STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 08/14/18 through 08/17/18. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.12 at tag F607 at a scope and severity (J) The tags F600 and F607 constituted Substandard Quality of Care. Immediate Jeopardy began on 07/30/18 and was removed on 08/16/18. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff and family member interviews, and observation the facility failed to	F 600	This allegation of compliance is submitted in compliance with applicable	8/18/18

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

Electronically Signed | 08/30/2018

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F 600	Continued From page 1 provide an environment free of abuse for 1 of 1 residents investigated for abuse, Resident #4. The facility failed to utilize information in the hospital's discharge summary and information from a family member to develop and implement interventions to protect Resident #4 from being abused by a family member on 7/30/18. Resident #4 had three red marks on his back and a red area on his face as a result of this abuse. Immediate jeopardy began on 7/30/18 when Nurse #1 observed abuse of Resident #4 and did not intervene to protect the resident and was removed on 8/16/18 when the facility provided and implement an acceptable credible allegation of Immediate Jeopardy Removal. The facility continues to remain out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective.. Findings included: Review of Resident #4's Hospital Discharge Summary dated 6/27/18 revealed the hospital had concerns of Resident #4 being abused and it was reported to Adult Protective Services. The Discharge Summary also noted the nursing staff had documented several witnessed episodes of Family Member #1 verbally and physically abusing Resident #4 including slapping his leg, poking at him, and throwing restraints at him. The Discharge Summary further revealed the hospital had initiated their abuse protocol and required Family Member #1 to be accompanied by security when she visited Resident #4. A telephone interview with Family Member #2 on	F 600	law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following credible allegations constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated. F600 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " Deficient practice □ the facility did not utilize the information contained in the hospital discharge summary or information from family member #2 to implement interventions to protect resident from spousal abuse during his stay. The reason why the facility did not implement any supervised visitation is because the interdisciplinary team did not recognize the concern with potential continued abuse. Family member #2 was recently appointed Healthcare Power of Attorney (HPOA) due to hospital initiated Adult Protective Services (APS) involvement. The new family member #2/HPOA did not request supervised visitation to family member #1. Family member #2 was aware that Family member #1 would be visiting daily. Therefore, the facility did not implement any additional interventions to further protect the resident during his stay.	

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F 600	Continued From page 2 8/15/18 at 12:12 pm revealed she arrived at the facility on 6/27/18 before Resident #4 arrived at the facility to be admitted. Family Member #2 stated she arrived early to let the facility know the hospital had involved Adult Protective Services due to Family Member #1's abuse of Resident #4 during his hospital stay. Family Member #2 stated she had told the Admission Director that Family Member #1 needed to be watched closely when she visited Resident #4. An interview with the Admission Director on 8/15/18 at 2:10 pm revealed Family Member #2 came to the facility on 6/27/18 before Resident #4 was admitted to the facility and told her there were allegations of abuse against Family Member #1 at the hospital and an Adult Protective Services case was opened. The Admission Director stated the Case Manager from the hospital told her Family Member #1 had swatted Resident #4 while he was in the hospital. The Admission Director stated Resident #4 was put into a semiprivate room at admission, but no other interventions were put into place to protect Resident #4. She also stated the facility had not attempted to call Adult Protective Services to get details about the incident. The facility's Discharge Planner stated during an interview on 8/15/18 at 1:45 pm that the Interdisciplinary Team discussed Family Member #1's abuse of Resident #4 while in the hospital during morning meeting the morning after Resident #4 was admitted but he did not implement a care plan or interventions regarding the risk of abuse. The facility's Discharge Planner stated Family Member #2 spoke with the Director of Nursing and the Admission Director regarding her concerns and he thought they	F 600	" While visiting on July 30, 2018, family member #1 slapped resident on the back in his room. This incident was witnessed by nurse #1 who was across the hall in another resident□s room. At the time, nurse #1 was administering a bolus tube feeding to a resident. Unfortunately, while knowing to rescue and report immediately, the reason why nurse #1 did not intervene immediately is because she did not think quickly enough to yell out for help, and made the decision to finish the bolus tube feeding. As soon as nurse #1 could safely finish she exited the room to immediately address the situation. By this time, a second incident between family member #1 and resident had occurred and staff had already separated them. " Facility Action o Visual assessment of resident body done by Nurse immediately following abuse, for any signs of bruising, redness, bleeding, agitation/anxiety □ 3 red areas noted on the mid-back area and a slight red color to right cheek area. o Family member #1 was arrested by the local police on July 30, 2018. There was a court order issued stating that she was not to visit her husband at the facility. Therefore, she was not allowed visitation on facility property during resident□s remainder of stay in the facility. Reception and nursing staff were made aware of court order restrictions prohibiting visitation to resident and facility. Resident is no longer in facility. The procedure for implementing the acceptable plan of correction for the	

