STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345541	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation (Event ID #T0DQ11) was conducted on 12/03/18 through 12/07/18. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity of J. CFR 483.12 at tag F607 at a scope and severity of J. Tags F600 and F607 constituted substandard quality of care. Immediate Jeopardy began on 08/18/18 and was removed on 12/07/18. An extended survey was completed.	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 reviews and staff interviews the facility failed to protect 2 of 3 residents from staff	F 600	Address How Corrective Action (S) Will Be Accomplished For Those Residents	12/12/18

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

Electronically Signed | 12/28/2018

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F 600	Continued From page 1 and/or resident physical abuse (Resident #1 and #2). The facility failed to protect Resident #1 from a facility Sitter from forcefully grabbing his left arm which caused a 4-centimeter tunneling skin tear. The facility also failed to protect Resident #1 and #2 from Resident #3 intentionally and deliberately rolling over both residents' feet with his motorized wheelchair. Resident #1's and Resident #2's feet were assessed by the facility's nursing staff and did not experience any physical injuries. Immediate Jeopardy began on 08/18/18 for Resident #1 when a Sitter (who was employed by the facility) grabbed his arm and caused a 4-centimeter (cm) skin tear. Immediate Jeopardy began on 11/25/18 for Resident #1 and Resident #2 when Resident #3 intentionally and deliberately rolled over their feet with his motorized wheelchair. Immediate Jeopardy was removed on 12/07/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential of minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. Findings included: 1. Resident #1 was admitted to the facility on 01/04/18 with diagnoses that included Lewy Body Dementia (LBD) (a Parkinson like dementia that progressively worsens). The most recent comprehensive Minimum Data Set (MDS) assessment dated 06/01/18 revealed he had severe cognitive impairment and required extensive 2-person assistance with most of his activities of daily living. The MDS had no	F 600	Found To Have Been Affected By The Deficient Practice: The employee in question was notified of the need to come in for another interview on 12/05/2018 and she arrived at 12:30 pm at which time an interview was conducted. Per our policy the employee is suspended now pending another investigation. The facility completed the investigation on December 12, 2018. After conducting another interview, the employee admitted to the Administrator and Director of Nursing that she lied about the circumstances surrounding the incident on 08/18/2018. When asked why, she stated that she didn□t want to lose her job but she had thought about it and this is the reason she reported to the surveyor a different story. She stated that based on the current information she understood that this was considered abuse. Therefore employee□s employment was terminated on December 12, 2018. The staff intervened with Resident #1 and Resident #3 by removing Resident #1 from the area and monitoring Resident #3, per #1 Nurse LPN witness statement and nurse□s note. After the incident with Resident #2 and #3 the staff in the dining room intervened by assisting Resident #3 from the dining room which was his intent when running over resident #2□s feet. The #1 Nurse LPN evaluated the resident #1 and #2□s feet at the time and there were no injuries or complaints from the residents per the nurse□s notes.	

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F 600	Continued From page 2 behaviors documented during the assessment period. Review of Resident #1's Care Area Assessment (CAA) for Cognition dated 06/01/18 revealed in part that he had a diagnosis of LBD and had experienced a rapid cognitive decline over the last few months. The CAA also indicated Resident #1 had poor safety awareness and impulsive behaviors. Review of Resident #1's Care Plan dated 06/01/18 stated in part that he had LBD which resulted in his rapid cognitive decline. The established goal was to maintain the ability to follow simple commands by utilizing interventions which included facing him while speaking to him, speaking slowly and distinctly to him and maintain eye contact during interaction with him. Review of a Nurses Note, written by Nurse #2, dated 08/18/18 at 10:22 AM indicated in part that Resident #1 was alert and verbal with confusion. Resident #1 received a skin tear to the top of left forearm which measured 4 cm long by 1.5 cm wide with a flap of skin tunneling 0.5 cm to the left side of the skin tear. Resident #1 was calm and in good a mood while treatment was being given. Resident #1 stated "the Sitter and he were scuffling, and she tore a chunk of meat from his arm then he punched her." The note specified, Resident #1 also stated that the Sitter said "ha, ha, ha I won." Resident #1 stated he felt some soreness in his left arm. Review of Employee's Accident/Incident Report dated 08/18/18 at 10:00 AM written by Nurse Supervisor (NS) #3 stated Resident Companion (Sitter) came up to her and stated Resident #1	F 600	On November 26, 2018 the DON completed a thorough skin assessment on Resident # 1 and Resident #2 involved in the 11/25/2018 incidents and there were no noted areas of bruising, discoloration, scratches and or injury. The residents did not appear to have any mental or emotional distress as a result of the incident as they mentally appeared to be at their baseline and did not express any signs of physical or mental distress. The Resident #3 was evaluated by Physical Therapy on 12/03/2018 to determine if the resident has the capability of maneuvering a motorized chair independently. It was determined that resident has great difficulty when decreased space is available. He is unable to see his feet or immediately by his sides due to decreased visual field. He tends to use the wheelchair to increase his visual field as opposed to turning his head. Required cues to turn his head instead, he would turn the chair. Due to the safety needs of the residents the Interdisciplinary Care Team and Physician has decided the resident will be evaluated on 12/06/2018 for a traditional wheelchair and placed in chair after the evaluation. Resident was placed in the traditional wheelchair on 12/06/2018 and continues with therapy working with him to be able to maneuver the chair in tight spaces. Address How Corrective Action Will Be	

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F 600	Continued From page 3 punched her in the face and she scratched him accidentally as she was moving his arms out of her face. The Sitter then began to cry and the NS #3 told her to remove herself from Resident #1's room. Review of the Sitter's statement dated 08/18/18 (untimed) revealed Resident #1 was trying to stand and she tried to get him to sit back down in his chair for his safety. Resident #1 then got very agitated and punched the Sitter in the jaw with his left arm. In response, the Sitter shoved his arm away in an urgent manner accidentally digging her nails into his arm in the process. The Sitter immediately went to NS #3 and told her what happened. When the Sitter went back to the room, Resident #1 had his left sleeve rolled up revealing a skin tear that she had unintentionally caused. Telephone interview with Resident Companion (Sitter) on 12/03/18 at 3:05 PM she stated Resident #1 had started to stand up and she told him to sit back down then he reached up with his hand and hit her in the face. The Sitter stated out of instinct she grabbed Resident #1's left hand to keep him from hitting her again. By this time Resident #1 was sitting down so she immediately went to the nurses' station to report what had happened. The Sitter stated while she was holding an ice pack to her right jaw they brought Resident #1 to the desk and when he saw her he said "Oh, you did this" while pointing to his skin tear. The Sitter stated Resident #1 was not bleeding a lot. On 12/03/18 at 4:30 PM the interview with the Sitter continued in person with demonstration of incident. The Sitter stated she and Resident #1	F 600	Accomplished For Those Residents Having Potential To Be Affected By The Same Deficient Practice: 1. All interview able residents were interviewed by the facility Social Worker and Director of Nursing to determine if they had been a recipient of, or witnessed abuse by a staff member, family member, visitor or another resident. The interviews were conducted on 12/05/2018 and there were no residents who had experienced or witnessed any abuse. 2. The facility performed ongoing audits of Incident reports, since October, 2018. However, this process was escalated further to include 24 hour nursing shift reports as well, which are reviewed for incidents involving possible resident to resident altercations, and or abuse. This new process was initiated by Administrator following the resident to resident altercation on 11/28/2018. To date, there have been no injuries of unknown origin to investigate. The Morning Meeting Signature Agenda reflects the Administrative and the Clinical Team attendance. Thus all non-interview able residents have not had any noted incidents 3. The Administrator, Director of Nursing and Corporate Nurse Consultant conducted In-services with all staff beginning on 12/05/2018 and completed on 12/07/2018 which is required to be completed prior to returning to work; and all new hires will be required to complete the following training in orientation prior to working with the resident;	

