STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 10/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR HEIGHTS CENTER	804 SOUTH POPLAR STREET ELIZABETHTOWN, NC 28337

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F 000	INITIAL COMMENTS A complaint survey was conducted from 10/26/17 through 10/28/17. Immediate Jeopardy was identified at: CFR 483.13 at tag F223 at a scope and severity (J) CFR 483.15 at tag F242 at a scope and severity (J) CFR 483.13 at tag F226 at a scope and severity (J) The tags F223, F242 and F226 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/25/17 and was removed on 10/28/17. An extended survey was conducted.	F 000		
F 223 SS=J	FREE FROM ABUSE/INVOLUNTARY SECLUSION CFR(s): 483.12(a)(1) 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 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 observation, physician interview,	F 223	This plan of correction represents Bladen	11/17/17

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

Electronically Signed | 11/17/2017

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F 223	Continued From page 1 resident interview, staff interview and record review the facility failed to protect residents from staff to resident physical abuse resulting in two bruises on the left wrist and two bruises on the left hip for 1 of 1 sampled residents (Resident #1). The immediate jeopardy (IJ) began on 10/25/17 when Nurse Aide #1 grabbed Resident #1 by both wrists causing her to fall to the floor resulting in bruising to her left wrist and left hip. The IJ was removed on 10/28/17 at 11:00 AM when the facility's acceptable credible allegation was verified. The facility remained out of compliance at a scope and severity of D (no actual harm with the potential for more than minimal harm that is not IJ) to all the facility to monitor and implement its plan of correction for abuse. Findings included: Resident #1 was admitted to the facility on 7/6/17 with diagnoses that included Dementia without behavioral disturbance, Anemia, Hypertension, Chronic Pain, Anxiety, Major Depression and Malignant Melanoma. Review of a Quarterly Minimum Data Set for Resident #1 dated 08/03/17 revealed the resident had intact cognition. She was independent for: bed mobility, transfers, locomotion on and off the unit, dressing, eating, personal hygiene and bathing. She required supervision for walking in corridor and toilet use and limited assistance for walking in room. Balance was steady at all times and she used a walker while ambulating. She was receiving Physical Therapy and Occupational Therapy. She participated in the assessment. She weighed 108 pounds.	F 223	East Health and Rehab's allegation of compliance. The submission of the following plan of correction does not constitute an admission or agreement by the provider as to the truths of the facts as alleged or conclusions presented by survey consultants from NCDHSR relating to alleged deficient practice. Please accept this corrective action as our plan of correction for F223. 1. As stated in the CMS 2567, on 10/25/17 at approximately 6:15am, the transport aide arrived at the facility to take identified resident to a scheduled appointment. On 10/25/17 at approximately 7:00am, an allegation of abuse was made by a staff member alleging that the transport aide had grabbed the resident by the wrists, pulled her up off the bed and shook her after the resident refused to go to the appointment. She also stated that the resident had pushed the transport aide and the transport aide then pushed the resident, causing her to fall to the floor. The transport aide was suspended pending our investigation. The 24-hour report was submitted for identified resident on 10/25/17 and 5 day report was submitted on 10/30/17. The resident was assessed by the doctor on 10/25/17 at approximately 10:00am with no injury identified. Resident's guardian was notified of abuse allegation and 24-hour report on 10/25/17 as well. The identified resident did report pain to her left hip and right inner calf on 10/26/17 when interviewed by the state surveyor. This	

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F 223	Continued From page 2 Record review showed that Resident #1 had a guardian which was the State of North Carolina. Record review of the facility Transportation Log revealed that no residents were transported on 10/25/17. Review of the General Nurse's Note of 10/25/17 at 8:48 AM documented: "Resident alert verbal oriented. Resident refused several times to go to the appointment several times. Transportation person was in to transport. Resident continuously refused to go. Transport was trying to get her out of bed, resident refusing, slipped to floor by bed. Resident denied hitting head or back. No apparent injury noted at present time. Denied pain at present. Will continue to monitor." Record review revealed that the facility filed a 24-Hour Initial Report to the Department of Health and Human Services on 10/25/17 for resident abuse. The allegation description was: "Allegation of abuse reported concerning transport nursing assistant trying to force resident to go to a doctor's appointment. Report stated the transport nursing assistant grabbed the resident's wrists and shook her, then pushed her causing her to fall. Resident is alert, but confused. No physical injury identified and resident has no recollection of the incident when interviewed." Law Enforcement was not notified. Review of X-rays taken on 10/26/17 of Resident #1's right tibia/fibula, bilateral hips, and pelvis showed all structures grossly intact. In an interview conducted with Resident #1 on 10/26/17 at 7:45 AM she stated that she had resided at the facility for two months. She said	F 223	was reported to the doctor and x-rays were ordered and obtained on 10/26/17. All results were negative for injury. Police Department was called on 10/27/17 at 3:10pm and an officer was sent to the facility to receive report of incident. Police investigation was completed on 11/3/17 with no charges filed. Facility abuse policy was reviewed and updated on 10/27/17 to reflect the need for staff to remove themselves from the environment if resident behavior is escalating. Abuse policy was also revised to include police notification when physical contact occurs. 2. Facility administrator and/or Director of Nursing will complete 24 hour reports for allegations of abuse as reported and notify police when physical contact is involved. Abuse training was completed for all active staff on 10/26/17 and 10/27/17 by the Staff Development Coordinator and Director of Nursing. Staff training on Management of Residents with Behaviors and Management of Residents who Refuse Care was also provided by the Staff Development Coordinator and Director of Nursing on 10/26/17 and 10/27/17. Both of these trainings will be provided upon hire for new employees and annually for all active employees. Alert and oriented residents were interviewed by the Social Worker on 10/27/17 to ensure no further allegations of abuse were identified. The administrator will be notified of all abuse allegations and will ensure police are notified for allegations where physical contact has occurred. The administrator and/or the Director of Nursing will be	

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that she had told the transporter (Nurse Aide #1) that she didn't feel good and was not going to the medical appointment that morning. She reported that Nurse Aide #1 then grabbed her by the left arm and right foot and twisted her off the bed causing her to fall to the floor hitting her left hip on the side of the bed as she fell. She said that her left hip and right foot were still hurting. She revealed that several staff members had seen the incident and had tried to convince Nursing Aide #1 that she did not have to go to the appointment. She stated she was hurting where she wasn't hurting before: shooting pain down her right leg, lower back pain, right calf pain, left arm above her elbow and left hip pain. She pointed to the bruises on her left wrist and said that was where Nurse Aide #1 had grabbed her.