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F 600	Continued From page 3 should implement the interventions. Review of the Medical Record for Resident #4 revealed he was admitted to the facility on 6/27/18 from the hospital with diagnoses of fracture related to a fall at home, Parkinson's Disease, Depression, Dementia and Adult Physical Abuse Confirmed. Review of a History and Physical Examination by the Physician on 6/30/18 at 10:27 am revealed Resident #4 was admitted from a hospital on 6/27/18. The History and Physical Exam also revealed there was concern for spouse abuse and Adult Protective Services was involved. Review of Resident #4's Comprehensive Minimum Data Set (MDS) assessment dated 7/4/18 revealed he was moderately cognitively impaired, he was able to understand others and was understood by others. He required extensive assistance of one staff member for moving about in the bed and extensive assistance of two staff members for transferring in and out of bed and was dependent on staff for eating. The Director of Nursing was interviewed on 8/15/18 at 1:35 pm. She stated she was told there was an open Adult Protective Services case open for Resident #4 when he was admitted on 6/27/18. She also stated Family Member #2 told her she suspected Resident #4 had been abused by Family Member #1 during his hospital stay. The Director of Nursing stated Resident #4 was in a semiprivate room and that was the only intervention the facility put into place to protect Resident #4 from being abused. The Director of Nursing stated Family Member #1 visited Resident #4 daily unsupervised until 7/30/18	F 600	specific deficiency cited; " The Director of Nursing (DON) and Regional Nurse Consultant completed one-on-one education to Nurse #1 regarding prompt reporting of any type of resident abuse and providing a safe environment for the resident during abuse on August 16, 2018. Included in this training was the following components: what to do if abuse is suspected, who to notify for abuse allegations, timely reporting of abuse concerns, and protecting the resident from abuse by immediate intervention. In-services also included calling out for help from other staff members if physically unable to stop any witnessed abuse. " The Director of Nursing (DON) and Regional Nurse Consultant completed education on August 15, 2018 for department heads to include: Abuse/Neglect/Misappropriation/Crime □ Initial Reporting Guidelines. On August 15, 2018, education was completed with the following department heads: o 1) Administrator o 2) Director of Nursing o 4) Business Office Manager o 5) Human Resources o 6) Dietary Manager o 7) Receptionist o 8) Discharge Planner/Social Services o 9) Environmental Services Manager o 10) Rehab Director o 12) Activity Director o 13) Medical Records o 14) Maintenance Director " Remaining nursing staff, dietary staff,	

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F 600	Continued From page 4	F 600		

when the incident occurred.

An Incident Report dated 7/30/18 at 11:18 am revealed Nurse #1 saw Resident #4's Family Member (Family Member #1) hit him on his right shoulder and then propelled him down the hall with her hand over his mouth. The report also revealed the Corporate Dietician also observed the Family Member (Family Member #1) with her hand over the resident's mouth and told him to "shut up" and then the Dietician witnessed Family Member #1 slap Resident #4 in the mouth and tell him to shut up again. The Incident Report stated Resident #4 told the Nurse Supervisor who completed the report that Family Member #1 hit him three times on the back, covered his mouth multiple times and slapped him in the mouth so that he could not speak and would not let him go to bed.

The Payroll Representative was interviewed on 8/15/18 at 1:00 pm and stated she was at her desk on 7/30/18 and heard a man yelling save me. She stated she got up and went to see what was happening. The Payroll Representative revealed Resident #4 was at the end of the entrance hall, in his wheelchair with Family Member #1 behind him. She stated Family Member #1 reached around Resident #4 and hit him in his right upper arm. The Payroll Representative stated she went back to the office and told her supervisor, the Business Office Manager, what had happened. She stated she did not attempt to intervene when Family Member #1 hit Resident #4.

