranoia, combativeness/physically abusive acts, impaired cognition, and poor awareness of safety. The goals of the care plan listed included: The resident would present with decreased episodes of inappropriate behaviors (hallucinations/delusions, combativeness during care, etc.), the resident will accept staff redirection/reorientation in a positive manner at each interaction daily over the next review, and the resident will present with decreased episodes of depressive mood (crying/tearfulness, complaints of feeling sad/down, depressed). The Approaches included: Refer to Mental Health as needed for the evaluation of depressive mood, encourage the resident to express his feelings and provide active listening, refer to mental health as needed for the evaluation of depressive mood and behaviors, monitor for the presence of hallucination/delusions every shift, document and record evidence of hallucinations and delusional behaviors in notes, Notify Medical Doctor (MD) of any increase in delusional thinking or hallucinations, and discourage inappropriate behaviors as they occur explaining the potential negative outcome of his actions. Resident #1's notes revealed the following: A nurses' note dated 7/22/17 documented the resident told a housekeeper to get out of his room. He then picked up a trash can and threatened to hit the housekeeper with the trash can. The resident complained of anxiety to the	F 223	receive in-servicing by the Director of Nursing, RN Unit Manager, or Regional Nurse Manager prior to working. All active residents were given a head to toe skin inspection by the Director of Nursing and the Treatment Nurse. Skin assessments were completed routinely beginning August 14, 2017. A 100% skin assessment was completed on August 24, 2017 to ensure there were no signs or symptoms of unreported abuse or resident to resident altercations. During this audit no residents were determined to have signs or symptoms of abuse. Any undocumented skin areas such as bruising or discoloration were investigated and treatment follow-up was initiated by the Director of Nursing or Treatment Nurse. All Staff, including licensed nurses, nurse aides, environmental services, administration, and dietary was educated on September 1, 2017 by the Director of Nursing, Administrator, or specific Department Manager that all room changes, including room changes occurring off-hours (Other than Monday thru Friday, 9am to 5pm) must be approved by the Administrator. Any staff not in-serviced by September 1, 2017 will not work until in-serviced. On September 1, 2017 the Interdisciplinary Team and Administrator reviewed all active residents for roommate compatibility to ensure all roommates were compatible without any recent signs	

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nurse and the nurse documented she medicated Resident #1 for anxiety. A nurses' note dated 7/27/17 documented the resident was arguing with his roommate. The curtain was pulled between the two residents and Resident #1 would peek around the curtain and the roommate would start fussing. No intervention was documented. Review of the Nurses' note from 7/29/17 for Resident #1 revealed a note documenting an event that took place on 7/27/17. Resident #1 was documented as having had issues with the roommate he had at the time, the issues included arguing with his roommate and was concerned his roommate was going to get him. The nurse documented she talked with the roommate and asked that he be nice to Resident #1 and not argue with him. The nurse also documented she asked them to be nice to each other. The nurse informed Resident #1 if he felt threatened he could leave the room and talk to the nurse and the resident agreed. The note further documented the resident was moved to a different room on 7/28/17.

Resident #1's nurses' notes had documentation on 8/13/17 the resident was waving his hands, talking in a loud voice and stating his roommate was going to stab him in the leg.

An interview conducted with Nurse #1 on 8/29/17 at 11:47 AM revealed Resident #1 had several room changes and roommates. She stated Resident #1 did not get along with the former roommates. When Resident #1 had a roommate he would say the roommate did not like him or they did not get along. The nurse further added most of the time the resident was calm unless he became upset about something. The nurse stated the resident had gotten upset about his

for concern.
Criteria included in consideration of roommate compatibility included; similar sleeping patterns, toileting needs, ability to vocalize needs, similar routines, and examples of mental, physical, psychosocial impairments that may cause conflicts, activity preferences, social preferences, and religious compatibility. The Interdisciplinary Team and Administrator also considered roommate compatibility may be determined by resident□s environmental preferences such as, lighting, noise levels, temperatures, and clutter within the living space. They took signs of incapability into consideration during this audit. Considerations of roommate incompatibility included; verbal bickering; complaints of inability to complete normal tasks, evidence of residents withdrawal from others, or desire to stay out of his or her room. No roommates were determined to be incompatible at the time of this meeting on September 1, 2017.

A Resident Council Meeting was held on Friday, September 1, 2017 at 4:30pm. All residents with a BIMS score at or above an 11 were invited to attend. In this meeting the Social Worker spoke with the residents regarding recognizing signs and symptoms of abuse, reporting abuse, reporting any concerns with Roommate compatibility or roommate abuse, verbal, physical, mental, or emotional. Residents were given examples of roommate compatibility which included; similar sleeping patterns, toileting needs, ability to

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roommates, she did not know if it was some paranoia. The nurse then added she guessed that was why administration kept trying to move him and put him with different people, but he always seemed to do better on his own.