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F 600	Continued From page 4 were watching television when he started to stand up and she stood up in front of him and leaned down to him and said (Resident #1) you need to sit down and at that time he had already sat back down then he "hit me on the right side of my face with his left hand and out of instinct I grabbed his arm to keep him from hitting me again" and in doing so my fingernails caused a skin tear on his arm. The Sitter stated she did not know she caused the skin tear to Resident #1's arm until he came to the nurses' station later and showed the nurse and me his arm. The Sitter stated, "It (the resident 's arm) clearly had the imprints of my fingernails and it was open with small drops of blood." The Sitter explained that she had not received training on what to do when a resident became agitated. Review of NS #3's written statement (undated) and timed 10:00 AM revealed the Sitter approached her and stated Resident #1 needed an Ativan. NS #3 asked the Sitter what Resident #1 was doing and the Sitter stated that he kept trying to get up and that he punched her in the jaw. NS #3 stated she wanted to assess Resident #1 before she gave him an Ativan and observed him from his doorway smiling and seemed okay. A minute later the Sitter approached NS #3 and said Resident #1 had a skin tear that he had punched her and she grabbed his arm to push him away and (caused a) skin tear. On 12/04/18 at 10:04 AM during an interview with NS #3, she stated that on 08/18/18 the Sitter came up to her (NS) and told her (NS) that Resident #1 was trying to stand up and she (Sitter) tried to restrain him and he punched her (Sitter) in the face. NS #3 stated she called the Interim Director of Nursing (IDON) and was	F 600	a. ABUSE - Resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. b. Types of abuse, i.e., (physical, verbal, chemical, sexual, and resident to resident abuse. c. What to do if abuse is witnessed, who to report the abuse to, d. How to react to combative behavior from residents; how to provide care and services to combative residents to prevent abuse to resident(s) or harm to the care giver; and e. Dementia training. f. Reporting of ANY SUSPICION of abuse of any type, neglect, exploitation and misappropriation of resident property. g. Notification of the incident to the Administrator and the Director of Nursing IMMEDIATELY. Failure to notify will result in disciplinary action. 4. The Administrator and the Director of Nursing received additional training on the Abuse policy and regulations, the investigation process and the regulations regarding timely notification by staff, and then timely reporting of the abuse to the required agencies and Dementia Training. This was completed on 12/06/2018 by the Corporate Nurse Consultant. Address What Measures Will Be Put Into Place Or Systemic Changes Made To Ensure That The Deficient Practice Will Not Recur: 1. The Director of Nursing implemented Administrative Nursing Staff rounds on the	

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F 600	Continued From page 5 instructed to get a statement from the Sitter then send the Sitter home. Review of Nurse #2's written statement (undated and untimed) revealed in part that while she was treating Resident #1's skin tear he stated that she (Sitter) grabbed his arm with her nails then he punched her. Resident #1 continued to state the Sitter tempted him to hit her saying "hit me, hit me" so Resident #1 said he hit her. Resident #1 said they were initially scuffling and that she always does this with him. On 12/03/18 at 5:31 PM during a telephone interview with Nurse #2 she stated she was asked by NS #3 to come and note a skin tear on Resident #1. Nurse #2 stated that it didn't look like a normal skin tear and described it as deep, tunneling, and had a crescent shaped skin flap. The Nurse also stated there was a moderate amount of bleeding. After NS #2 treated the skin tear, she documented the measurements and what Resident #1 stated happened in her nurses' notes and reported it to NS #3 and called the IDON. Review of the Investigation Timeline written by IDON and dated 08/24/18 and signed by Administrator on 08/24/18 revealed the IDON was called on 08/18/18 at approximately 10:45 AM and informed that Resident #1 had swung at his Sitter while being redirected to sit down. While attempting to sit Resident #1 down he swung at the Sitter striking her in the right side of her face/jaw and that while the Sitter was trying to move his hands away a skin tear was caused on the left forearm of Resident #1. The IDON told NS #3 to assess both Resident #1 and the Sitter for injuries and get a written statement from the	F 600	resident care units on 10/17/2018 (entering rooms and showers where care was being provided) and have continued to monitor four (4) times a week to ensure that care delivery is being conducted in a way that preserved the resident□s privacy, dignity and freedom from abuse. There have been no incidents noted since that time. These rounds will continue at four (4) per week (including at least one (1) on the 11-7 shift for the next six (6) months and then two (2) per week for the following six (6) months to ensure that the deficient practice does not reoccur. 2. The facility has performed ongoing daily audits of Incident reports, since October, 2018. However, this process was escalated further to include 24 hour nursing shift reports as well, which are reviewed for possible resident to resident altercations, and or abuse. This new process was initiated by Administrator following the resident to resident altercation on 11/28/2018. To date, there have been no injuries of unknown origin to investigate. 3. All interview able residents were interviewed by the facility Social Worker and Director of Nursing to determine if they had been a recipient of, or witnessed abuse by a staff member, family member, visitor or another resident. The interviews were conducted on 12/05/2018 and there were no residents who had experienced or witnessed any abuse. The Administrative Staff conducts QA Rounds on a daily basis and are required to interview at least two (2) residents to	