The Corporate Dietician was interviewed on 8/15/18 at 1:30 pm and stated she was sitting at her desk on 7/30/18 and heard a man screaming

environmental staff, and therapy staff began training on August 15, 2018. Included in this training are the following components: what to do if abuse is suspected, who to notify for abuse allegations, timely reporting of abuse concerns, and protecting the resident from abuse by immediate intervention. In-services also included for staff to call out for help from other staff members if they are physically unable to stop any witnessed abuse. 145 out of 153 employees have completed the training.

" Any employee that did not receive the education will be removed from the schedule until education is completed.

" MDS coordinator reviewed discharge summaries of current residents on August 16, 2018 for history of abuse or APS concerns. No other residents were identified as at risk for abuse or require protection due to history of abusive situations.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or incompliance with the regulatory requirements;

" Once a referral is received for a new admission to the facility, the Admission Director was instructed on 8/16/18 to review the discharge summary for potential abuse allegations or concerns. Administrator will audit 50% of all new admission discharge summaries for abuse concerns and to ensure appropriate interventions have been

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F 600	Continued From page 5 for someone to save him. She said she looked out her office door and saw Family Member #1 pushing Resident #4 towards the front of the building with her hand over his mouth and she slapped him in the neck/head area. The Corporate Dietician stated Family Member #1 turned the wheelchair around and headed back toward Resident #4's room and then hit him again in the same area. The Corporate Dietician stated she went to report the incident to the Administrator but did not attempt to intervene. An interview with Nurse #1 on 8/15/18 at 2:00 pm revealed on 7/30/18 she saw Resident #4's family member (Family Member #1) hit him in his room from the room across the hall. She stated Family Member #1 hit him in his right upper arm/shoulder area and then immediately started down the hall toward the nurses' desk and then the front of the building. She stated she had her hand over his mouth as she was moving down the hall because he was yelling. She stated she did not intervene or call for help but did notify the RN Supervisor. On 8/15/18 at 2:40 pm the Nursing Supervisor was interviewed. She stated she did not witness the incident on 7/30/18 when Resident #4 was abused by Family Member #1. She stated she was told by the MDS Coordinator that the Administrator wanted her to obtain a skin assessment, incident report, and get statements from staff about the incident. The RN Supervisor stated she was getting statements from the staff when Nurse #1 told her she saw Family Member #1 hit Resident #4. The Nursing Supervisor stated when Nurse #1 reported she had seen Family Member #1 hit Resident #4 in his room it was after other staff had seen Resident #4 being	F 600	implemented, if necessary, weekly x 1 month, every other week x 2 months, and monthly x 3 months. " The Director of Nursing (DON) was instructed on 8/16/18 that effective immediately, if abuse concerns are identified at admission, the Admission Director will notify the Director of Nursing (DON). The Director of Nursing (DON), or designee, will implement a care plan and protective interventions, such as supervised visitation, for any new admission identified with ongoing abuse investigation concerns Date of compliance is August 18, 2018 The Administrator is responsible for implementing the acceptable plan of correction.	

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F 600	Continued From page 6	F 600		

hit at the entrance hall to the building. The Nursing Supervisor stated when she did the skin assessment for Resident #4 on 7/30/18 he had three red marks on his back and a red area on his face.

The Business Office Manager was interviewed on 8/15/18 at 2:55 pm. She stated the Payroll Representative reported to her Family Member #1 had hit Resident #4 in the Entrance Hallway of the facility on 7/30/18. She stated she went out into the hallway and followed Family Member #1 and Resident #4 into the Family Room. She stated she asked Family Member #1 if she hit Resident #4 and Family Member #1 stated she had and she could hit him whenever she wanted since she was his Power of Attorney. The Business Office Manager stated the Administrator arrived at that time and told Family Member #1 she should leave, and he was calling the Police.

The Incident/Investigation Report dated 7/30/18 from the police department revealed on 7/30/18 at 1:10 pm the Administrator reported a "domestic assault" regarding Resident #4. The report stated the Police Officer spoke with Resident #4 and he told the officer Family Member #1 had hit him on the back three times and covered his mouth. The Police Officer's report stated he took witness statements and a warrant was obtained for Family Member #1 for simple assault and assault on a handicapped person.

A phone interview on 8/16/18 at 6:00 pm with the Police Officer revealed Resident #4 stated Family Member #1 had hit him multiple times in the head and had held her hand over his mouth so that he could not yell for help.