An interview conducted with the Regional Operations Manager (ROM) on 8/29/17 at 2:20 PM revealed Resident #1 had several room changes based on his request. She stated Resident #1 would be in a room for a week or so with a resident and he would get paranoid about his roommate and he would request a room change. In regards to Resident #2, the ROM explained his spouse was transferred to another room in the facility in July due to concerns Resident #2 had become argumentative toward his wife. There was a concern he became aggressive toward his spouse. The ROM added Resident #2 and his spouse had severe cognitive loss.

An interview conducted with the facility Social Worker (SW) on 8/30/17 at 2:12 PM revealed Resident #1 had several room changes due to him not getting along with people, she was not sure if it was him or the roommate. Resident #1 liked being in a room by himself. In regards to the room placement of Resident #1 with Resident #2 she stated she had to put residents together in a room. She added some department heads had some hesitation with the roommate combination but there were no identified specific concerns just general statements of "It will not work." The SW stated when compared to other possible room assignment for Resident #1 it was believed to be the best option. She stated she was never alarmed or concerned with the combination of Resident #1 and Resident #2. The SW added

vocalize needs, similar routines, and examples of impairments that may cause conflicts, activity preferences, social preferences, and religious compatibility. Residents were also educated that roommate compatibility may be determined by resident□s environmental preferences such as, lighting, noise levels, temperatures, and clutter within the living space. The residents have been educated on how to report any concerns twenty-four hours per day, three hundred sixty-five days per year. The residents were provided with examples of roommate incompatibility which may also be considered abuse. These examples were; verbal bickering, complaints of inability to complete normal tasks, evidence of residents withdrawal from others, or desire to stay out of his or her room. Any resident with a BIMS score of 11 or above not attending the Resident Council Meeting on September 1, 2017 will receive individual in-servicing by the Social Worker on September 1, 2017.

All staff, including but not limited to Administrator, Administration, Nurses, Nurse Aides, Environmental Services, and Dietary employees were in-serviced on September 1, 2017 regarding roommate compatibility, assisting with selecting compatible roommates, recognizing signs or symptoms of roommate non-compatibility, reporting procedures if roommates show evidence of non-compatibility. Staff was given examples of roommate compatibility which included; similar sleeping patterns,

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Resident #1 was seen by psychiatric services for his behaviors associated with his schizophrenia including his paranoia. The SW stated she spoke with Resident #1 earlier in the day before the incident on 8/14/17. The resident had told her he was worried his roommate was going to hurt him and did not want to go back into his room. The resident was unable to clarify on 8/14/17 how he thought someone was going to hurt him, she added it was just kind of a fear or paranoia. She explained it was not uncommon for Resident #1 to be paranoid about his roommate and he had a history of believing his roommates were going to hurt him. One time the resident did state he thought his former roommate was going to jump him. In regards to Resident #2 she stated he was very demented and was getting agitated toward his spouse. Resident #2 was starting to show aggression toward her, it was reported to her (the SW) he had been yelling at his spouse. The SW stated when she had to combine residents in rooms she would review the potential roommate combination with the Inter Departmental Team and take into consideration the information that was shared.

Per the facility 24 hour report for resident abuse, dated 8/14/17 revealed on 8/14/17 at 7:20 PM Resident #1 assaulted Resident #2. Review of the 5 Working Day Report, dated 8/18/17, revealed Resident #1 was discovered in the room, behind a closed door with Resident #2. Resident #2 was discovered on the floor with blood on his face, head, chest, pants, and floor. Resident #2 was yelling, "Get him off of me." Resident #1 was discovered sitting in the room in his wheelchair with a set of keys in his hands with blood present on his hands.

toileting needs, ability to vocalize needs, similar routines, and examples of impairments that may cause conflicts, activity preferences, social preferences, and religious compatibility. Staff was also educated that roommate compatibility may be determined by resident□s environmental preferences such as, lighting, noise levels, temperatures, and clutter within the living space. The staff was provided with examples of roommate incompatibility which may also be considered abuse. These examples were; verbal bickering; complaints of inability to complete normal tasks, evidence of residents withdrawal from others, or desire to stay out of his or her room. These in-services included reporting procedures for staff should the event occur off hours. Instructions were provided for reporting twenty-four hours per day, three hundred sixty-five days per year. This in-servicing was conducted by the Regional Operations Manager, Director of Clinical Services, or Regional Nurse Manager. Any staff not in-serviced by September 1, 2017 will not work until in-serviced.