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F 600	Continued From page 6 Sitter then send her home. The Sitter was noted with red mark on the right side of her face/jaw. Resident #1 had a skin tear on his left forearm. The skin tear was treated with normal saline and dressed with a xeroform gauze and dry dressing. The Physician's On-Call was notified of the situation and the family was notified via message. The IDON completed a 24-Hour Initial Report and faxed it to the state agency. The IDON also spoke with Resident #1 and asked him how he hurt his arm in which he replied "I punched her." however Resident #1 was not a reliable source due to the diagnosis of LBD. The Investigative Timeline continued to indicate on 08/22/18 at 1:30 pm the Sitter was brought in to meet with the IDON and the Administrator to provide a verbal statement of the incident. The Sitter reported she was attempting to redirect Resident #1 to sit back down and he began to get agitated with her and swung at her hitting her in the right side of her face/jaw. In response to him swinging at her she reacted by forcefully pushing his arm away from her face. She left the room to notify the nurse of the increase in agitation. Upon returning to the room with the nurse she and the nurse noted blood on the sleeve of his left forearm. When the sleeve was rolled up a skin tear was observed. The Sitter was asked to demonstrate how she reacted when he hit her since she used the word "forcefully." Both the IDON and the Administrator witnessed her reaction and felt that it was a reaction to being hit and she did not mean to cause a skin tear to his arm. The Sitter was told by the Administrator that she was being suspended until Monday, August 27th at which time they would call her and let her know about returning to work once the facility's investigation was complete. At that time they felt it was not appropriate for her to work as a Resident	F 600	determine if they have experienced any type of abuse. None has been reported. 4. Staff interviews were conducted by outside RN Consultant on 12/5/2018-12/6/2018. The interviews involved detail questioning pertaining to resident abuse awareness, prevention and reporting process of all facility staff. Interview results were reviewed by Administration on December 10, 2018 for possible concerns. There were no incidents of abuse reported in these interviews. 5. All staff members were addressed prior to their next tour of duty as to the abuse prohibition policy with emphasis on not only reporting direct knowledge of any incident, but also immediately reporting knowledge of any rumor or hearsay of abuse (of any type), thereby promoting investigation as to the validity of the rumor/hearsay. Failure to do so will warrant disciplinary action. Additionally, staff members were addressed as to the revised policy which clearly specified the educational training on dementia, during orientation. As a means to ensure ongoing compliance, the orientation process has been amended to fully integrate dementia training for CNA□s and Nurses, to ensure care givers are receiving tools to care for combative residents, as per facility policy. Additionally, immediate reporting of any rumor or hearsay which could indicate any type of abuse will be addressed during orientation of newly hired employees to ensure enforcement of facility policy No	

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F 600	Continued From page 7 Companion. The Timeline stated, "we did not feel this was abuse and therefore were not able to substantiate abuse since there were no witnesses and the resident was not a reliable source due to the diagnosis of Lewy Body Dementia." During an interview with the IDON on 12/04/18 at 11:47 AM she reported that she was notified of the incident between Resident #1 and the Sitter in the morning of 08/18/18 and arrived at the facility in the early afternoon. The IDON stated she was told by NS #3 that Resident #1 became combative with the Sitter and punched her in the face after they got into a scuffle. The IDON stated she instructed NS #3 to get a statement from the Sitter then send her home. The IDON stated that when she got to the facility Resident #1's skin tear was already dressed and she did not remove the dressing to assess his skin tear. The IDON stated she interviewed Resident #1 but because of his progressive LBD he could not remember the incident. The IDON stated she reviewed the Sitter's statement and read it as when Resident #1 went up to hit her she pushed his hand out of the way and caused the skin tear. The IDON continued to state that they (Administration) brought the Sitter in to act out of incident and they did not feel the act was intentional or abusive. During an interview with the Administrator on 12/04/18 at 3:45 PM she stated the Sitter received the same training on residents with agitation as the other direct care staff and she did what she should have done by reporting the incident which she did right away. The Administrator stated she did not consider the incident between the Sitter and Resident #1 abuse.	F 600	concerns were revealed based on staff interviews. An observation of the overall environment and at risk residents is ongoing and is being conducted by the Champion designated licensed nurse (Nurse Managers), and documented on Behavior monitoring flow sheets. The flow sheets will be submitted to DON and discussed by IDT at daily stand up meeting. 6. Incident Reports and (24-Hour Nursing Report) will be reviewed Monday through Friday in morning meetings for any unusual incident to include bruises, skin tears and injuries of unknown origin and resident to resident abuse. An immediate investigation will be started for all bruises or unknown origin, skin tears of unknown origin or any other incident or injury of unknown origin and any occurrence that is suspected abuse will be reported immediately to the Huntersville Police Department and the North Carolina Health Care Personnel Registry. The incident reports are completed electronically by the staff nurses and the nurse supervisors are responsible to print the incident report(s) for their unit before the morning meeting and are responsible to bring them to the morning meeting. In addition they will bring the 24-Hour Nursing Report to the meeting and the two documents will be compared to ensure incidents of unknown origin are investigated and interventions put into place. In the event the nursing supervisor is absent the responsibility of printing the incident reports and the 24-Hour Nursing Report is assigned to the	

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F 600	Continued From page 8 2. Resident #3 was admitted to the facility on 05/14/18 with diagnoses that included: encounter for orthopedic aftercare following surgical amputation, unspecified dementia without behaviors, and cognitive communication deficit among others. A review of Resident #3's most recent MDS Assessment revealed Resident #3 was moderately cognitively impaired with no noted behaviors during the look back period. A. Review of Resident #3's nurse's notes revealed a noted dated 11/25/18 at 1:25PM that was written by Nurse #1. The note specified Resident #3 was leaving the dining room and had an altercation with Resident #1 in which Resident #3 utilized his motorized wheelchair to roll over Resident #1's feet. Per the nurse's note, the altercation was a result of Resident #1 being in the way of Resident #3 and not moving out of the way as fast as Resident #3 wanted. The nurse's note revealed Resident #3 reported that he rolled over Resident #1's feet because Resident #1 did not move out of his way so "he had to teach him a lesson." Further review of the progress note revealed Resident #3 appeared to have "no remorse and stated again that he had to teach him a lesson." Review of the nurse note revealed Nurse #1 spoke with Resident #3 after the incident and noted telling him that type of behavior would not be accepted. Resident #1 was admitted to the facility on 01/04/18 with diagnoses that included: Dementia with Lewy bodies, dementia with behaviors, cognitive communication deficit, major depressive disorder muscle weakness, abnormal posture, unsteadiness on feet, and a history of falling and unspecified fracture of lower leg among others. Review of Resident #1's most recent quarterly	F 600	ADON and then to the DON. 7. The Corporate Compliance Nurse will be responsible to review the Administrative Nursing Staff rounds Sheets on a weekly basis for three (3) months; a bi-monthly basis for three (3) months and then monthly for six (6) months to determine that facility is in compliance with the credible allegation of compliance and interventions have been put into place. If there are discrepancies in the monitoring tool, the Corporate Compliance Nurse will be responsible to inform the Administrator and conduct an investigation to determine why the discrepancy is there and if needed to assist in correcting the issue. 8. The Corporate Compliance Nurse will also conduct rounds on a weekly basis for three (3) months; a bi-monthly basis for three (3) months and then monthly for six (6) months and conduct interviews with the staff and residents to ensure that all incidents have been reported and compare with the Clinical Teams reviews and interventions. 9. Resident to resident abuse monitoring will be conducted every shift on the flow sheet logs, by the appointed licensed nurse, termed Champion nurse. These logs are reviewed daily by DON and IDT. 10. For any resident with combative behaviors, only Nurses or CNAs will be allowed to provide any direct care to include sitting with a resident if this is indicated in the resident care plan. During the Orientation training the Nurses and CNA□s will receive dementia training and have to demonstrate the ability to work	