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An observation on 8/16/18 at 10:16 am with the Maintenance Director revealed the distance from room 211A, where the resident resided, to the entrance hallway and then back to the family room was 221.5 feet.

The Administrator was notified of Immediate Jeopardy on 8/15/18 at 5:30 pm
On 8/17/18 the facility provided an acceptable credible allegation of immediate jeopardy removal dated 8/16/18 that included:

The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;

"Deficient practice - the facility did not utilize the information contained in the hospital discharge summary or information from family member #2 to implement interventions to protect resident from spousal abuse during his stay. The reason why the facility did not implement any supervised visitation is because the interdisciplinary team did not recognize the concern with potential continued abuse. Family member #2 was recently appointed Healthcare Power of Attorney (HPOA) due to hospital-initiated Adult

"Protective Services (APS) involvement. The new family member #2/HPOA did not request supervised visitation to family member #1. Family member #2 was aware that Family member #1 would be visiting daily. Therefore, the facility did not implement any additional interventions to further protect the resident during his stay.
"While visiting on July 30, 2018, Family Member

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F 600	Continued From page 8	F 600		

#1 slapped resident on the back in his room. This incident was witnessed by nurse #1 who was across the hall in another resident's room. At the time, nurse #1 was administering a bolus tube feeding to a resident. Unfortunately, while knowing to rescue and report immediately, the reason why nurse #1 did not intervene immediately is because she did not think quickly enough to yell out for help and made the decision to finish the bolus tube feeding. As soon as nurse #1 could safely finish she exited the room to immediately address the situation. By this time, a second incident between Family Member #1 and resident had occurred and staff were already intervening appropriately.

Facility Action
oVisual assessment of resident body done by Nurse immediately following abuse, for any signs of bruising, redness, bleeding, agitation/anxiety - 3 red areas noted on the mid-back area and a slight red color to right cheek area.
oFamily member #1 was arrested by the local police on July 30, 2018. There was a court order issued stating that she was not to visit her husband at the facility. Therefore, she was not allowed visitation on facility property during resident's remainder of stay in the facility. Reception and nursing staff were made aware of court order restrictions prohibiting visitation to resident and facility. Resident is no longer in facility.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited;

The Director of Nursing (DON) and Regional Nurse Consultant completed one-on-one education to Nurse #1 regarding prompt reporting

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of any type of resident abuse and providing a safe environment for the resident during abuse on August 16, 2018. Included in this training was the following components: what to do if abuse is suspected, who to notify for abuse allegations, timely reporting of abuse concerns, and protecting the resident from abuse by immediate intervention. In-services also included calling out for help from other staff members if physically unable to stop any witnessed abuse.

The Director of Nursing (DON) and Regional Nurse Consultant completed education on August 15, 2018 for department heads to include: Abuse/Neglect/Misappropriation/Crime - Initial Reporting Guidelines. On August 15, 2018, education was completed with the following department heads:

- o 1) Administrator
- o 2) Director of Nursing
- o 4) Business Office Manager
- o 5) Human Resources
- o 6) Dietary Manager
- o 7) Receptionist
- o 8) Discharge Planner/Social Services
- o 9) Environmental Services Manager
- o 10) Rehab Director
- o 12) Activity Director
- o 13) Medical Records
- o 14) Maintenance Director

Remaining nursing staff, dietary staff, environmental staff, and therapy staff began training on August 15, 2018. Included in this training are the following components: what to do if abuse is suspected, who to notify for abuse allegations, timely reporting of abuse concerns, and protecting the resident from abuse by

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immediate intervention. In-services also included for staff to call out for help from other staff members if they are physically unable to stop any witnessed abuse. 145 out of 153 employees have completed the training.

Any employee that did not receive the education will be removed from the schedule until education is completed.

MDS coordinator reviewed discharge summaries of current residents on August 16, 2018 for history of abuse or APS concerns. No other residents were identified as at risk for abuse or require protection due to history of abusive situations.

The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or incompliance with the regulatory requirements;

Once a referral is received for a new admission to the facility, the Admission Director was instructed on 8/16/18 to review the discharge summary for potential abuse allegations or concerns. Administrator will audit 50% of all new admission discharge summaries for abuse concerns and to ensure appropriate interventions have been implemented, if necessary, weekly x 1 month, every other week x 2 months, and monthly x 3 months.