On September 1, 2017, the Psychiatrist for OnSite Psychiatry Services provided education via telephone to the Administrator, Director of Nursing, Regional Operations Manager, Director of Clinical Services, Regional Nurse Managers, and all Department Managers. This education consisted of defining the diagnosis schizophrenia, signs and symptoms of residents with

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F 223	Continued From page 9 An interview conducted with Nursing Assistant (NA) #1 on 8/29/17 at 3:04 PM revealed she was working the evening of 8/14/17 at the time of the incident involving Resident #1 and Resident #2. She stated Resident #1 had a history of delusions and hallucinations. NA #1 stated she heard someone calling faintly, "help." She stated she left the break room and went down the hall and by the time she got to the room of Resident #1 and Resident #2 other staff had responded to the incident prior to her arrival. The nurses were around Resident #2 and he was bleeding from his mouth, his head, had a bruise on his arm, and a bruise on his back. Resident #1 was taken out of the room and put into the nurses' station with NA#2. An interview conducted with NA #2 on 8/29/17 at 3:29 PM revealed she was working the evening of 8/14/17 at the time of the incident involving Resident #1 and Resident #2. She stated she had been working with Resident #1 for 2-3 weeks. She stated he spent most of his time in his room with the door closed. NA #2 stated the evening of the incident she heard someone calling. On her way to investigate who was calling she was informed to stay at the nurses' station with Resident #1 by a nurse. While NA #2 was providing 1:1 with Resident #1, he explained to her he went into the room and Resident #2 had his privacy curtain closed. Resident #1 stated he wanted it opened so he opened the privacy curtain. Resident #2 closed the privacy curtain. Resident #1 stated when he opened the privacy curtain Resident #2 had a pistol in his hand and came at Resident #1. Resident #1 took the keys from around his neck and hit Resident #2 in the head 2-3 times, Resident #2 fell to the floor, and then Resident #1 started kicking Resident #2.	F 223	schizophrenia, providing treatment to residents with schizophrenia, recognizing signs and symptoms, potential triggers, of escalating behaviors from a resident with a diagnosis of schizophrenia, and techniques to deescalate behaviors. All staff, including but not limited to Administrative Clerical Support, Nurses, Nurse Aides, Environmental Services, and Dietary employees received in-servicing on September 1, 2017 regarding the diagnosis of schizophrenia, behaviors, delusions, and hallucinations related to the diagnosis of schizophrenia, behaviors related to the diagnosis of schizophrenia have the potential to escalate, what are signs and symptoms of the behavior escalation, and what are techniques to deescalate the behaviors related to the diagnosis of schizophrenia. Staff will be in-serviced on procedures for reporting any signs or symptoms of behaviors related to the diagnosis of schizophrenia. These in-services included reporting procedures for staff should the event occur off hours. Instructions will be provided for reporting twenty-four hours per day, three hundred sixty-five days per year. Following education provided by the Psychiatrist, in-servicing of support staff was completed by the Administrator, Director of Nursing, Director of Clinical Services, Regional Nurse Manager, Administrator, or the Director of Nursing. Any staff not in-serviced by September 1, 2017 will not work until in-serviced. On September 1, 2017, any Responsible Party of a resident with a BIMS score less	

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F 223	Continued From page 10 An interview conducted with the Unit Manager (UM) on 8/29/17 at 3:52 PM revealed she was working the evening of 8/14/17 at the time of the incident involving Resident #1 and Resident #2. The UM described Resident #1 as a resident who liked to stay to himself, he was difficult to get along with, he wanted things his way, he often stayed in his room, he liked to have the door closed when he was in his room, and he had room changes because of his behaviors. The resident's behaviors included having the television too loud and wanting to have the door closed. In regards to Resident #2 she stated he often stayed in his room, and his spouse had to be moved out of the room they shared because of an altercation Resident #2 had with his wife. She stated she heard a resident calling for help the evening of 8/14/17 and when she heard where it was coming from (the room of Resident #1 and Resident #2) the sound was muffled because the door was closed. She arrived to the room after other staff members had responded to the incident and the door was opened. Other staff members were assisting Resident #2 off of the floor, he was provided first aid to his wounds, and they started assessing his injuries. Resident #1 was taken out of the room and he was stating he wanted his belongings out of the room. An interview conducted with Nurse #2 on 8/29/17 at 4:10 PM revealed she worked on 8/11/17 when Resident #1 was placed in the room with Resident #2 and she felt both residents were displeased about being roommates and did not really talk to each other. Resident #2 asked where his spouse was going to sleep and the nurse explained his spouse was going to sleep in another room and Resident #1 would be in the	F 223	than 11 was telephoned by the Administrator, Director of Nursing, RN Unit Manager, Social Worker, or Regional Nurse Manager. This telephone call was inclusive of verbal education on signs and symptoms of all types of abuse including verbal, mental, emotional, physical, involuntary seclusion, and misappropriation of resident property. Each Responsible Party was provided detailed instructions and contact information to report any concerns of abuse. Each Responsible Party was provided with examples to recognize roommate compatibility concerns, how, and who to report these concerns to twenty-four hours per day, three hundred sixty-five days per year. All Responsible Parties were reached via telephone by midnight of September 1, 2017. All Responsible Parties were mailed a letter on September 1, 2017 detailing signs and symptoms of roommate compatibility and reporting procedures for any time of day when roommate incompatibility is suspected. This letter was inclusive of education defining all types of abuse, recognizing signs of abuse, and steps for reporting abuse. A copy of Resident Rights was provided to Responsible Parties along with all other educational materials. These letters were postmarked and mailed on September 1, 2017. To ensure quality assurance, the Administrator, Director of Nursing, or RN Unit Manager will interview ten staff	