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OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

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F 600	Continued From page 9 Minimum Data Set (MDS) Assessment revealed Resident #1 was cognitively impaired with no noted behaviors. Resident #1 was coded as requiring extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. Resident #1 was coded as requiring limited assistance with locomotion on & off the unit. A review of Resident #1's medical record revealed no documented skin assessment of Resident #1's feet when Resident #3 ran over his feet on 11/25/18. An interview with Medication Aide #1 on 12/04/18 at 3:41 PM revealed on 11/25/18 she was out in the hall and heard Resident #3 state "get out of my way" angrily. She reported she noted Resident #3 had the control stick to his motorized wheelchair pushed as far to the left as it would go towards Resident #1. She stated Resident #3 reported to her that Resident #1 should have moved out of his way. She reported Resident #1 appeared frightened and scared, staring off into space. She stated Resident #3's motorized wheelchair to be off balance at times due to Resident #3 continuing to try and traverse up and over Resident #1's feet. She stated she was surprised Resident #3 did not tip the motorized wheelchair over. She stated she separated the residents she immediately reported the incident to her supervisor and that she had not been asked by administration to provide a statement in regards to what she witnessed. During an interview with Nurse #1 on 12/04/18 at 10:12 AM she revealed that she did not witness Resident #3 running over Resident #1's feet first hand on 11/25/18 and that it was reported to her	F 600	with combative residents, to de-escalate the behaviors, and provide care in a manner and way that protects the resident from abuse. They will receive additional training at least annually but as needed as well. The decision to implement this procedure was made on October 17, 2018 and then re-evaluated on 12/05/2018. The staff was educated about this procedure which on 12/06/2018 by the Director of Nursing and Administrator and all others were required to be in-serviced prior to returning to work. 11. As a means of quality assurance, the Administrator shall be responsible to report all allegations and investigations initiated, as per policy, to the President of the company, on a daily basis when received, in an effort to review and confirm appropriate immediate action taken, including thorough investigation as per facility policy. 12. All investigations, with summary of findings and resolution, shall be presented ongoing and reviewed by the QA Committee on a monthly basis to ensure adherence with facility policy, with frequency of review revised only should the Committee deem appropriate. Indicate How The Facility Plans To Monitor It□s Performance To Make Sure That Solutions Are Sustained. The Facility Must Develop A Plan For Ensuring That Correction Is Achieved And Sustained:	

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F 600	Continued From page 10 by Nurse Aide #1. She continued, reporting that she documented the incident in the nurse's notes as Nurse Aide #1 reported it to her. She stated after the incident was reported to her, she completed only a visual assessment of Resident #1's feet and noted no injuries and she observed no broken skin or bruising with no complaints of pain from Resident #1. She reported notifying the DON through a text message and received a response of "OK, thanks" in a return text message. The Nurse stated she did not set up any monitoring systems for Resident #3 to prevent him from exhibiting this inappropriate behavior again. An interview with Nurse Supervisor #1 on 12/04/18 at 10:45AM revealed she was informed of the incident by Nurse #1. She stated she reported the incident to Nurse Supervisor #2 on 11/26/18 who reported she would notify the Director of Nursing. The NS indicated she was not aware of any monitoring systems that were put into place to prevent Resident #3's behavior from happening again. An interview with Nurse Supervisor #2 on 12/04/18 at 1:35PM revealed she was notified of the incident on 11/26/18 during her morning report that Resident #3 had run over two different resident's feet the day before. She stated she instructed Nurse #1 to complete an incident report and document the incident and pass the information on during her report. She stated she spoke with the Director of Nursing (DON) that morning and asked the DON about the incidents. She reported the DON informed her that she was already aware of the incident and the facility was ordering a urinalysis for Resident #3.	F 600	1. The resident care unit rounds will be presented at weekly QA meetings and monthly to the QAPI Committee for evaluation to determine if the system is adequate and if not to devise and re-implement a system to ensure that the alleged deficient practice does not occur again. 2. All incident reports will be reviewed monthly at the QAPI Committee Meeting for any bruises, skin tears and injury of unknown origin and investigations of incidents of unknown origin to determine if any patterns or practices exist that may be considered abuse. 3. All investigations, with summary of findings and resolution, shall be presented ongoing and reviewed by the QA Committee on a monthly basis to ensure adherence with facility policy, with frequency of review revised only should the Committee deem appropriate. 4. If any patterns or practices are noted, the QAPI Committee will begin an immediate investigation to ensure that solutions are put into place to ensure corrective action is achieved and sustained. 5. The QA Committee, QAPI Committee and the Medical Director have been apprised of this plan and commit their support to assisting the facility with achieving and sustaining compliance with this alleged citation. The QAPI Committee was notified on 12/06/2018.	

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F 600	Continued From page 11 During an interview with the Director of Nursing (DON) on 12/04/18 it was revealed she had been made aware of the incident on the morning of 11/26/18 and reported she was scheduled to monitor the hall where Resident #1 and Resident #3 for other quality assurance measures that the facility was currently monitoring. She reported she received a text message the morning of 11/26/18 from Nurse #1 and reported she had already been informed by Nurse Supervisor #2 by the time she had received the text message. She reported she spoke to both residents involved in the incident about their general wellbeing but denied specifically asking about the incident with the motorized wheelchair. The DON stated both residents denied having any issues or complaints at that time. She reported she observed and visually assessed Resident #1's feet and found them to have no issues or problems with redness, bruising, swelling, skin tears or other injuries. The DON reported she informed the Administrator about the incident involving Resident #1 and Resident #3. An interview with the Administrator on 12/04/18 in the morning revealed she had been made aware of the incident on 11/26/18 and reported she re-educated Nurse #1 on making sure she contacted administrative staff until someone was reached. She stated she did not start an abuse investigation, contact local law enforcement, local adult protective services or the state agency due to her belief that the incident was not abuse. She reported not completing an internal investigation due to her belief that the incident was not abuse, stating it was a resident to resident incident and that is was not reportable. She denied implementing any interventions to attempt to prevent similar incidents from happening again.	F 600		

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B. Review of Resident #3's nurse's notes revealed a nurse's note dated 11/25/18 at 7:18 PM, written by Nurse #1, stated Resident #3 had an incident with Resident #2 while leaving the dining room. Further review of the nurse's note revealed Resident #3 ran over Resident #2's feet with his motorized wheelchair reportedly because Resident #2 was in his way. Additional review of the nurse's note indicated this was the 2nd incident of Resident #3 running over another resident's feet due to the other residents reportedly being in Resident #3's way. The nurse's note also revealed the nurse stated she would continue to monitor Resident #3's behavior, told Resident #3 that behavior would not be tolerated and passed the information of the incident onto the 3rd shift Nurse Supervisor.