An observation of the left wrist and left hip of Resident #1 on 10/26/17 at 7:45 AM revealed two circular bruises on her left wrist and two bruises on her left hip.

In an interview with Nurse #3 on 10/26/17 at 8:43 AM she stated that when she reported for work the morning of 10/25/17 she heard screaming and followed it to Resident #1's room. She said the resident was on the floor screaming. She said Nurse Aide #1 and Nurse Aide #2 were yelling at each other. She said the resident told her she had been abused. She revealed she told staff to leave the room and move away from the doorway. She said she and Nurse #1 put the resident back into bed. She stated she tried to de-escalate the situation and had told everyone present to write a statement of the incident before they left the shift.

In an interview with the Administrator on 10/26/17

notified of any resident refusing to attend a scheduled appointment and validate the resident's family member, POA, or guardian is notified of the refusal.
3. The administrator and/or designee will observe delivery of care to residents during facility rounds daily x 5 days, then weekly x 3 weeks, then weekly x 1 month, then monthly x 1 month to ensure residents choices are being honored and care is provided in a dignified, respectful and appropriate manner. The administrator and/or Director of Nursing will report any allegations of abuse and results of rounds observations to the facility's Performance Improvement Committee monthly x 3 months for review and to ensure continued compliance.
4. The Administrator and Director of Nursing are responsible for implementing this plan of correction.

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at 9:15 AM he stated that because Resident #1 had a guardian at the Department of Social Services (DSS) that she had no rights and could not refuse to go to an appointment scheduled by DSS.

In an interview conducted on 10/26/17 at 9:31 AM with Housekeeper #1 she revealed that she had heard a lot of commotion on the hallway when she reported to work at 6:56 AM on 10/25/17. She said she went to Resident #1's doorway and saw the resident swinging her arms trying to hit Nurse Aide #1 in the face. She said she saw Nurse Aide #1 grab both the resident's arms. She stated she saw the resident trying to get loose and when she jerked away she fell against the bed and hit the floor. She said Nurse Aide #2 was standing with her at the doorway and said to Nurse Aide #1, "you pushed her down and that's abuse. I ought to call the police on you myself."

In an interview conducted with Nurse Aide #1 on 10/26/17 at 10:30 AM she stated that she had arrived to work at 6:10 AM on 10/25/17 to transport Resident #1 to an appointment. She revealed that she asked Nurse #1 if Resident #1 was ready to go to the appointment and was told no. She said Nurse #1 told her that the resident said she was not going to go to the appointment. She revealed that she asked Nurse #1 to help her convince the resident to go to the appointment because it was important but that she did not. She said she also asked the resident's third shift aide (Nurse Aide #2) to help her but that she went down an opposite hall and did not help her. Nurse Aide #1 stated that she then called the Director of Nursing (DON) to ask her to tell Nurse #1 and Nurse Aide #2 to help her convince Resident #1 to go to the appointment. She said

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that Nurse #1 came to the room but that the resident refused to go. She reported that she took clothes out of the resident's closet and laid them on the bed. She reported that Resident #1 jumped out of the bed and ran toward her saying that she was going to "whoop her --- (curse word)." She said the resident had on slippery socks. She said she removed herself from the situation and went outside to move the van. She reported that when she returned to the room the resident rose up off the bed kicking, swinging and screaming. She said that she grabbed both of the resident's arms and when she let go the resident fell back on the bed and slid onto the floor. She said Nurse Aide #2 and Housekeeper #1 were standing in the doorway. She said that Nurse #3 told her to leave the room and that she went to her office, called the DON, and wrote a statement concerning the incident.

In an interview conducted with Nurse Aide #3 ON 10/26/17 at 11:26 AM she revealed that when she reported to work on 10/25/17 she heard yelling coming from Resident #1'S room. She said Resident #1 was on the bed saying that she was not going to the appointment. She said that she told the resident that she needed to go to the appointment. She stated that Nurse Aide #1 asked her to help get the resident ready for the appointment and that she left the room to go and get gloves. She said that when she returned Nurse Aide #1 and Resident #1 were standing up and Nurse Aide #1 was holding the resident by both arms. She stated that she saw the resident rear back and fall to the floor. She said that she did not see the resident trying to strike Nurse Aide #1 as she had left the room to get gloves.

In an interview with Nurse Aide #2 on 10/26/17

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12:41 PM via the telephone she revealed she was the aide caring for the Resident #1 on third shift the morning of 10/25/17. Said she asked the resident twice during the shift to get ready for the appointment and the resident said she wasn't going. She said she refused to force the resident to get ready to go because she didn't want to go. She said she was at the nurse's station when she heard the resident yelling for help and she ran to the room. She said when she got to the doorway Nurse Aide #1 was holding the resident by both her wrists. The resident was sitting on the side of the bed. She said she heard Nurse Aide #1 say, "You're going to get the ---- (curse word) up." She said she saw Resident #1 push Nurse Aide #1 and then Nurse Aide #1 push the resident to the floor. She said she told Nurse Aide #1 that she should call the police because it was abuse and that Nurse Aide #1 responded by telling her to mind her own business. She reported that Nurse #3 came to the room and told everyone to leave. She said that when the DON arrived she told her that she should have gotten the resident up for the appointment using any means necessary because she was "DSS". She said she told the DON that she saw Nurse Aide #1 push the resident to the floor. She said the DON asked her if she had called the state and informed her that she was not allowed to call.

In an interview with Nurse #1 on 10/26/17 at 2:43 PM she stated she was the nurse caring for Resident #1 on the morning of 10/25/17. She said the resident was alert, oriented and reliable. She said when she had passed medications earlier in the shift the resident had told her she was not going to the appointment the following morning. She said she gave the resident Ativan at 5:00 AM (because of the appointment) and

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again the resident said she wasn't going. She said when Nurse Aide #1 asked her why the resident wasn't ready to go she said she told her the resident was refusing to go. She said Nurse Aide #1 told her the resident could not refuse because she was DSS. Nurse #1 said she told Nurse Aide #1 that she was not going to force anyone to go to an appointment. She said the DON called the facility and asked her to talk to the resident which she said she did and again the resident refused to go to the appointment. She said she left the room to care for another resident. She reported that all the sudden she heard screaming and yelling. She said she and the oncoming day shift nurse (Nurse #3) went to the resident's room. She said Nurse Aide #1 and Nurse Aide #2 where yelling at each other. She said Nurse #3 told everyone to leave the room and they assessed the resident. She reported that the resident told her that Nurse Aide #1 grabbed her arms and pulled her out of bed. She said the resident told her that her left leg was weak and that she slipped to the floor. She said the resident told her that her wrists had been twisted. Nurse #1 reported that she did not see any bruising at that time. She revealed when she went back to check on the resident the resident told her that her back was hurting. She stated that she told the resident that the day shift nurse would give her some medication for pain. She said she called the Nurse Practitioner (NP) on duty to report the incident. She reported that the NP asked her if she had given the resident the ordered Ativan at 5:00 AM and told her that she should have called psychiatric services.