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room now. She said Resident #2 said OK and went back to looking out the window. Nurse #2 stated she was present at the facility at the time of the incident on 8/14/17. Nurse #2 stated Resident #1 spent most of the day out of the room he shared with Resident #2 on 8/14/17. She explained Resident #1 had a history of delusional behavior such as believing other residents, including his roommates were out to get him. She stated she heard someone calling for help the evening of the incident involving Resident #1 and Resident #2. She added when she opened the door to the room she observed Resident #2 to be lying on the floor, in front of his bed. He was laying sideways, on one elbow. Resident #1 was sitting in his wheelchair and was calm. She assessed Resident #2 and found he had quite a bit of blood on him. When they attempted to assist him into a sitting position Resident #2 continued to holler. He was saying he was 82 years old (the resident was 89 years old) and keep him, referring to Resident #1, out of here. Resident #2 also stated if he were to get his hands on him, he would kill him, referring to Resident #1.

Review of the emergency room documentation dated 8/14/17 revealed Resident #2 complained of right hip pain and had head laceration. The physical exam revealed the resident blood pressure was 141/69 and had 1 centimeters (cm) laceration to the right parietal (top of the head) scalp with hematoma and 0.5 cm laceration to the right upper lip. There was a contusion to the left shoulder. The resident was awake, alert, and conversive. The result of the radiology study of the right hip showed impacted right femoral neck fracture, osteopenia and degenerative findings. The CT (computed tomography, a diagnostic

members per week for four weeks, five staff members per week for four weeks, and two staff members per week for a minimum of three months and on-going as needed should issues arise. The interview will consist of the following questions; have you observed any signs or symptoms of abuse, resident to resident altercations, signs of roommate incapability, or signs of escalating schizophrenic behaviors. Any necessary follow-up or education will be provided immediately and documented. Results of these interviews will be presented in the QAPI Committee Meeting for a minimum of six consecutive meetings or on-going as needed should issues arise.

To ensure quality assurance, the Social Worker will interview five residents per week for four consecutive weeks, and one resident per week for an additional eight weeks or on-going as needed should issues arise. The interview will consist of the following questions; have you observed any signs or symptoms of abuse, resident to resident altercations, or signs of roommate incapability. Any necessary follow-up will be completed immediately by the Director of Nursing, Social Worker, or Administrator. Findings of these interviews will be presented to the QAPI Committee for a minimum of three consecutive meetings.

To ensure quality assurance, the Social Worker, Director of Nursing, or Administrator will interview one family

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F 223	Continued From page 12 medical test that produces images of the head) scan of the head did not show bleeding or mass. A CT scan of the face did not show any fractures. The wounds were cleaned and irrigated. Two staples were placed in the right scalp laceration. Two sutures were placed in the right upper lip. Review of the hospital medical record revealed Resident #2 was moved to a different hospital on 8/15/17. He underwent surgery to repair the broken hip. Postoperatively, the resident had respiratory failure requiring overnight intubation (mechanical respiration through a breathing tube). The resident was extubated (removal of the breathing tube) on 8/16/17. The resident was agitated so they could not place a nasogastric tube to provide hydration and nutrition. Palliative (end of life) care was consulted due to the resident's declining clinical condition. His sodium level worsened due to dehydration and inability to eat. The palliative care note revealed the health care power of attorney (HCPOA) was interviewed. He stated the resident had no difficulty swallowing prior to this hospital admission, but now the resident has minimal verbal communication and was exhibiting signs of difficulty swallowing after prolonged use of the breathing tube after surgery. The resident was scheduled for a swallowing exam for the evaluation of swallowing difficulty. The health care power of attorney told Palliative care that in the event the resident was unable to pass the swallowing evaluation, the resident would not want a permanent feeding tube and the resident would not want to be resuscitated in the event he experienced cardiac arrest or respiratory arrest. The resident did not pass the swallowing exam. The resident had labored breathing and died at 1:52 AM on 8/24/17 likely due to aspiration according to the discharge summary.	F 223	member per week for a minimum of four weeks or on-going as needed should issues arise. The interview will consist of the following questions; have you observed any signs or symptoms of abuse, resident to resident altercations, or signs of roommate incapability. Any concerns or additional follow up will be addressed immediately by the Administrator or the Director of Nursing. Findings of these interviews will be present in the next QAPI Committee Meeting following completion of the four week or on-going as needed should issues arise. s. The QAPI Committee Meeting will review current roommate assignments for a minimum of three consecutive meetings or on-going as needed should issues arise. to ensure compatibility and Interdisciplinary decisions are appropriate and effective.	