The DON was instructed on 8/16/18 that effective immediately, if abuse concerns are identified at admission, the Admission Director will notify the DON. The DON, or designee, will implement a care plan and protective interventions, such as supervised visitation, for any new admission

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identified with ongoing abuse investigation concerns.
Date of compliance is August 16, 2018
The Administrator is responsible for implementing the acceptable plan of correction.

Validation Information:
The credible allegation for Immediate Jeopardy removal was validated on 8/17/18 at 4:00 pm, which removed the Immediate on 8/16/18. Validation of the facility's credible allegation of Immediate Jeopardy removal included; Interviews with Nurse #1, RN Supervisor, Corporate Dietician, Director of Nursing, Discharge Planner, Admission Director, Payroll Representative, Business Office Manager, and multiple Nurses, Nurse Assistants, Housekeepers, Therapist, Maintenance Staff, and Dietary staff revealed the facility had educated the staff on "what to do if abuse is suspected, who to notify for abuse allegations, timely reporting of abuse concerns, and protecting the resident from abuse by immediate intervention". The discharge summaries of all current residents were reviewed on 8/16/18 for any risk of abuse. To ensure no further incidents happened in the future the Admission Director will review all potential admissions for abuse allegations or concerns. The Administrator will audit 50% of all new admission discharge summaries for abuse concerns and ensure interventions have been implemented. The Admission Director will notify the Director of Nursing of any abuse concerns identified at admission and the Director of Nursing will implement the care plan and the interventions to protect the resident. The facility had no new admissions since the credible allegation of Immediate Jeopardy removal had

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F 600	Continued From page 12 been implemented.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, staff and family member interviews, and observation the facility failed to develop abuse policies and procedures for protection of residents and failed to implement their abuse policies and procedures in prevention for 1 of 1 residents investigated for abuse, Resident #4. The facility failed to prevent family member abuse on 7/30/18 which resulted in Resident #4 having three bruised areas to his back and a red area to his face. Immediate jeopardy began on 7/30/18 when staff observed abuse of Resident #4 and did not intervene to protect the resident. The immediate jeopardy was removed on 8/16/18 when the facility provided an acceptable credible allegation of removal. The facility continues to remain out of compliance at a D (no harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to amend the abuse	F 607	F607 Plan of Correction This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center□s allegation of compliance. All alleged deficiencies have been, or will be completed by the dates indicated. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;	9/14/18

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F 607	Continued From page 13 policy to include protection of residents from abuse, and to ensure monitoring systems put into place are effective. Findings included: A review of the facility's Abuse/Neglect/Misappropriation/Crime Policy with an effective date of 11/22/16 revealed the facility's procedure was "Patients of the Center have the legal right to be free from verbal, sexual, mental and physical abuse, corporal punishments, involuntary seclusion including abuse facilitated or enabled through the use of technology, and free from chemical and physical restraints except in an emergency and/or as authorized in writing by a physician" and "All employees are responsible for reporting to the Administrator any and all suspected or witnessed incidents of patient abuse, neglect, theft, exploitation and/or mistreatment of a patient as well as reasonable suspicion of a crime against a patient". The policy did not include intervening or protection of the resident when abuse is observed. The Discharge Summary from the hospital dated 6/27/18 revealed the hospital had concerns for abuse and it was reported to Adult Protective Services. The Discharge Summary also noted the nursing staff had documented several witnessed episodes of Family Member #1 verbally and physically abusing Resident #4 including slapping his leg, poking at him, and throwing restraints at him. The Discharge Summary further revealed the hospital had initiated their abuse protocol and required Family Member #1 to be accompanied by security when she visited Resident #4.	F 607	" Deficient practice □ the facility failed to develop and implement abuse policies and procedures that include intervening and protection of residents from abuse. Facility Action o Facility developed a four-question test that is specific to what to do if abuse is suspected, who to report it to and when, and what to do if abuse is witnessed. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " All staff were educated by the Director of Nursing (DON), Staff Development Coordinator (SDC), or designee on what to do if abuse is suspected, who to report it to and when, and what to do if abuse is witnessed. " All new employees will be educated by the Staff Development Coordinator (SDC) or designee during orientation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or incompliance with the regulatory requirements; " The Administrator or designee will ask 5 employees the four questions weekly for four weeks, and 5 employees monthly for five months. The findings will be reviewed at the quarterly QAPI meetings. Date of compliance is September 14, 2018 The Administrator is responsible for implementing the acceptable plan of	