In an interview conducted with the DSS Supervisor on 10/26/17 at 4:30 PM she stated that DSS was the guardian for Resident #1. She

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revealed that DSS makes the medical decisions for Resident #1. She said that the facility had contacted DSS on 10/24/17 and informed them that the resident did not want to go to the appointment scheduled for 10/25/17. She said that they requested that the facility try to convince the resident to go to the appointment so that DSS did not appear neglectful but that the resident had the right to refuse treatment.

In an interview with the Medical Director on 10/27/17 at 12:47 PM he stated that he had assessed Resident #1 on 10/25/17. He said he had been told the resident had refused to go to her appointment that morning and he had gone to her room to talk to her about the appointment. He said that the resident told him someone had grabbed her calf and that it hurt. He reported that he looked at her calf and found nothing abnormal. He also stated that he saw no bruising on the resident at that time. He stated that he was not aware of an altercation between the resident and a member of the staff until the resident told him. He said that he had reviewed her current orders for pain medication and had not made any changes because she had not been taking all the medication that was available to her.

On 10/27/17 at 2:45 PM the facility was notified of IJ. The facility provided the following credible allegation of compliance on 10/27/17:

Plan for correcting this deficiency:

On 10/25/17 at approximately 6:15am, the transport aide arrived at the facility to take identified resident to a scheduled appointment. On 10/25/17 at approximately 7:00am, an allegation of abuse was made by a staff member

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alleging that the transport aide had grabbed the resident by the wrists, pulled her up off the bed and shook her after the resident refused to go to the appointment. She also stated that the resident had pushed the transport aide and the transport aide then pushed the resident, causing her to fall to the floor. The transport aide was suspended pending our investigation. The 24-hour report was submitted for identified resident on 10/25/17. Facility is still currently working on investigation of incident. The resident was assessed by the doctor on 10/25/17 at approximately 10:00am with no injury identified. Resident's guardian was notified of abuse allegation and 24-hour report on 10/25/17 as well. The identified resident did report pain to her left hip and right inner calf on 10/26/17 when interviewed by the state surveyor. This was reported to the doctor and x-rays were ordered and obtained on 10/26/17. All results were negative for injury. Police Department was called on 10/27/17 at 3:10pm and an officer was sent to the facility to receive report of incident. The facility did recognize the incident as abuse, but did not notify the police after the physical contact between the resident and the staff member.

Procedure for implementing the acceptable plan of correction for the deficiency cited:

1. Facility will complete 24-hour reports for allegations of abuse as reported and notify police when physical contact is reported.
2. Alert and oriented residents were interviewed by the Social Worker on 10/27/17 and no further allegations of abuse were identified.
3. Police Department was called on 10/27/17 at 3:10pm and an officer was sent to the facility to receive report of incident.

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4. Abuse training was completed for all active employees by the Staff Development Nurse on 10/26/17 and 10/27/17.
5. Staff training will be provided by the Staff Development Nurse on Management of Residents with Behaviors and Management of Residents Who Refuse Care. This training will include staff allowing residents to refuse care, allow residents to calm if agitated, and allowing residents to have choices honored.

Monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

1. The administrator will review all allegations of abuse and ensure police are notified for allegations where physical contact has occurred.
2. The administrator and/or designee will be notified of any resident refusing to attend a scheduled appointment. The administrator and/or designee will ensure resident's family member, POA, or guardian is notified of the refused appointment.

The validation of the credible allegation was completed on 10/28/17 at 11:00 AM by doing the following:

1. Nine employees on duty were interviewed regarding identification of the different types of abuse and how to report abuse if identified.
2. The Social Worker was interviewed on 10/28/17 at 10:15 AM and she confirmed that she interviewed alert and oriented residents and no further allegations of abuse were identified.
3. A list of all alert and oriented residents in the facility was obtained and the residents were

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F 223	Continued From page 11 interviewed regarding allegations of abuse. No other allegations were identified. 4. The 24 hour report of abuse was reviewed. Police were at the facility to investigate on 10/27/17. The police report number of the ongoing investigation is 2017E-1061. 5. The abuse training sign sheets were reviewed for in-services held on 10/25 and 10/27/17. Some education was provided by phone for employees not on site. 6. The honoring of resident rights to refuse appointments in-service was reviewed for sign in sheets dated 10/27/17.	F 223		
F 226 SS=J	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F 226		11/17/17

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F 226	Continued From page 12 (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and record review the facility failed to notify law enforcement concerning staff to resident physical abuse resulting in two bruises on the left wrist and two bruises on the left hip for 1 of 1 sampled residents (Resident #1). The immediate jeopardy (IJ) began on 10/25/17 when Nurse Aide #1 grabbed Resident #1 by both wrists causing her to fall to the floor resulting in bruising to her left wrist and left hip and law enforcement was not notified. The IJ was removed on 10/28/17 at 11:00 AM when the facility's acceptable credible allegation was verified. The facility remained out of compliance at a scope and severity of D (no actual harm with the potential for more than minimal harm that is not IJ) to all the facility to monitor and implement its plan of correction for abuse. Findings included: Resident #1 was admitted to the facility on 07/6/17 with diagnoses that included Dementia without behavioral disturbance, Anemia, Hypertension, Chronic Pain, Anxiety, Major Depression and Malignant Melanoma.	F 226	This plan of correction represents Bladen East Health and Rehab's allegation of compliance. The submission of the following plan of correction does not constitute an admission or agreement by the provider as to the truths of the facts as alleged or conclusions presented by survey consultants from NCDHSR relating to alleged deficient practice. Please accept this corrective action as our plan of correction for F226. 1. As stated in the CMS 2567, the facility failed to notify law enforcement concerning staff to resident physical abuse resulting in two bruises on the left wrist and two bruises on the left hip for Resident #1. On 10/25/17 at approximately 6:15am, the transport aide arrived at the facility to take identified resident to a scheduled appointment. On 10/25/17 at approximately 7:00am, an allegation of abuse was made by a staff member alleging that the transport aide had grabbed the resident by the wrists, pulled her up off the bed and shook her after the resident refused to go to the	