Resident #2 was admitted to the facility on 5/26/18 with diagnoses that included: major depressive disorder, chronic kidney disease, pain in right and left knee and restless leg syndrome among others. A review of Resident #2's most recent MDS Assessment dated 11/24/18 and coded as a quarterly assessment revealed Resident #2 to be cognitively impaired with noted physical and verbal behaviors directed towards others occurring 1-3 days during the look back period. Resident #2 was coded as requiring extensive assistance with bed mobility, locomotion on the unit and dressing. Resident #2 was coded as being totally dependent with transfer.

A review of Resident #2's medical record revealed no documented skin assessment of Resident #2's feet after Resident #3 ran over his feet with a motorized wheelchair.

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F 600	Continued From page 13 An interview on 12/04/18 at 10:12 AM with Nurse #1 who completed the nurse's note on 11/25/18 revealed she did not witness Resident #3 running over Resident #2's feet with his motorized wheelchair first hand. She reported Dietary Aide #1 reported the incident to her and she wrote her nurse's note as a reflection of the incident as it was reported to her. She stated she visually assessed Resident #2's feet and noted there to be no injuries and reported no lingering pain. She stated she reported the incident to the Director of Nursing after the incident by text message and reportedly received a response of "OK, thanks" by text. An interview with Dietary Aide #1 on 12/04/18 at 11:15 AM revealed she was in the dining room assisting residents when she heard Resident #2 yell out "oh, oh, he ran over my foot." She stated she turned around and observed Resident #3 continuing to try and engage his wheelchair over Resident #2's feet. She reported observing Resident #2 attempt to grab Resident #3 but by that time Resident #3 had already run over Resident #2's foot. She reportedly ran over to the two residents to separate them and informed a nurse, whom she could not identify, walking down the hall with whom she asked for help. Dietary Aide #1 reported she was asked to write a statement about the incident but reported she had forgotten and did not complete it until 12/04/18. An interview with Nurse Supervisor #1 on 12/04/18 at 10:45 AM revealed she was informed of the incident by Nurse #1. She stated she reported the incident to Nurse Supervisor #2 on 11/26/18 who reported she would notify the Director of Nursing.	F 600		

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An interview with Nurse Supervisor #2 on 12/04/18 at 1:35 PM revealed she was notified of the incident on 11/26/18 during her report that Resident #3 had run over two different resident's feet. She stated she instructed Nurse #1 to complete an incident report and document the incident and pass the information on during her report. She stated she spoke with the Director of Nursing (DON) that morning and asked the DON about the incidents. She reported the DON informed her that she was already aware of the incident and the facility was ordering a urinalysis for Resident #3.

During an interview with the Director of Nursing (DON) on 12/04/18 at 11:45 AM it was revealed she had been made aware of the incident on the morning of 11/26/18 and reported she was scheduled to monitor the hall where Resident #2 and Resident #3 for other quality assurance measures that the facility was currently monitoring. She reported she spoke to both residents involved in the incident about their general well being but denied specifically asking about the incident with the motorized wheelchair. The DON stated that both residents reported no current issues or complaints. She stated she observed and visually assessed Resident #1's feet on the morning of 11/26/18 and found them to have no issues or problems with redness, bruising, swelling, skin tears or other injuries and had no complaints of pain. The DON reported she informed the Administrator on 11/26/18 about the incident involving Resident #2 and Resident #3.

An interview with the Administrator on 12/04/18 11:45 AM revealed she had been made aware of

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the incident regarding Resident #3 running his motorized wheelchair over the feet of Resident #1 and Resident #2 on 11/26/18 and reported she re-educated Nurse #1 on making sure she contacted administrative staff until someone was reached. She stated she did not start an abuse investigation, contact local law enforcement, local adult protective services or the state agency due to her belief that the incident was not abuse. She reported not completing an internal investigation due to her belief that the incident was not abuse, stating it was a resident to resident incident and that is was not reportable. She reported there was no further follow-up was completed based on her determination that the incident of Resident #3 running over Resident #2's feet with his motorized wheelchair was not abuse.

The Administrator was informed of Immediate Jeopardy on 12/05/18 at 11:00 am. The facility's provided an acceptable Credible Allegation of Immediate Jeopardy removal on 12/07/18 at 10:50 AM which specified the following:

Credible Allegation of Immediate Jeopardy removal
F-600

FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

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

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treat the resident's medical symptoms.

Address How Corrective Action (S) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:

The following interventions were put into place by the facility:

08/18/2018 Incident:

1. The facility did not substantiate the abuse of Resident #1 on 08/18/2018 when Resident Companion was struck by Resident #1 and Resident Companion grabbed his arm resulting in a skin tear, based on the witness statement and the facilities' investigation at that time. Based on the Resident Companion's statement we immediately removed the employee and suspended her until the investigation was complete. Based on our investigation and interview with the employee the decision was made to move the employee to the Dietary department as a Dietary Aide where she will not be able to provide care with the residents. Thus we were in compliance as of the 08/18/2018 date.
2. However due to the complaint survey citing the facility for failure to prevent abuse due to the employee's statement on 12/03/2018 the facility has decided to re-open the investigation.
3. The Police were notified on 12/05/2018 at 10:00 am and they came to the facility around 10:30 am at which time we made a report.
4. The facility sent in a 24 Hour Report to NCDHSR to indicate that they had re-opened the investigation.
5. The employee in question was notified of the need to come in for another interview on 12/05/2018 and she arrived at 12:30 pm at which

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time an interview was conducted. Per our policy the employee is suspended now pending another investigation. If the investigation supports bringing her back to work she will have go through another orientation at which time she will receive training on Abuse, How to react to combative behavior from residents, and Dementia Training. Therefore the facility has provided an environment free from abuse.

11/25/2018 Incident:

1. November 25, 2018 there was an incident where Resident #3 ran over the feet of Resident #1 and Resident #2. The staff intervened with Resident #1 and Resident #3 by removing Resident #1 from the area and monitoring Resident #3, per #1 Nurse LPN witness statement and nurse's note. After the incident with Resident #2 and #3 the staff in the dining room intervened by assisting Resident #3 from the dining room which was his intent when running over resident #2's feet. The #1 Nurse LPN evaluated the resident #1 and #2's feet at the time and there were no injuries or complaints from the residents per the nurse's notes. The facility did not identify the root cause of the incident as an abusive act. At the time of incident, the resident's intent was not clear. Though Resident #3 stated he meant to run over the resident's feet when asked by staff, upon further consideration by administration, this admission could be erroneous due to resident's acute mental status related to Urinary Tract Infection. Resident #3 does not have a history of aggression or altercation and was being treated for acute UTI. The Resident to Resident Altercations resulted in no physical harm to Resident #1 or Resident #2. The facility did not

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submit report, as per resident to resident abuse.