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Resident #2's discharge diagnoses from his hospitalization on 8/24/17 were respiratory failure due to aspiration, dysphagia, surgical repair of right femoral neck fracture during the hospitalization, postoperative respiratory failure, and acute kidney injury.

Review of Resident #2's Certificate of Death revealed a date of injury of 8/14/17. The date of death was listed as 8/24/17. The resident's immediate cause or condition that resulted in death was listed as complications of a right femoral neck (hip) fracture. The description as to how the hip fracture occurred was listed as a ground level fall after assault by another resident. The manner of death listed was homicide.

Review of the Incident/Investigation report from the local Police Department with a date of 8/14/17 and a time of 7:38 PM revealed a crime of aggravated assault on handicapped person and murder. The victim was listed as Resident #2. The crimes listed were aggravated assault on a handicapped person and number. The description of the incident was the suspect hit, kicked, and otherwise assaulted victim, causing injuries that led to the death of the victim. The injury listed was severe lacerations

Several unsuccessful attempts were made to interview law enforcement regarding the incident between Resident #1 and Resident #2.

An interview conducted with the ROM on 8/29/17 at 2:20 PM revealed Resident #1 was placed under one to one supervision with NA#2 upon discovery of the assault until he was transported by the local Police Department to the local

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emergency room. The ROM further clarified Resident #1 did not currently reside at the facility and was incarcerated without bond.

An interview conducted with the Licensed Clinical Social Worker (LCSW) with the consult psychiatric services on 8/30/17 at 4:28 PM revealed she was seeing Resident #1 since February of 2017. She stated he was very paranoid and delusional. She said he thought other people wanted to hurt him. She also stated she thought other residents were Satanist and thought others were out to get him because they worshipped Satan. During their visits Resident #1 had talked about his previous roommate being a Satanist. The LCSW added the resident had expressed hallucinations to her in the past including thoughts that his roommate had a gun or weapon and thought his roommate was going to kill him. The LCSW clarified he had made these comments about residents who were bedbound and did not represent a threat to Resident #1. The LCSW saw the resident on 8/14/17 and he told her he thought his roommate and the other resident who lived next door to him were going to jump him. The LCSW asked Resident #1 on 8/14/17 if he felt so overwhelmed he felt he was going to hurt himself or someone else and he responded no. Resident #1's behavior, delusions, and paranoia were lessened when the resident did not have a roommate. When Resident #1 did not have a roommate he was able to make progress about his delusions and paranoia. When Resident #1 had a roommate he would not allow the LCSW to visit him in the room and they would have to conduct their visit in another location in the facility. When he had a roommate, Resident #1 would sit outside the room at times and not enter the room.

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F 223	Continued From page 15 In regards to Resident #2 the LCSW explained he was very demented. On one occasion he had asked where his spouse was and he was looking for his car keys so he could take her home. An interview conducted with the psychiatrist with the consult psychiatric services on 8/31/17 at 2:38 PM revealed she had visited Resident #1 on 7/10/17. She stated she had seen him due to a concern about the resident reaching out and touching staff, visitors, and other residents. She added he had chronic paranoia but it seemed managed and controlled by his medications regime. Despite attempts made via phone from 8/31/17 through 9/1/17 and request to facility staff to interview Resident #2's medical doctor from regarding his decline and death, Resident #2's medical doctor did not come to the facility or return calls to be interviewed. Calls were made on 8/31/17 to the hospital where Resident #2 died and attempts were made to interview the medical doctor who provided care resulted in no interviews. A call was made and a message was left at the medical doctor's office on 8/31/17 in regards to interview Resident #2's hospital medical doctor and no response was received. The Administrator, DON, Director of Clinical Services, Clinical Consultant and Regional Operations Manager were notified of the Immediate Jeopardy on 8/31/17 at 7:20 PM.	F 223		
F 490 SS=J	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that	F 490		9/6/17