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F 226	Continued From page 13 Review of a Quarterly Minimum Data Set for Resident #1 dated 08/03/17 revealed the resident had intact cognition. She was independent for: bed mobility, transfers, locomotion on and off the unit, dressing, eating, personal hygiene and bathing. She required supervision for walking in corridor and toilet use and limited assistance for walking in room. Balance was steady at all times and she used a walker while ambulating. She was receiving Physical Therapy and Occupational Therapy. She participated in the assessment. She weighed 108 pounds. Record review showed that Resident #1 had a guardian which was the State of North Carolina. Review of the General Nurse's Note of 10/25/17 at 8:48 AM documented: "Resident alert verbal oriented. Resident refused several times to go to the appointment several times. Transportation person was in to transport. Resident continuously refused to go. Transport was trying to get her out of bed, resident refusing, slipped to floor by bed. Resident denied hitting head or back. No apparent injury noted at present time. Denied pain at present. Will continue to monitor." Record review revealed that the facility filed a 24-Hour Initial Report to the Department of Health and Human Services on 10/25/17 for resident abuse. The allegation description was: "Allegation of abuse reported concerning transport nursing assistant trying to force resident to go to a doctor's appointment. Report stated the transport nursing assistant grabbed the resident's wrists and shook her, then pushed her causing her to fall. Resident is alert, but confused. No physical injury identified and	F 226	appointment. She also stated that the resident had pushed the transport aide and the transport aide then pushed the resident, causing her to fall to the floor. The transport aide was suspended pending our investigation. The 24-hour report was submitted for identified resident on 10/25/17 and 5 day report was submitted on 10/30/17. The resident was assessed by the doctor on 10/25/17 at approximately 10:00am with no injury identified. Resident's guardian was notified of abuse allegation and 24-hour report on 10/25/17 as well. The identified resident did report pain to her left hip and right inner calf on 10/26/17 when interviewed by the state surveyor. This was reported to the doctor and x-rays were ordered and obtained on 10/26/17. All results were negative for injury. The facility did recognize the incident as abuse, but did not recognize the need to notify the police after the physical contact between the resident and the staff member. However, the police department was called on 10/27/17 at 3:10pm and an officer was sent to the facility. Police investigation was completed on 11/3/17 with no charges filed. Abuse policy was revised to include police notification when physical contact occurs. 2. Facility administrator and/or Director of Nursing will complete 24 hour reports for allegations of abuse as reported and notify police when physical contact is involved. Abuse training was completed for all active staff on 10/26/17 and 10/27/17 by the Staff Development Coordinator and Director of Nursing. This	

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F 226	Continued From page 14 resident has no recollection of the incident when interviewed." Law Enforcement was not notified. Review of the facility Abuse Prohibition Policy stated: "Any outcomes resulting in the substantiation of abuse will be reported to the appropriate agencies as required by the law and professional ethical standards." The facility added the following addendum to the Abuse Prohibition Policy on 10/27/17: "For all abuse allegations with reported physical contact involved will be reported to the local police department immediately." In an interview conducted with Resident #1 on 10/26/17 at 7:45 AM she stated that she had resided at the facility for two months. She said that she had told the transporter (Nurse Aide #1) that she didn't feel good and was not going to the medical appointment that morning. She reported that Nurse Aide #1 then grabbed her by the left arm and right foot and twisted her off the bed causing her to fall to the floor hitting her left hip on the side of the bed as she fell. She said that her left hip and right foot were still hurting. She revealed that several staff members had seen the incident and had tried to convince Nurse Aide #1 that she did not have to go to the appointment. She stated she was hurting where she wasn't hurting before: shooting pain down her right leg, lower back pain, right calf pain, left arm above her elbow and left hip pain. She pointed to the bruises on her left wrist and said that was where Nurse Aide #1 had grabbed her. An observation of the left wrist and left hip of Resident #1 on 10/26/17 at 7:45 AM revealed two circular bruises on her left wrist and two bruises on her left hip.	F 226	training included identification of types of abuse and reporting of allegations of potential abuse. This training will be provided upon hire for new employees and annually for all active employees. The administrator will be notified of all abuse allegations and will ensure police are notified for allegations where physical contact has occurred. 3. The Administrator will audit all incidents of physical abuse for 6 months to ensure law enforcement has occurred. These results will be reported to the facility's Performance Improvement Committee monthly x 6 months for review and to ensure continued compliance. 4. The Administrator and Director of Nursing are responsible for implementing this plan of correction.	

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Review of X-rays taken on 10/26/17 of Resident #1's right tibia/fibula, bilateral hips, and pelvis showed all structures grossly intact.

In an interview with Nurse #3 on 10/26/17 at 8:43 AM she stated that when she reported for work the morning of 10/25/17 she heard screaming and followed it to Resident #1's room. She said the resident was on the floor screaming. She said Nurse Aide #1 and Nurse Aide #2 were yelling at each other. She said the resident told her she had been abused. She revealed she told staff to leave the room and move away from the doorway. She said she and Nurse #1 put the resident back into bed. She stated she tried to de-escalate the situation and had told everyone present to write a statement of the incident before they left the shift.

In an interview conducted on 10/26/17 at 9:31 AM with Housekeeper #1 she revealed that she had heard a lot of commotion on the hallway when she reported to work at 6:56 AM on 10/25/17. She said she went to Resident #1's doorway and saw the resident swinging her arms trying to hit Nurse Aide #1 in the face. She said she saw Nurse Aide #1 grab both the resident's arms. She stated she saw the resident trying to get loose and when she jerked away she fell against the bed and hit the floor. She said Nurse Aide #2 was standing with her at the doorway and said to Nurse Aide #1, "you pushed her down and that's abuse. I ought to call the police on you myself."