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F 607	Continued From page 14 A telephone interview with Family Member #2 on 8/15/18 at 12:12 pm revealed she arrived at the facility on 6/27/18 before Resident #4 arrived at the facility to be admitted. Family Member #2 stated she arrived early to let the facility know the hospital had involved Adult Protective Services due to Family Member #2's abuse of Resident #4 during his hospital stay. Family Member #2 stated she had told the Admission Director that Family Member #1 needed to be watched closely when she visited Resident #4. An interview with the Admission Director on 8/15/18 at 2:10 pm revealed Family Member #2 came to the facility on 6/27/18 before Resident #4 was admitted to the facility and told her there were allegations of abuse against Family Member #1 at the hospital and an Adult Protective Services case was opened. The Admission Director stated the Case Manager from the hospital told her Family Member #1 had swatted Resident #4 while he was in the hospital. The Admission Director stated Resident #4 was put into a semiprivate room at admission, but no other interventions were put into place to protect Resident #4. She also stated the facility had not attempted to call Adult Protective Services to get details about the incident or provided supervised visits for Family Member #1. The Director of Nursing was interviewed on 8/15/18 at 1:35 pm. She stated she was told there was an open Adult Protective Services case open for Resident #4 when he was admitted. She also stated Family Member #2 told her she suspected Resident #4 had been abused by Family Member #1 during his hospital stay. The Director of Nursing stated Resident #4 was in a semiprivate room and that was the only	F 607	correction.	

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intervention the facility put into place to protect Resident #4. The Director of Nursing stated the Family Member #1 had visited daily unsupervised until 7/30/18 when the incident occurred. The Director of Nursing stated they had discussed in morning meeting the morning after Resident #4 was admitted but she did not implement interventions regarding the risk of abuse.

The facility's Discharge Planner stated during an interview on 8/15/18 at 1:45 pm that the Interdisciplinary Team discussed Family Member #1's abuse of Resident #4 while in the hospital during morning meeting the morning after Resident #4 was admitted but he did not implement interventions regarding the risk of abuse.

An interview on 8/15/18 at 2:25 pm with the Social Worker revealed she learned about Family Member #1's history of abuse from the Activity Director. The Social Worker stated Family Member #1 came into the facility on 6/27/18 after Resident #4 was admitted. She stated Family Member #1 told her she had "flicked him on the wrist with his restraints while in the hospital". The Social Worker stated she did not document the conversation with Family Member #1 or implement interventions to prevent abuse.

A History and Physical Examination by the Physician on 6/30/18 at 10:27 am revealed Resident #4 was admitted from a hospital on 6/27/18. The History and Physical Exam also revealed there was concern for spouse abuse and Adult Protective Services was involved.

Resident #4 was admitted on 6/27/18 from the hospital with diagnoses of fracture related to a fall

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at home, Parkinson's Disease, Depression, Dementia and Adult Physical Abuse Confirmed. His comprehensive Minimum Data Set (MDS) assessment dated 7/4/18 revealed he was moderately cognitively impaired, he was able to understand others and was understood by others. He required extensive assistance of one staff member for moving about in the bed and extensive assistance of two staff members for transferring in and out of bed and was dependent on staff for eating.

An Incident Report dated 7/30/18 at 11:18 am revealed Nurse #1 saw Resident #4's Family Member (Family Member #1) hit him on his right shoulder and then propelled him down the hall with her hand over his mouth. The report also revealed the Corporate Dietician also observed the Family Member (Family Member #1) with her hand over the resident's mouth and told him to "shut up" and then the Dietician witnessed Family Member #1 slap Resident #4 in the mouth and tell him to shut up again. The Incident Report stated Resident #4 told the Nurse Supervisor who completed the report that Family Member #1 hit him three times on the back, covered his mouth multiple times and slapped him in the mouth so that he could not speak and would not let him go to bed.

The Payroll Representative was interviewed on 8/15/18 at 1:00 pm and stated she was at her desk on 7/30/18 and heard a man yelling save me. She stated she got up and went to see what was happening. The Payroll Representative revealed Resident #4 was at the end of the entrance hall, in his wheelchair with Family Member #1 behind him. She stated Family Member #1 reached around Resident #4 and hit

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him in his right upper arm. The Payroll Representative stated she went back to the office and told her supervisor, the Business Office Manager, what had happened. She stated she did not attempt to intervene when Family Member #1 hit Resident #4. The Payroll Representative stated she knew she should report abuse to her supervisor, but she was not aware she should intervene.