2. On November 26, 2018 the DON completed a thorough skin assessment on Resident # 1 and Resident #2 involved in the 11/25/2018 incidents and there were no noted areas of bruising, discoloration, scratches and or injury. The residents did not appear to have any mental or emotional distress as a result of the incident as they mentally appeared to be at their baseline and did not express any signs of physical or mental distress.

3. The Resident #3 was evaluated by Physical Therapy on 12/03/2018 to determine if the resident has the capability of maneuvering a motorized chair independently. It was determined that resident has great difficulty when decreased space is available. He is unable to see his feet or immediately by his sides due to decreased visual field. He tends to use the wheelchair to increase his visual field as opposed to turning his head. Required cues to turn his head instead, he would turn the chair. Due to the safety needs of the residents the Interdisciplinary Care Team and Physician has decided the resident will be evaluated on 12/06/2018 for a traditional wheelchair and placed in chair after the evaluation.

Address How Corrective Action Will Be Accomplished For Those Residents Having Potential To Be Affected By The Same Deficient Practice:

1. All interview able residents were interviewed by the facility Social Worker and Director of Nursing to determine if they had been a recipient

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of, or witnessed abuse by a staff member, family member, visitor or another resident. The interviews were conducted on 12/05/2018 and there were no residents who had experienced or witnessed any abuse.
2. The facility performed ongoing audits of Incident reports, since October, 2018. However, this process was escalated further to include 24 hour nursing shift reports as well, which are reviewed for incidents involving possible resident to resident altercations, and or abuse. This new process was initiated by Administrator following the resident to resident altercation on 11/28/2018. To date, there have been no injuries of unknown origin to investigate. The Morning Meeting Signature Agenda reflects the Administrative and the Clinical Team attendance. Thus all non-interview able residents have not had any noted incidents
3. The Administrator, Director of Nursing and Corporate Nurse Consultant conducted In-services with all staff beginning on 12/05/2018 and completed on 12/07/2018 which is required to be completed prior to returning to work; and all new hires will be required to complete the following training in orientation prior to working with the resident;
a. ABUSE - Resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.
b. Types of abuse, i.e., (physical, verbal, chemical, sexual, and resident to resident abuse.
c. What to do if abuse is witnessed, who to report the abuse to,
d. How to react to combative behavior from residents; how to provide care and services to combative residents to prevent abuse to resident(s) or harm to the care giver; and
e. Dementia training.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20 f. Reporting of ANY SUSPICION of abuse of any type, neglect, exploitation and misappropriation of resident property. g. Notification of the incident to the Administrator and the Director of Nursing IMMEDIATELY. Failure to notify will result in disciplinary action. 4. The Administrator and the Director of Nursing received additional training on the Abuse policy and regulations, the investigation process and the regulations regarding timely notification by staff, and then timely reporting of the abuse to the required agencies and Dementia Training. This was completed on 12/06/2018 by the Corporate Nurse Consultant. Address What Measures Will Be Put Into Place Or Systemic Changes Made To Ensure That The Deficient Practice Will Not Recur: 1. Due to the safety needs of the all residents the Interdisciplinary Care Team and Physician has decided the Resident #3 will be evaluated on 12/06/2018 for a traditional wheelchair and placed in chair after the evaluation. 2. The Nursing Staff were informed by the Nurse Manager of the incident and instructed them to be hyper vigilant with observation of Resident #3) on 11/25/2018. All staff has been made aware of the Resident ' s behavior and the need to be hyper vigilant with observation by 12/07/2018. The Director of Nursing has completed QA rounds ensure resident does not exhibit any further behaviors/abuse. If this does occur to report immediately any concerning resident behaviors to the Director of Nursing and Administrator.	F 600		

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F 600	Continued From page 21	F 600		

3. The Director of Nursing implemented Administrative Nursing Staff rounds on the resident care units on 10/17/2018 (entering rooms and showers where care was being provided) and have continued to monitor four (4) times a week to ensure that care delivery is being conducted in a way that preserved the resident's privacy, dignity and freedom from abuse. There have been no incidents noted since that time. These rounds will continue at four (4) per week (including at least one (1) on the 11-7 shift for the next six (6) months and then two (2) per week for the following six (6) months to ensure that the deficient practice does not reoccur. The facility performed ongoing daily audits of Incident reports, since October, 2018. However, this process was escalated further to include 24 hour nursing shift reports as well, which are reviewed for possible resident to resident altercations, and or abuse. This new process was initiated by Administrator following the resident to resident altercation on 11/28/2018. To date, there have been no injuries of unknown origin to investigate.

4. All interview able residents were interviewed by the facility Social Worker and Director of Nursing to determine if they had been a recipient of, or witnessed abuse by a staff member, family member, visitor or another resident. The interviews were conducted on 12/05/2018 and there were no residents who had experienced or witnessed any abuse.

5. Staff interviews were conducted by outside RN Consultant on 12/5/2018-12/6/2018. The interviews involved detail questioning pertaining to resident abuse awareness, prevention and reporting process of all facility staff. Interview results were reviewed by Administration for

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F 600	Continued From page 22 possible concerns. 6. All staff members were addressed prior to their next tour of duty as to the abuse prohibition policy with emphasis on not only reporting direct knowledge of any incident, but also immediately reporting knowledge of any "rumor" or hearsay of abuse (of any type), thereby promoting investigation as to the validity of the rumor/hearsay. Failure to do so will warrant disciplinary action. Additionally, staff members were addressed as to the revised policy which clearly specified the educational training on dementia, during orientation. As a means to ensure ongoing compliance, the orientation process has been amended to fully integrate dementia training for CNA's and Nurses, to ensure care givers are receiving tools to care for combative residents, as per facility policy. Additionally, immediate reporting of any rumor or hearsay which could indicate any type of abuse will be addressed during orientation of newly hired employees to ensure enforcement of facility policy No concerns were revealed based on staff interviews. Observations of the overall environment and at risk residents is ongoing and is being conducted by the Champion designated licensed nurse, and documented on Behavior monitoring flow sheets. The flow sheets will be submitted to DON and discussed by IDT at daily stand up meeting. 7. Incident Reports and (24-Hour Nursing Report) will be reviewed Monday through Friday in morning meetings for any unusual incident to include bruises, skin tears and injuries of unknown origin and resident to resident abuse. An immediate investigation will be started for all bruises or unknown origin, skin tears of unknown origin or any other incident or injury of unknown	F 600		

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origin and any occurrence that is suspected abuse will be reported immediately to the Huntersville Police Department and the North Carolina Health Care Personnel Registry. The incident reports are completed electronically by the staff nurses and the nurse supervisors are responsible to print the incident report(s) for their unit before the morning meeting and are responsible to bring them to the morning meeting. In addition they will bring the 24-Hour Nursing Report to the meeting and two documents will be compared to ensure incidents of unknown origin are investigated and interventions put into place. In the event the nursing supervisor is absent the responsibility of printing the incident reports and the 24-Hour Nursing Report is assigned to the ADON and then to the DON.