In an interview conducted with Nurse Aide #1 on 10/26/17 at 10:30 AM she stated that she had arrived to work at 6:10 AM on 10/25/17 to transport Resident #1 to an appointment. She

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revealed that she asked Nurse #1 if Resident #1 was ready to go to the appointment and was told no. She said Nurse #1 told her that the resident said she was not going to go to the appointment. She revealed that she asked Nurse #1 to help her convince the resident to go to the appointment because it was important but that she did not. She said she also asked the resident's third shift aide (Nurse Aide #2) to help her but that she went down an opposite hall and did not help her. Nurse Aide #1 stated that she then called the Director of Nursing (DON) to ask her to tell Nurse #1 and Nurse Aide #2 to help her convince Resident #1 to go to the appointment. She said that Nurse #1 came to the room but that the resident refused to go. She reported that she took clothes out of the resident's closet and laid them on the bed. She reported that Resident #1 jumped out of the bed and ran toward her saying that she was going to "whoop her --- (curse word)." She said the resident had on slippery socks. She said she removed herself from the situation and went outside to move the van. She reported that when she returned to the room the resident rose up off the bed kicking, swinging and screaming. She said that she grabbed both of the resident's arms and when she let go the resident fell back on the bed and slid onto the floor. She said Nurse Aide #2 and Housekeeper #1 were standing in the doorway. She said that Nurse #3 told her to leave the room and that she went to her office, called the DON, and wrote a statement concerning the incident.

In an interview conducted with Nurse Aide #3 ON 10/26/17 at 11:26 AM she revealed that when she reported to work on 10/25/17 she heard yelling coming from Resident #1'S room. She said Resident #1 was on the bed saying that she was

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not going to the appointment. She said that she told the resident that she needed to go to the appointment. She stated that Nurse Aide #1 asked her to help get the resident ready for the appointment and that she left the room to go and get gloves. She said that when she returned Nurse Aide #1 and Resident #1 were standing up and Nurse Aide #1 was holding the resident by both arms. She stated that she saw the resident rear back and fall to the floor. She said that she did not see the resident trying to strike Nurse Aide #1 as she had left the room to get gloves.

In an interview with Nurse Aide #2 on 10/26/17 12:41 PM via the telephone she revealed she was the aide caring for the Resident #1 on third shift the morning of 10/25/17. Said she asked the resident twice during the shift to get ready for the appointment and the resident said she wasn't going. She said she refused to force the resident to get ready to go because she didn't want to go. She said she was at the nurse's station when she heard the resident yelling for help and she ran to the room. She said when she got to the doorway Nurse Aide #1 was holding the resident by both her wrists. The resident was sitting on the side of the bed. She said she heard Nurse Aide #1 say, "You're going to get the ---- (curse word) up." She said she saw Resident #1 push Nurse Aide #1 and then Nurse Aide #1 push the resident to the floor. She said she told Nurse Aide #1 that she should call the police because it was abuse and that Nurse Aide #1 responded by telling her to mind her own business. She reported that Nurse #3 came to the room and told everyone to leave. She said that when the DON arrived she told her that she should have gotten the resident up for the appointment using any means necessary because she was "DSS". She said she told the

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DON that she saw Nurse Aide #1 push the resident to the floor. She said the DON asked her if she had called the state and informed her that she was not allowed to call.

In an interview with Nurse #1 on 10/26/17 at 2:43 PM she stated she was the nurse caring for Resident #1 on the morning of 10/25/17. She said the resident was alert, oriented and reliable. She said when she had passed medications earlier in the shift the resident had told her she was not going to the appointment the following morning. She said she gave the resident Ativan at 5:00 AM (because of the appointment) and again the resident said she wasn't going. She said when Nurse Aide #1 asked her why the resident wasn't ready to go she said she told her the resident was refusing to go. She said Nurse Aide #1 told her the resident could not refuse because she was DSS. Nurse #1 said she told Nurse Aide #1 that she was not going to force anyone to go to an appointment. She said the DON called the facility and asked her to talk to the resident which she said she did and again the resident refused to go to the appointment. She said she left the room to care for another resident. She reported that all the sudden she heard screaming and yelling. She said she and the oncoming day shift nurse (Nurse #3) went to the resident's room. She said Nurse Aide #1 and Nurse Aide #2 where yelling at each other. She said Nurse #3 told everyone to leave the room and they assessed the resident. She reported that the resident told her that Nurse Aide #1 grabbed her arms and pulled her out of bed. She said the resident told her that her left leg was weak and that she slipped to the floor. She said the resident told her that her wrists had been twisted. Nurse #1 reported that she did not see

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any bruising at that time. She revealed when she went back to check on the resident the resident told her that her back was hurting. She stated that she told the resident that the day shift nurse would give her some medication for pain. She said she called the Nurse Practitioner (NP) on duty to report the incident. She reported that the NP asked her if she had given the resident the ordered Ativan at 5:00 AM and told her that she should have called psychiatric services.

In an interview conducted with the DSS Supervisor on 10/26/17 at 4:30 PM she stated that DSS was the guardian for Resident #1. She revealed that DSS makes the medical decisions for the resident. She said that the facility had contacted DSS on 10/24/17 and informed them that the resident did not want to go to the appointment scheduled for 10/25/17. She said that they requested that the facility try to convince the resident to go to the appointment so that DSS did not appear neglectful but that the resident had the right to refuse treatment.

In an interview with the Medical Director on 10/27/17 at 12:47 PM he stated that he had assessed Resident #1 on 10/25/17. He said he had been told the resident had refused to go to her appointment that morning and he had gone to her room to talk to her about the appointment. He said that the resident told him someone had grabbed her calf and that it hurt. He reported that he looked at her calf and found nothing abnormal. He also stated that he saw no bruising on the resident at that time. He stated that he was not aware of an altercation between the resident and a member of the staff until the resident told him. He said that he had reviewed her current orders for pain medication and had not made any

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changes because she had not been taking all the medication that was available to her.

On 10/27/17 at 2:45 PM the facility was notified of IJ. The facility provided the following credible allegation of compliance on 10/27/17:

Plan for correcting this deficiency:

On 10/25/17 at approximately 7:00am, an allegation of abuse was made by a staff member alleging that the transport aide had grabbed the resident by the wrists, pulled her up off the bed and shook her after the resident refused to go to the appointment. She also stated that the resident had pushed the transport aide and the transport aide then pushed the resident, causing her to fall to the floor. The transport aide was suspended pending our investigation. The 24-hour report was submitted for identified resident on 10/25/17. Facility is still currently working on investigation of incident. The resident was assessed by Dr. on 10/25/17 at approximately 10:00am with no injury identified. Resident's guardian was notified of abuse allegation and 24-hour report on 10/25/17 as well. The identified resident did report pain to her left hip and right inner calf on 10/26/17 when interviewed by the state surveyor. This was reported to the doctor and x-rays were ordered and obtained on 10/26/17. All results were negative for injury. Police Department was called on 10/27/17 at 3:10pm and an officer was sent to the facility to receive report of incident. The facility did recognize the incident as abuse, but did not notify the police after the physical contact between the resident and the staff member. Abuse training completed with facility staff 10/26/17 and 10/27/17 which included

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identification of types of abuse and reporting incidents with physical contact to the police. Abuse policy was reviewed and updated to reflect the need for staff to remove themselves from the environment if resident behavior is escalating. Abuse policy was also revised to include police notification when physical contact occurs.