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F 490	Continued From page 16 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 record review, staff, Licensed Clinical Social Worker (LCSW) and psychiatrist interviews, the administration failed to recognize potential harmful effects of paranoia and delusions and failed to implement a system of thoughtful decision making with roommate assignments. In addition the facility failed to create and maintain a safe environment for the residents. The result of the previous listed failures resulted in injuries and subsequent death to one of three sampled residents (Resident #2) who were investigated for abuse. The findings included: Immediate jeopardy began on 8/14/17 at 7:20 PM Resident #1 assaulted Resident #2. Resident #2 was discovered on the floor with blood on his face, head, chest, pants, and floor. Resident #1 was discovered sitting in the room in his wheelchair with a set of keys in his hands with blood present on his hands. The immediate jeopardy is present and ongoing. Cross Refer to F 223: Based on record review, staff, Licensed Clinical Social Worker (LCSW) and psychiatrist interviews, the facility failed to protect 1 (Resident # 2) of 3 sampled residents from abuse. Resident #1, who was exhibiting behaviors of paranoia assaulted Resident #2, who was cognitively impaired. Resident #2, was admitted to the hospital on 8/14/17 and died on 8/24/17.	F 490	Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. On August 14, 2017 at approximately 7:20pm, per resident statements, Resident #1 and Resident #2 were involved in a physical altercation which took place in the room which the two shared. This altercation resulted in Resident #1 requiring additional medical attention beyond first aide at the facility. Both Resident #1 and Resident #2 were immediately separated by nursing staff at approximately 7:20pm on August 14, 2017. Resident #2 was placed with one to one supervision by a designated nurse aide immediately upon separation until departure from the facility. Resident #1 left the facility via EMS transport at 7:40pm on August 14, 2017. Resident #1 was admitted to the hospital on August 14, 2017 and expired in the hospital on August 24, 2017.	

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Resident #2 left the facility via Police Escort at 8:30pm on August 14, 2017. Resident #2 was incarcerated and remains incarcerated at this time.

The facility notified local police of the suspected crime at approximately 7:30pm on August 14, 2017. A 24-Hour report was filed within two hours of the incident per regulation for reporting suspicion of a crime. In addition to the 24-hour report, a 5-Day investigation and report was submitted on Friday, August 18, 2017.

Beginning August 15, 2017, all room changes or roommate selections, including new admissions, will be decided in a group decision amongst the Interdisciplinary Team with input from floor staff, including but not limited to, nurse aides, nurses, housekeeping, and other members of administration. Criteria consideration of roommate compatibility will include; similar sleeping patterns, toileting needs, ability to vocalize needs, similar routines, and examples of mental, physical, psychosocial impairments that may cause conflicts, activity preferences, social preferences, and religious compatibility. Staff was also educated that roommate compatibility may be determined by resident□s environmental preferences such as, lighting, noise levels, temperatures, and clutter within the living space. The Administrator will make the final approval on all room changes or roommate selections beginning August 15, 2017.

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F 490	Continued From page 18	F 490	Staff interviews were initiated August 14, 2017 at approximately 8:00pm by the Director of Nursing and the RN Unit Manager to ensure no one had witnessed any previous resident to resident altercations, signs or symptoms of abuse and/or neglect. Staff interviewed includes; licensed nurses, nurse aides, dietary, and environmental services. Any reported resident to resident altercations or signs and symptoms of abuse were investigated by the Director of Nursing and determined to be previously addressed accordingly. One staff member was reeducated regarding proper procedures for reporting potential allegations of abuse. Staff interviews continued through August 25, 2017. Any staff not interviewed beyond August 25, 2017 did not work until an interview by the Director of Nursing, Unit Manager, or the Regional Nurse Manager was completed. A review of active residents Nursing notes for the past (90) days occurred between August 14, 2017 and August 25, 2017. This review was completed by the Director of Nursing, Regional Operations Manager, Director of Clinical Services, and two Regional Nurse Managers. The review monitored for behavior charting or other forms of documentation which may indicate signs of resident to resident altercations or signs and symptoms of abuse. The audit found no other incidents of resident to resident altercations which had not been addressed appropriately at the time of occurrence.	

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F 490	Continued From page 19	F 490	All active residents with a BIMS score of 11 or higher were interviewed by the Social Worker, Director of Nursing, or the Regional Nurse Manager beginning August 14, 2017 and continuing through August 25, 2017. These interviews were conducted to ensure everyone felt safe and had not witnessed any incidents of abuse or resident to resident altercations. One resident reported an incident of another resident touching him. This resident confirmed on the date of interview that he did not report this incident to anyone nor was the incident witnessed. This incident was clarified by the Regional Operations Manager on August 25, 2017 and determined not to be an allegation of abuse. All Staff, including but not limited to, licensed nurses, nurse aides, dietary, housekeeping, administration, and clerical support, were in-serviced between August 14, 2017 and August 25, 2017. In-services were conducted by the Director of Nursing and RN Unit Manager. The in-service included recognizing signs and symptoms of abuse and neglect, preventing resident abuse, resident to resident altercations, recognizing and reporting signs or symptoms of resident to resident altercations, reporting abuse/neglect/resident to resident altercations to facility management. All staff in-serviced were informed that Administration is available 24 hours per day, 365 days per year and any suspected allegations of abuse, signs of resident to	