8. The Corporate Compliance Nurse will be responsible to review the Administrative Nursing Staff rounds Sheets on a weekly basis for three (3) months; a bi-monthly basis for three (3) months and then monthly for six (6) months to determine that facility is in compliance with the credible allegation of compliance and interventions have been put into place. If there are discrepancies in the monitoring tool, the Corporate Compliance Nurse will be responsible to inform the Administrator and conduct an investigation to determine why the discrepancy is there and if needed to assist in correcting the issue.

9. The Corporate Compliance Nurse will also conduct rounds on a weekly basis for three (3) months; a bi-monthly basis for three (3) months and then monthly for six (6) months and conduct interviews with the staff and residents to ensure that all incidents have been reported and compare with the Clinical Teams reviews and interventions.

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10. Resident to resident abuse monitoring will be conducted every shift on the flow sheet logs, by the appointed licensed nurse, termed "Champion" nurse. These logs are reviewed daily by DON and IDT.

11. For any resident with combative behaviors, only Nurses or CNAs will be allowed to provide any direct care to include sitting with a resident if this is indicated in the resident care plan. During the Orientation training the Nurses and CNA's will receive dementia training and have to demonstrate the ability to work with combative residents, to de-escalate the behaviors, and provide care in a manner and way that protects the resident from abuse. They will receive additional training at least annually but as needed as well. The decision to implement this procedure was made on October 17, 2018 and then re-evaluated on 12/05/2018. The staff was educated about this procedure which is required to be completed prior to returning to work; on 12/06/2018 by the Director of Nursing, Administrator.

12. As a means of quality assurance, the Administrator shall be responsible to report all allegations and investigations initiated, as per policy, to the President of the company, on a daily basis when received, in an effort to review and confirm appropriate immediate action taken, including thorough investigation as per facility policy.

13. All investigations, with summary of findings and resolution, shall be presented ongoing and reviewed by the QA Committee on a monthly basis to ensure adherence with facility policy, with frequency of review revised only should the Committee deem appropriate.

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Indicate How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained. The Facility Must Develop A Plan For Ensuring That Correction Is Achieved And Sustained:

1. The QA Committee, QAPI Committee and the Medical Director have been apprised of this plan and commit their support to assisting the facility with achieving and sustaining compliance with this alleged citation. The QAPI Committee was notified on 12/06/2018.
2. The resident care unit rounds will be presented at weekly QA meetings and monthly to the QAPI Committee for evaluation to determine if the system is adequate and if not to devise and re-implement a system to ensure that the alleged deficient practice does not occur again.

3. All incident reports will be reviewed monthly at the QAPI Committee Meeting for any bruises, skin tears and injury of unknown origin and investigations of incidents of unknown origin to determine if any patterns or practices exist that may be considered abuse.
4. All investigations, with summary of findings and resolution, shall be presented ongoing and reviewed by the QA Committee on a monthly basis to ensure adherence with facility policy, with frequency of review revised only should the Committee deem appropriate.
5. If any patterns or practices are noted, the QAPI Committee will begin an immediate investigation to ensure that solutions are put into place to ensure corrective action is achieved and sustained.

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F 600	Continued From page 26 The facility's credible allegation of IJ removal was verified on 12/07/18 at 4:09 PM when the facility staff were interviewed and demonstrated they were in-serviced on the topic of abuse and their responsibility to report abuse in any form.	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 reviews and staff interviews the facility failed to implement their Abuse policy in the areas of Identifying, Investigating and Reporting for 2 of 3 Residents reviewed for abuse. The facility failed to identity, investigate and report to law enforcement an incident of physical abuse when a Sitter forcefully grabbed Resident #1 and caused a 4-centimeter skin tear to his arm. The facility also failed to identify, investigate and report an incident of resident to resident abuse to law enforcement and the state survey agency when Resident #3 intentionally and deliberately rolled over Resident #1 and Resident #2's feet with his motorized wheelchair. Resident #1 and Resident #2's feet were assessed by the facility's nursing staff to have no	F 607	Address How Corrective Action (S) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: 1. The facility did not substantiate the abuse of Resident #1 on 08/18/2018 when Resident Companion was struck by Resident #1 and Resident Companion grabbed his arm resulting in a skin tear, based on the witness statement and the facilities investigation at that time. Based on the Resident Companions statement we immediately removed the employee and suspended her until the investigation	12/12/18

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F 607	Continued From page 27 physical injuries. Immediate Jeopardy began on 08/18/18 for Resident #1 when a Sitter (who was employed by the facility) grabbed his arm and caused a 4-centimeter (cm) skin tear. Immediate Jeopardy began on 11/25/18 for Resident #1 and Resident #2 when Resident #3 intentionally and deliberately rolled over their feet with his motorized wheelchair. Immediate Jeopardy was removed on 12/07/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential of minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. The finding included: Review of the facility's Abuse Policy and Procedure dated 04/05/05 revealed in part, area of Identification stated "(Facility) will follow up with accidents or incident that occur to ensure that abuse and/or neglect have not occurred." In Investigating/Protection, the facility "will review all incidents to determine, if possible, the cause of the incident and injury that may have occurred." 1) A complete and thorough follow up will be completed to identify the cause of all injuries. 2) Needed investigations will be conducted with the resident's safety as the foremost concern in order to protect the resident from future harm. In further review, the area of Reporting/Response read in part, 3) For all incidents/accidents that are suspected abuse, neglect, or misappropriation, the following agencies may be contacted: A) North Carolina Division of Facility Services (state survey agency) and F) Police Department.	F 607	was complete. Based on our investigation and interview with the employee the decision was made to move the employee to the Dietary department as a Dietary Aide where she will not be able to provide monitoring or companionship to the residents. Thus we were in compliance as of the 08/18/2018 date. 2. However due to the complaint survey citing the facility for failure to prevent abuse due to the employee□s statement on 12/03/2018 the facility decided to re-open the investigation. 3. The Police were notified on 12/05/2018 at 10:00 am and they came to the facility around 10:30 am at which time we made a report. 4. The facility sent in a 24 Hour Report to NCDHSR to indicate that they had re-opened the investigation. 5. The employee in question was notified of the need to come in for another interview on 12/05/2018 and she arrived at 12:30 pm at which time an interview was conducted. Per our policy the employee was suspended pending another investigation. The facility completed the investigation on December 12, 2018. After conducting another interview, the employee admitted to the Administrator and Director of Nursing that she lied about the circumstances surrounding the incident on 08/18/2018. When asked why, she stated that she didn□t want to lose her job but she had thought about it and this is the reason she reported to the surveyor a different story. She stated that based on the current information she understood that this was	