Procedure for implementing the acceptable plan of correction for the deficiency cited:

1. Facility will complete 24-hour reports for allegations of abuse as reported.
2. Alert and oriented residents were interviewed by the Social Worker on 10/27/17 and no further allegations of abuse were identified.
3. Police Department was called on 10/27/17 at 3:10pm and an officer was sent to the facility to receive report of incident.
4. Abuse training was completed for all active employees by the Staff Development Nurse on 10/26/17 and 10/27/17 which included identification of types of abuse and reporting incidents with physical contact to the police.
5. Staff training will be provided by the Staff Development Nurse on Management of Residents with Behaviors and Management of Residents Who Refuse Care. This training will include staff allowing residents to refuse care, allow residents to calm if agitated, and allowing residents to have choices honored.

Monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

1. The administrator will review all allegations of abuse and ensure police are notified for

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F 226	Continued From page 22 allegations where physical contact has occurred. 2. The administrator and/or designee will be notified of any resident refusing to attend a scheduled appointment. The administrator and/or designee will ensure resident's family member, POA, or guardian is notified of the refused appointment. The validation of the credible allegation was completed on 10/28/17 at 11:00 AM by doing the following: 1. Nine employees on duty were interviewed regarding identification of the different types of abuse and how to report abuse if identified. 2. The Social Worker was interviewed on 10/28/17 at 10:15 AM and she confirmed that she interviewed alert and oriented residents and no further allegations of abuse were identified. 3. A list of all alert and oriented residents in the facility was obtained and the residents were interviewed regarding allegations of abuse. No other allegations were identified. 4. The 24 hour report of abuse was reviewed. Police were at the facility to investigate on 10/27/17. The police report number of the ongoing investigation is 2017E-1061. 5. The abuse training sign sheets were reviewed for in-services held on 10/25 and 10/27/17. Some education was provided by phone for employees not on site.	F 226		
F 242 SS=J	SELF-DETERMINATION - RIGHT TO MAKE CHOICES CFR(s): 483.10(f)(1)-(3) (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services	F 242		11/17/17

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F 242	Continued From page 23 consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and record review the facility failed to allow a resident the choice to refuse to attend a medical appointment resulting in a staff to resident physical abuse resulting in two bruises on the left wrist and two bruises on the left hip for 1 of 1 sampled residents (Resident #1). The immediate jeopardy (IJ) began on 10/25/17 when Resident #1 refused to go to an appointment and staff was insistent that she go. Nurse Aide #1 grabbed Resident #1 by both wrists causing her to fall to the floor resulting in bruising to her left wrist and left hip. The IJ was removed on 10/28/17 at 11:00 AM when the facility's acceptable credible allegation was verified. The facility remained out of compliance at a scope and severity of D (no actual harm with the potential for more than minimal harm that is not IJ) to all the facility to monitor and implement its plan of correction for abuse. Findings included: Resident #1 was admitted to the facility on	F 242	This plan of correction represents Bladen East Health and Rehab's allegation of compliance. The submission of the following plan of correction does not constitute an admission or agreement by the provider as to the truths of the facts as alleged or conclusions presented by survey consultants from NCDHSR relating to alleged deficient practice. Please accept this corrective action as our plan of correction for F242. 1. Per the CMS 2567, the facility failed to allow a resident the choice to refuse to attend a medical appointment resulting in a staff to resident physical abuse resulting in two bruises on the left wrist and two bruises on the left hip for Resident #1. On 10/25/17 at approximately 6:15am, the transport aide arrived at the facility to take identified resident to a scheduled appointment. On 10/25/17 at approximately 7:00am, an allegation of abuse was made by a staff member alleging that the transport aide had	

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07/6/17 with diagnoses that included Dementia without behavioral disturbance, Anemia, Hypertension, Chronic Pain, Anxiety, Major Depression and Malignant Melanoma.

Review of a Quarterly Minimum Data Set for Resident #1 dated 08/03/17 revealed the resident had intact cognition. She was independent for: bed mobility, transfers, locomotion on and off the unit, dressing, eating, personal hygiene and bathing. She required supervision for walking in corridor and toilet use and limited assistance for walking in room. Balance was steady at all times and she used a walker while ambulating. She was receiving Physical Therapy and Occupational Therapy. She participated in the assessment. She weighed 108 pounds.

Record review showed that Resident #1 had a guardian which was the State of North Carolina.

Review of the General Nurse's Note of 10/25/17 at 8:48 AM documented: "Resident alert verbal oriented. Resident refused several times to go to the appointment several times. Transportation person was in to transport. Resident continuously refused to go. Transport was trying to get her out of bed, resident refusing, slipped to floor by bed. Resident denied hitting head or back. No apparent injury noted at present time. Denied pain at present. Will continue to monitor."

Record review revealed that the facility filed a 24-Hour Initial Report to the Department of Health and Human Services on 10/25/17 for resident abuse. The allegation description was: "Allegation of abuse reported concerning transport nursing assistant trying to force resident to go to a doctor's appointment. Report stated grabbed the resident by the wrists, pulled her up off the bed and shook her after the resident refused to go to the appointment. She also stated that the resident had pushed the transport aide and the transport aide then pushed the resident, causing her to fall to the floor. The transport aide was suspended pending our investigation. The 24-hour report was submitted for identified resident on 10/25/17 and 5 day report was submitted on 10/30/17. The resident was assessed by the doctor on 10/25/17 at approximately 10:00am with no injury identified. Resident's guardian was notified of abuse allegation and 24-hour report on 10/25/17 as well. The identified resident did report pain to her left hip and right inner calf on 10/26/17 when interviewed by the state surveyor. This was reported to the doctor and x-rays were ordered and obtained on 10/26/17. All results were negative for injury. Police Department was called on 10/27/17 at 3:10pm and an officer was sent to the facility to receive report of incident. Police investigation was completed on 11/3/17 with no charges filed. Facility abuse policy was reviewed and updated on 10/27/17 to reflect the need for staff to remove themselves from the environment if resident behavior is escalating. Resident did not attend the appointment at Duke Cancer Center scheduled for 10/25/17. The appointment was rescheduled for 11/1/17 at 2:00pm with Duke Cancer Center to honor resident's choice for an afternoon appointment. Resident was informed of upcoming