The Business Office Manager was interviewed on 8/15/18 at 2:55 pm. She stated the Payroll Representative reported to her Family Member #1 had hit Resident #4 in the Entrance Hallway of the facility. She stated she went out into the hallway and followed Family Member #1 and Resident #4 into the Family Room. She stated she asked Family Member #1 if she hit Resident #4 and Family Member #1 stated she had and she could hit him whenever she wanted since she was his Power of Attorney. The Business Office Manager stated the Administrator arrived at that time and told Family Member #1 she should leave, and he was calling the Police.

The Corporate Dietician was interviewed on 8/15/18 at 1:30 pm and stated she was sitting at her desk on 7/30/18 and heard a man screaming for someone to save him. She said she looked out her office door and saw Family Member #1 pushing Resident #4 towards the front of the building with her hand over his mouth and she slapped him in the neck/head area. The Corporate Dietician stated Family Member #1 turned the wheelchair around and headed back toward Resident #4's room and then hit him again in the same area. The Corporate Dietician stated she went to report the incident to the Administrator but did not attempt to intervene.

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She stated she was not aware she should intervene, but she stated she knew she should report the abuse to the Administrator.

An interview with Nurse #1 on 8/15/18 at 2:00 pm revealed she saw Resident #4's family member (Family Member #1) hit him in his room from the room across the hall. She stated Family Member #1 hit him in his right upper arm/shoulder area and then immediately started down the hall toward the nurses' desk and then the front of the building. She stated she had her hand over his mouth as she was moving down the hall because he was yelling. She stated she did not intervene or call for help but did notify the RN Supervisor.

On 8/15/18 at 2:40 pm the Nurse Supervisor was interviewed. She stated she did not witness the incident on 7/30/18 when Resident #4 was abused by Family Member #1. She stated she was told by the MDS Coordinator that the Administrator wanted her to obtain a skin assessment, incident report, and get statements from staff about the incident. The RN Supervisor stated she was getting statements from the staff when Nurse #1 told her she saw Family Member #1 hit Resident #4. The RN Supervisor stated when Nurse #1 reported she had seen Family Member #1 hit Resident #4 in his room it was after other staff had seen Resident #4 being hit at the entrance hall to the building. The RN Supervisor stated when she did the skin assessment for Resident #4 on 7/30/18 he had three red marks on his back and a red area on his face.

The Incident/Investigation Report dated 7/30/18 from the police department revealed on 7/30/18 at 1:10 pm the Administrator reported a "domestic

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assault" regarding Resident #4. The report stated the Police Officer spoke with Resident #4 and he told the officer Family Member #1 had hit him on the back three times and covered his mouth. The Police Officer's report stated he took witness statements and a warrant was obtained for Family Member #1 for simple assault and assault on a handicapped person. Family Member #1 was later arrested and appeared before the Magistrate and released under a $2500.00 unsecured bond and is scheduled to appear in court on 8/31/18.

An observation on 8/16/18 at 10:16 am with the Maintenance Director revealed the distance from room 211A, where the resident resided, to the entrance hallway and then back to the family room was 221.5 feet.

The Administrator was notified of Immediate Jeopardy of F607 on 8/15/18 at 5:30 pm.

Lexington Health Care Credible Allegation of Compliance dated 8/15/18:
This allegation of compliance is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following credible allegation constitutes the center's allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated.

The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency cited:

Deficient practice-the facility did not utilize the

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information contained in the hospital discharge summary or information from family member #2 to implement interventions to protect resident form spousal abuse during his stay. The reason why the facility did not implement any supervised visitation is because the interdisciplinary team did not recognize the concern with potential continued abuse. Family Member #2 was recently appointed Heathcare Power of Attorney (HPOA) due to hospital initiated Adult Protective Services (APS) involvement. The new family member #2/HPOA did not request supervised visitation to family member #1. Family member #2 was aware that Family member #1 would be visiting daily. Therefore, the facility did not implement any additional interventions to further protect the resident during his stay.