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F 490	Continued From page 20	F 490	resident altercations, roommate incapability including; verbal bickering; complaints of inability to complete normal tasks, evidence of residents withdrawal from others, or desire to stay out of his or her room will be addressed and/or corrected by administration. Any active staff determined not to receive the in-service prior to August 25, 2017 did receive in-servicing by the Director of Nursing, RN Unit Manager, or Regional Nurse Manager prior to working. All active residents were given a head to toe skin inspection by the Director of Nursing and the Treatment Nurse. Skin assessments were completed routinely beginning August 14, 2017. A 100% skin assessment was completed on August 24, 2017 to ensure there were no signs or symptoms of unreported abuse or resident to resident altercations. During this audit no residents were determined to have signs or symptoms of abuse. Any undocumented skin areas such as bruising or discoloration were investigated and treatment follow-up was initiated by the Director of Nursing or Treatment Nurse. All Staff, including licensed nurses, nurse aides, environmental services, administration, and dietary was educated on September 1, 2017 by the Director of Nursing, Administrator, or specific Department Manager that all room changes, including room changes occurring off-hours (Other than Monday thru Friday, 9am to 5pm) must be	

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	345051	A. BUILDING _____ B. WING _____	C 09/05/2017

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approved by the Administrator. The staff was assured that administration has systems in place to ensure that residents reside in an abuse free environment. Any staff not in-serviced by September 1, 2017 will not work until in-serviced.

On September 1, 2017 the Interdisciplinary Team and Administrator reviewed all active residents for roommate compatibility to ensure all roommates were compatible without any recent signs for concern. Criteria consideration of roommate compatibility included; similar sleeping patterns, toileting needs, ability to vocalize needs, similar routines, and examples of mental, physical, psychosocial impairments that may cause conflicts, activity preferences, social preferences, and religious compatibility. The Interdisciplinary Team and Administrator also considered roommate compatibility may be determined by resident□s environmental preferences such as, lighting, noise levels, temperatures, and clutter within the living space. They took signs of incapability into consideration during this audit. Considerations of roommate incompatibility included; verbal bickering; complaints of inability to complete normal tasks, evidence of residents withdrawal from others, or desire to stay out of his or her room. No roommates were determined to be incompatible at the time of this meeting on September 1, 2017.

A Resident Council Meeting was held on Friday, September 1, 2017 at 4:30pm. All

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F 490	Continued From page 22	F 490	residents with a BIMS score at or above an 11 were invited to attend. In this meeting the Social Worker spoke with the residents regarding recognizing signs and symptoms of abuse, reporting abuse, reporting any concerns with Roommate compatibility or roommate abuse, verbal, physical, mental, or emotional. Residents were given examples of roommate compatibility which included; similar sleeping patterns, toileting needs, ability to vocalize needs, similar routines, and examples of impairments that may cause conflicts, activity preferences, social preferences, and religious compatibility. Residents were also educated that roommate compatibility may be determined by resident□s environmental preferences such as, lighting, noise levels, temperatures, and clutter within the living space. The residents have been educated on how to report any concerns twenty-four hours per day, three hundred sixty-five days per year. Residents were assured that administration has systems in place to guarantee they reside in an abuse free environment. The residents were provided with examples of roommate incompatibility which may also be considered abuse. These examples were; verbal bickering, complaints of inability to complete normal tasks, evidence of residents withdrawal from others, or desire to stay out of his or her room. Any resident with a BIMS score of 11 or above not attending the Resident Council Meeting on September 1, 2017 will receive individual in-servicing by the Social Worker on September 1, 2017.	

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F 490	Continued From page 23	F 490	All staff, including but not limited to Administrator, Administration, Nurses, Nurse Aides, Environmental Services, and Dietary employees were in-serviced on September 1, 2017 regarding roommate compatibility, assisting with selecting compatible roommates, recognizing signs or symptoms of roommate non-compatibility, reporting procedures if roommates show evidence of non-compatibility. Staff was given examples of roommate compatibility which included; similar sleeping patterns, toileting needs, ability to vocalize needs, similar routines, and examples of impairments that may cause conflicts, activity preferences, social preferences, and religious compatibility. Staff was also educated that roommate compatibility may be determined by resident□s environmental preferences such as, lighting, noise levels, temperatures, and clutter within the living space. The staff was provided with examples of roommate incompatibility which may also be considered abuse. These examples were; verbal bickering; complaints of inability to complete normal tasks, evidence of residents withdrawal from others, or desire to stay out of his or her room. These in-services included reporting procedures for staff should the event occur off hours. Instructions were provided for reporting twenty-four hours per day, three hundred sixty-five days per year. This in-servicing was conducted by the Regional Operations Manager, Director of Clinical Services, or Regional	