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F 242	Continued From page 25 the transport nursing assistant grabbed the resident's wrists and shook her, then pushed her causing her to fall. Resident is alert, but confused. No physical injury identified and resident has no recollection of the incident when interviewed." Law Enforcement was not notified. In an interview conducted with Resident #1 on 10/26/17 at 7:45 AM she stated that she had resided at the facility for two months. She said that she had told the transporter (Nurse Aide #1) that she didn't feel good and was not going to the medical appointment that morning. She reported that Nurse Aide #1 then grabbed her by the left arm and right foot and twisted her off the bed causing her to fall to the floor hitting her left hip on the side of the bed as she fell. She said that her left hip and right foot were still hurting. She revealed that several staff members had seen the incident and had tried to convince Nurse Aide #1 that she did not have to go to the appointment. She stated she was hurting where she wasn't hurting before: shooting pain down her right leg, lower back pain, right calf pain, left arm above her elbow and left hip pain. She pointed to the bruises on her left wrist and said that was where Nurse Aide #1 had grabbed her. An observation of the left wrist and left hip of Resident #1 on 10/26/17 at 7:45 AM revealed two circular bruises on her left wrist and two bruises on her left hip. Review of X-rays taken on 10/26/17 of Resident #1's right tibia/fibula, bilateral hips, and pelvis showed all structures grossly intact. In an interview with Nurse #3 on 10/26/17 at 8:43 AM she stated that when she reported for work the morning of 10/25/17 she heard screaming	F 242	11/1/17 appointment on 10/31/17 and again refused to attend. Resident's guardian, Bladen County Department of Social Services and physician, Dr. Jose Gonzalez were notified of resident's refusal on 10/31/17. A meeting with physician, facility social worker, and resident's guardian was held on 11/1/17 to discuss the resident's needs and future goals concerning the treatment of her cancer. 2. Training for all staff on honoring resident choices was completed by the Staff Development Coordinator on 10/27/17. Staff training on Management of Residents with Behaviors and Management of Residents who Refuse Care was also provided by the Staff Development Coordinator and Director of Nursing on 10/27/17. Both of these trainings will be provided upon hire for new employees and annually for all active employees. 3. The Social Worker or his/her designee will interview at least 5 alert and oriented residents to determine if their choices are being honored weekly x 3 weeks, then monthly x 3 months. The administrator and/or designee will observe delivery of care to residents during facility rounds daily x 5 days, then weekly x 3 weeks, then weekly x 1 month, and monthly x 1 month to ensure residents choices are being honored. The administrator and/or Director of Nursing will report results of rounds observations to the facility's Performance Improvement Committee monthly x 3 months for review and to ensure continued compliance.	

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and followed it to Resident #1's room. She said the resident was on the floor screaming. She said Nurse Aide #1 and Nurse Aide #2 were yelling at each other. She said the resident told her she had been abused. She revealed she told staff to leave the room and move away from the doorway. She said she and Nurse #1 put the resident back into bed. She stated she tried to de-escalate the situation and had told everyone present to write a statement of the incident before they left the shift.

In an interview with the Administrator on 10/26/17 at 9:15 AM he stated that because Resident #1 had a guardian at the Department of Social Services (DSS) that she had no rights and could not refuse to go to an appointment scheduled by DSS.

In an interview conducted on 10/26/17 at 9:31 AM with Housekeeper #1 she revealed that she had heard a lot of commotion on the hallway when she reported to work at 6:56 AM on 10/25/17. She said she went to Resident #1's doorway and saw the resident swinging her arms trying to hit Nurse Aide #1 in the face. She said she saw Nurse Aide #1 grab both the resident's arms. She stated she saw the resident trying to get loose and when she jerked away she fell against the bed and hit the floor. She said Nurse Aide #2 was standing with her at the doorway and said to Nurse Aide #1, "you pushed her down and that's abuse. I ought to call the police on you myself."

In an interview conducted with Nurse Aide #1 on 10/26/17 at 10:30 AM she stated that she had arrived to work at 6:10 AM on 10/25/17 to transport Resident #1 to an appointment. She revealed that she asked Nurse #1 if Resident #1

4. The Administrator and Director of Nursing are responsible for implementing this plan of correction.

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was ready to go to the appointment and was told no. She said Nurse #1 told her that the resident said she was not going to go to the appointment. She revealed that she asked Nurse #1 to help her convince the resident to go to the appointment because it was important but that she did not. She said she also asked the resident's third shift aide (Nurse Aide #2) to help her but that she went down an opposite hall and did not help her. Nurse Aide #1 stated that she then called the Director of Nursing (DON) to ask her to tell Nurse #1 and Nurse Aide #2 to help her convince Resident #1 to go to the appointment. She said that Nurse #1 came to the room but that the resident refused to go. She reported that she took clothes out of the resident's closet and laid them on the bed. She reported that Resident #1 jumped out of the bed and ran toward her saying that she was going to "whoop her --- (curse word)." She said the resident had on slippery socks. She said she removed herself from the situation and went outside to move the van. She reported that when she returned to the room the resident rose up off the bed kicking, swinging and screaming. She said that she grabbed both of the resident's arms and when she let go the resident fell back on the bed and slid onto the floor. She said Nurse Aide #2 and Housekeeper #1 were standing in the doorway. She said that Nurse #3 told her to leave the room and that she went to her office, called the DON, and wrote a statement concerning the incident.

In an interview conducted with Nurse Aide #3 ON 10/26/17 at 11:26 AM she revealed that when she reported to work on 10/25/17 she heard yelling coming from Resident #1'S room. She said Resident #1 was on the bed saying that she was not going to the appointment. She said that she

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told the resident that she needed to go to the appointment. She stated that Nurse Aide #1 asked her to help get the resident ready for the appointment and that she left the room to go and get gloves. She said that when she returned Nurse Aide #1 and Resident #1 were standing up and Nurse Aide #1 was holding the resident by both arms. She stated that she saw the resident rear back and fall to the floor. She said that she did not see the resident trying to strike Nurse Aide #1 as she had left the room to get gloves.