While visiting on July 30, 2018, family member #1 slapped resident on the back in his room. This incident was witnessed by nurse #1 who was across the hall in another resident's room. At the time, nurse #1 was administering a bolus tube feeding to a resident. Unfortunately, while knowing to rescue and report immediately, the reason why nurse #1 did not intervene immediately is because she did not think quickly enough to yell out for help, and made the decision to finish the bolus tube feeding. As soon as nurse #1 could safely finish she exited the room to immediately address the situation. By this time, a second incident between family member #1 and resident had occurred and staff were already intervening appropriately.

Facility Action

Visual assessment of resident body done by Nurse immediately following abuse, for any signs

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of bruising, redness, bleeding, agitation/anxiety-3 red areas noted on the mid back area and a slight red color to right cheek area.

Family member #1 was arrested by local police on July 30, 2018. There was a court order issued stating she was not to visit her husband at the facility. Therefore, she was not allowed visitation on facility property during resident's remainder of stay in the facility. Reception and nursing staff were made aware of court order restrictions prohibiting visitation to resident and facility. Resident is no longer in facility.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited:

The Director of Nursing (DON and the Regional Nurse Consultant completed one-on-one education to Admission Director regarding the review of all new admission paperwork to include previous abuse allegation history or APS involvement. Admission Director was also educated to provide these details to the nursing staff prior to admission so that an acceptable plan of care can be created for individuals with abuse potential or history. Education was completed on August 16, 2018.

MDS Coordinator reviewed discharge summaries of current residents on August 16, 2018 for history of abuse or APS concerns. No other residents were identified as at risk for abuse or required protection due to history of abusive situations.

The Director of Nursing (DON) and Regional Nurse Consultant completed education on August 15, 2018 for department heads to include:

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Abuse/Neglect/Misappropriation/Crime-Initial Reporting Guidelines. On August 15,2 018, education was completed with the following department heads:

1) Administrator
2) Director of Nursing
3) Business Office Manager
4) Human Resources
5) Dietary Manager
6) Receptionist
7) Discharge Planner/Social Worker
8) Environmental Services Manager
9) Rehab Director
10) Activity Director
11) Medical Records
12) Maintenance Director

Remaining nursing staff, dietary staff, environmental staff and therapy staff began training on August 15, 2018. Included in this training are the following components: what to do if abuse is suspected, who to notify for abuse allegations, timely reporting of abuse concerns, and protecting the resident from abuse by immediate intervention. In-services also included for staff to call out for help from other staff members if they are physically unable to stop any witnessed abuse. 145 out of 153 employees have completed the training.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or incompliance with the regulatory requirements:

Once a referral is received for a new admission to the facility, the Admission Director was instructed on 8/16/18 to review the discharge summary for

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potential abuse allegations or concerns. Administrator will audit 50% of all new admission discharge summaries for abuse concerns and to ensure appropriate interventions have been implemented, if necessary, weekly x 1 month, every other week x 2 months, and monthly x 3 months.

The DON was instructed on 8/16/18 that effective immediately, if abuse concerns are identified at admission, the Admission Director will notify the DON. The DON, or designee, will implement a care plan and protective interventions, such as supervised visitation, for any new admission identified with ongoing abuse investigation concerns.

Date of compliance is August 16, 2018.

The Administrator is responsible for implementing the acceptable plan of correction.

Validation Information:

Validation of the facility's allegation of Immediate Jeopardy removal was completed on 8/17/18. Interviews with Nurse #1, RN Supervisor, Corporate Dietician, Director of Nursing, Discharge Planner, Admission Director, Payroll Representative, Business Office Manager, and multiple Nurses, Nurse Assistants, Housekeepers, Therapist, Maintenance Staff, and Dietary staff revealed the facility had educated the staff on "what to do if abuse is suspected, who to notify for abuse allegations, timely reporting of abuse concerns, and protecting the resident from abuse by immediate intervention". The discharge summaries of all current residents were reviewed on 8/16/18 for any risk of abuse.

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F 607	Continued From page 24 To ensure no further incidents happened in the future the Admission Director will review all potential admissions for abuse allegations or concerns. The Administrator will audit 50% of all new admission discharge summaries for abuse concerns and ensure interventions have been implemented. The Admission Director will notify the Director of Nursing of any abuse concerns identified at admission and the Director of Nursing will implement the care plan and the interventions to protect the resident. The facility had no new admissions since the allegation of Immediate Jeopardy removal had been implemented.	F 607		