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F 490	Continued From page 24	F 490	Nurse Manager. Any staff not in-serviced by September 1, 2017 will not work until in-serviced. On September 1, 2017, the Psychiatrist for OnSite Psychiatry Services provided education via telephone to the Administrator, Director of Nursing, Regional Operations Manager, Director of Clinical Services, Regional Nurse Managers, and all Department Managers. This education consisted of defining the diagnosis schizophrenia, signs and symptoms of residents with schizophrenia, providing treatment to residents with schizophrenia, recognizing signs and symptoms, potential triggers, of escalating behaviors from a resident with a diagnosis of schizophrenia, and techniques to deescalate behaviors. All staff, including but not limited to Administrative Clerical Support, Nurses, Nurse Aides, Environmental Services, and Dietary employees received in-servicing on September 1, 2017 regarding the diagnosis of schizophrenia, behaviors, delusions, and hallucinations related to the diagnosis of schizophrenia, behaviors related to the diagnosis of schizophrenia have the potential to escalate, what are signs and symptoms of the behavior escalation, and what are techniques to deescalate the behaviors related to the diagnosis of schizophrenia. Staff will be in-serviced on procedures for reporting any signs or symptoms of behaviors related to the diagnosis of schizophrenia. These in-services included reporting procedures for staff should the event	

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occur off hours. Instructions will be provided for reporting twenty-four hours per day, three hundred sixty-five days per year. Following education provided by the Psychiatrist, in-servicing of support staff was completed by the Administrator, Director of Nursing, Director of Clinical Services, Regional Nurse Manager, Administrator, or the Director of Nursing. Any staff not in-serviced by September 1, 2017 will not work until in-serviced.

On September 1, 2017, any Responsible Party of a resident with a BIMS score less than 11 was telephoned by the Administrator, Director of Nursing, RN Unit Manager, Social Worker, or Regional Nurse Manager. This telephone call was inclusive of verbal education on signs and symptoms of all types of abuse including verbal, mental, emotional, physical, involuntary seclusion, and misappropriation of resident property. Each Responsible Party was provided detailed instructions and contact information to report any concerns of abuse. Each Responsible Party was provided with examples to recognize roommate compatibility concerns, how, and who to report these concerns to twenty-four hours per day, three hundred sixty-five days per year. All Responsible Parties were reached via telephone by midnight of September 1, 2017.

All Responsible Parties were mailed a letter on September 1, 2017 detailing signs and symptoms of roommate compatibility and reporting procedures for

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F 490	Continued From page 26	F 490	any time of day when roommate incompatibility is suspected. This letter was inclusive of administration contact information and the assurance of the administrations responsibility to provide their loved one with the highest quality of life. The letter provided education defining all types of abuse, recognizing signs of abuse, and steps for reporting abuse including how to contact administration twenty-four hours per day to ensure proper systems were executed. A copy of Resident Rights was provided to Responsible Parties along with all other educational materials. These letters were postmarked and mailed on September 1, 2017. The Administrator, Director of Nursing, Regional Operations Manager, and Director of Clinical Services completed a Facility Self-Assessment Tool and a QAPI Self-Assessment Tool on September 1, 2017 to ensure the facility had resources and systems in place to efficiently attain the highest practicable physical, mental, and psychosocial well-being of each resident. Administration has been integrally involved in developing the policies and procedures described above with respect to F-223 and F-490. Administration has reinforced to all staff: 1) expectation of adherence to all policies and procedures described above; a zero tolerance policy for abuse; is actively committed to creating and maintaining a culture of compliance within the facility. It has been	

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F 490	Continued From page 27	F 490	reinforced to all staff that any incidents of actual or suspected abuse be reported directly to the administrator or his designee immediately. On September 1, 2017 administration was informed by the Regional Operations Manager that oversight will be provided from the corporate office to guarantee effective procedures are followed. This system was implemented to confirm administration at the facility is enforcing policies and procedures to provide the residents with an abuse free environment. Oversight will be provided by the Regional Operations Manager, Director of Clinical Services, or a Regional Clinical Manager and will include, but not be limited to, reviewing decisions regarding room changes, observing for compliance with reporting, and ensuring effective systems and education are in place to maintain a safe and abuse-free environment for the residents to live. To ensure quality assurance of facility administration, the Regional Operations Manager, Director of Clinical Services, or Regional Nurse Manager will review and approve monitoring tools for F-223 and F-490 monthly for a minimum of three consecutive month or on-going as needed should issues arise.	