In an interview with Nurse Aide #2 on 10/26/17 12:41 PM via the telephone she revealed she was the aide caring for the Resident #1 on third shift the morning of 10/25/17. Said she asked the resident twice during the shift to get ready for the appointment and the resident said she wasn't going. She said she refused to force the resident to get ready to go because she didn't want to go. She said she was at the nurse's station when she heard the resident yelling for help and she ran to the room. She said when she got to the doorway Nurse Aide #1 was holding the resident by both her wrists. The resident was sitting on the side of the bed. She said she heard Nurse Aide #1 say, "You're going to get the ---- (curse word) up." She said she saw Resident #1 push Nurse Aide #1 and then Nurse Aide #1 push the resident to the floor. She said she told Nurse Aide #1 that she should call the police because it was abuse and that Nurse Aide #1 responded by telling her to mind her own business. She reported that Nurse #3 came to the room and told everyone to leave. She said that when the DON arrived she told her that she should have gotten the resident up for the appointment using any means necessary because she was "DSS". She said she told the DON that she saw Nurse Aide #1 push the

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resident to the floor. She said the DON asked her if she had called the state and informed her that she was not allowed to call.

In an interview with Nurse #1 on 10/26/17 at 2:43 PM she stated she was the nurse caring for Resident #1 on the morning of 10/25/17. She said the resident was alert, oriented and reliable. She said when she had passed medications earlier in the shift the resident had told her she was not going to the appointment the following morning. She said she gave the resident Ativan at 5:00 AM (because of the appointment) and again the resident said she wasn't going. She said when Nurse Aide #1 asked her why the resident wasn't ready to go she said she told her the resident was refusing to go. She said Nurse Aide #1 told her the resident could not refuse because she was DSS. Nurse #1 said she told Nurse Aide #1 that she was not going to force anyone to go to an appointment. She said the DON called the facility and asked her to talk to the resident which she said she did and again the resident refused to go to the appointment. She said she left the room to care for another resident. She reported that all the sudden she heard screaming and yelling. She said she and the oncoming day shift nurse (Nurse #3) went to the resident's room. She said Nurse Aide #1 and Nurse Aide #2 where yelling at each other. She said Nurse #3 told everyone to leave the room and they assessed the resident. She reported that the resident told her that Nurse Aide #1 grabbed her arms and pulled her out of bed. She said the resident told her that her left leg was weak and that she slipped to the floor. She said the resident told her that her wrists had been twisted. Nurse #1 reported that she did not see any bruising at that time. She revealed when she

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went back to check on the resident the resident told her that her back was hurting. She stated that she told the resident that the day shift nurse would give her some medication for pain. She said she called the Nurse Practitioner (NP) on duty to report the incident. She reported that the NP asked her if she had given the resident the ordered Ativan at 5:00 AM and told her that she should have called psychiatric services.

In an interview conducted with the DSS Supervisor on 10/26/17 at 4:30 PM she stated that DSS was the guardian for Resident #1. She revealed that DSS makes the medical decisions for Resident #1. She said that the facility had contacted DSS on 10/24/17 and informed them that the resident did not want to go to the appointment scheduled for 10/25/17. She said that they requested that the facility try to convince the resident to go to the appointment so that DSS did not appear neglectful but that the resident had the right to refuse treatment.

In an interview with the Medical Director on 10/27/17 at 12:47 PM he stated that he had assessed Resident #1 on 10/25/17. He said he had been told the resident had refused to go to her appointment that morning and he had gone to her room to talk to her about the appointment. He said that the resident told him someone had grabbed her calf and that it hurt. He reported that he looked at her calf and found nothing abnormal. He also stated that he saw no bruising on the resident at that time. He stated that he was not aware of an altercation between the resident and a member of the staff until the resident told him. He said that he had reviewed her current orders for pain medication and had not made any changes because she had not been taking all the

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medication that was available to her.

On 10/27/17 at 2:45 PM the facility was notified of IJ. The facility provided the following credible allegation of compliance on 10/27/17:

Plan for correcting this deficiency:

On 10/25/17 at approximately 6:15am, the transport aide arrived at the facility to take identified resident to a scheduled appointment. On 10/25/17 at approximately 7:00am, an allegation of abuse was made by a staff member alleging that the transport aide had grabbed the resident by the wrists, pulled her up off the bed and shook her after the resident refused to go to the appointment. She also stated that the resident had pushed the transport aide and the transport aide then pushed the resident, causing her to fall to the floor. The transport aide was suspended pending our investigation. The 24-hour report was submitted for identified resident on 10/25/17. Facility is still currently working on investigation of incident. The resident was assessed by the doctor on 10/25/17 at approximately 10:00am with no injury identified. Resident's guardian was notified of abuse allegation and 24-hour report on 10/25/17 as well. The identified resident did report pain to her left hip and right inner calf on 10/26/17 when interviewed by the state surveyor. This was reported and x-rays were ordered and obtained on 10/26/17. All results were negative for injury. Police Department was called on 10/27/17 at 3:10pm and an officer was sent to the facility to receive report of incident. The facility did recognize the incident as abuse, but did not notify the police after the physical contact between the resident and the staff member.

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Procedure for implementing the acceptable plan of correction for the deficiency cited:

1. Staff training for honoring resident choice to attend appointments was completed for all active employees by the Staff Development Nurse on 10/27/17.
2. Staff training will be provided by the Staff Development Nurse on Management of Residents with Behaviors and Management of Residents Who Refuse Care. This training will include staff allowing residents to refuse care, allow residents to calm if agitated, and allowing residents to have choices honored.

Monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

1. The administrator and/or designee will be notified of any resident refusing to attend a scheduled appointment. The administrator and/or designee will ensure resident's family member, POA, or guardian is notified of the refused appointment.

The validation of the credible allegation was completed on 10/28/17 at 11:00 AM by doing the following:

1. Nine employees on duty were interviewed regarding identification of the different types of abuse and how to report abuse if identified.
2. The Social Worker was interviewed on 10/28/17 at 10:15 AM and she confirmed that she interviewed alert and oriented residents and no further allegations of abuse were identified.

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F 242	Continued From page 33 3. A list of all alert and oriented residents in the facility was obtained and the residents were interviewed regarding allegations of abuse. No other allegations were identified. 4. The 24 hour report of abuse was reviewed. Police were at the facility to investigate on 10/27/17. The police report number of the ongoing investigation is 2017E-1061. 5. The abuse training sign sheets were reviewed for in-services held on 10/25 and 10/27/17. Some education was provided by phone for employees not on site. 6. The honoring of resident rights to refuse appointments in-service was reviewed for sign in sheets dated 10/27/17.	F 242		