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F 607	Continued From page 28 A review of the facility's policy (dated 04/05/05) entitled "Abuse Policy and Procedures" revealed a section entitled "Resident to Resident Abuse and Family to Resident Abuse". Review of this section revealed subsection #4 that stated investigations would be conducted of all reports of resident to resident and/or family to resident abuse and that the investigation will be conducted with the resident's safety as the foremost concern in order to protect the resident or residents from future harm. 1. Resident #1 was admitted to the facility on 01/04/18 with diagnoses which included Lewy Body Dementia (LBD) (a Parkinson like dementia that progressively worsens). The most recent comprehensive Minimum Data Set (MDS) assessment dated 06/01/18 revealed he had severe cognitive impairment and required extensive 2-person assistance with most of his activities of daily living. The MDS had no behaviors documented during the assessment period. Review of Resident #1's Care Area Assessment (CAA) for Cognition dated 06/01/18 revealed in part that he had a diagnosis of LBD and had experienced a rapid cognitive decline over the last few months. The CAA also indicated Resident #1 had poor safety awareness and impulsive behaviors. Review of Resident #1's Care Plan dated 06/01/18 stated in part that he had LBD which resulted in his rapid cognitive decline. The established goal was to maintain the ability to follow simple commands by utilizing interventions which included facing him while speaking to him,	F 607	considered abuse. Therefore employee□s employment was terminated on December 12, 2018. 6. For Resident #1 his care plan was updated on 08/30/2018 by the MDS Nurse to reflect how to approach him when providing care and services to minimize his behaviors and to gain his cooperation; to always have two staff members when providing his care; to explain in a calm voice what is going to be done to the resident before starting care and to stop care if resident becomes combative and to re-approach after he has become calm and cooperative to finish care. For the incident on November 25, 2018 the following applies: 1. Where Resident #3 ran over the feet of Resident #1 and Resident #2 the staff intervened with Resident #1 and Resident #3 by removing Resident #1 from the area and monitoring Resident #3, per #1 Nurse LPN witness statement and nurse□s note. 2. With the second incident with Resident #2 and #3 the staff in the dining room intervened by assisting Resident #3 from the dining room which was his intent when running over resident #2□s feet. The #1 Nurse LPN evaluated the resident #1 and #2□s feet at the time and there were no injuries or complaints from the residents per the nurse□s notes. 3. The facility did not identify the root	

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speaking slowly and distinctly to him and maintain eye contact during interaction with him.

Review of a Nurses Note, written by Nurse #2, dated 08/18/18 at 10:22 AM indicated in part that Resident #1 was alert and verbal with confusion. Resident #1 received a skin tear to the top of left forearm which measured 4 cm long by 1.5 cm wide with a flap of skin tunneling 0.5 cm to the left side of the skin tear. Resident #1 was calm and in good a mood while treatment was being given. Resident #1 stated "the Sitter and he were scuffling, and she tore a chunk of meat from his arm then he punched her." The note specified, Resident #1 also stated that the Sitter said "ha, ha, ha I won." Resident #1 stated he felt some soreness in his left arm.

Review of the Sitter's statement dated 08/18/18 (untimed) revealed Resident #1 was trying to stand and she tried to get him to sit back down in his chair for his safety. Resident #1 then got very agitated and punched the Sitter in the jaw with his left arm. In response, the Sitter shoved his arm away in an urgent manner accidentally digging her nails into his arm in the process. The Sitter immediately went to NS #3 and told her what happened. When the Sitter went back to the room, Resident #1 had his left sleeve rolled up revealing a skin tear that she had unintentionally caused.

Review of Employee's Accident/Incident Report dated 08/18/18 at 10:00 AM written by Nurse Supervisor (NS) #3 stated Resident Companion (Sitter) came up to her and stated Resident #1 punched her in the face and she scratched him accidentally as she was moving his arms out of her face. The Sitter then began to cry and the NS

cause of the incident as an abusive act. At the time of incident, the resident□s intent was not clear. Though Resident #3 stated he meant to run over the resident□s feet when asked by staff, upon further consideration by administration, this admission could be erroneous due to resident□s acute mental status related to Urinary Tract Infection. Resident #3 does not have a history of aggression or altercation and was being treated for acute UTI. The Resident to Resident Altercation resulted in no physical harm to Resident #1 and #2. The facility did not submit a report, as per resident to resident abuse.

4. On November 26, 2018 the DON completed a thorough skin assessment on Resident # 1 and Resident #2 involved in the 11/25/2018 incident and there were no noted areas of bruising, discoloration, scratches and or injury. Resident #1 and #2 did not appear to have any mental or emotional distress as a result of the incident as they mentally appeared to be at their baseline and did not express any signs of physical or mental distress.

5. Resident #3 was evaluated by Physical Therapy on 12/03/2018 to determine if the resident has the capability of maneuvering a motorized chair independently. It was determined that resident has great difficulty when decreased space is available. He is unable to see his feet or immediately by his sides due to decreased visual field. He tends to use the wheelchair to increase his visual field as opposed to turning his head. Required cues to turn

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F 607	Continued From page 30 #3 told her to remove herself from Resident #1's room. Telephone interview with Resident Companion (Sitter) on 12/03/18 at 3:05 PM she stated Resident #1 had started to stand up and she told him to sit back down then he reached up with his hand and hit her in the face. The Sitter stated out of instinct she grabbed Resident #1's left hand to keep him from hitting her again. By this time Resident #1 was sitting down so she immediately went to the nurses' station to report what had happened. The Sitter stated while she was holding an ice pack to her right jaw they brought Resident #1 to the desk and when he saw her he said "Oh, you did this" while pointing to his skin tear. The Sitter stated Resident #1 was not bleeding a lot. On 12/03/18 at 4:30 PM the interview with the Sitter continued in person with demonstration of incident. The Sitter stated she and Resident #1 were watching television when he started to stand up and she stood up in front of him and leaned down to him and said (Resident #1) you need to sit down and at that time he had already sat back down then he "hit me on the right side of my face with his left hand and out of instinct I grabbed his arm to keep him from hitting me again" and in doing so my fingernails caused a skin tear on his arm. The Sitter stated she did not know she caused the skin tear to Resident #1's arm until he came to the nurses' station later and showed the nurse and me his arm. The Sitter stated, "It (the resident's arm) clearly had the imprints of my fingernails and it was open with small drops of blood." The Sitter explained that she had not received training on what to do when a resident became agitated.	F 607	his head instead, he would turn the chair. Due to the safety needs of the residents the Interdisciplinary Care Team and Physician has decided the resident will be evaluated on 12/06/2018 for a traditional wheelchair and placed in chair after the evaluation. Resident was placed in the traditional wheelchair on 12/06/2018 and continues with therapy working with him to be able to maneuver the chair in tight spaces. Address How Corrective Action Will Be Accomplished For Those Residents Having Potential To Be Affected By The Same Deficient Practice: 1. All interviewable residents were interviewed by the facility Social Worker and Director of Nursing to determine if they had been a recipient of, or witnessed abuse by a staff member, family member, visitor or another resident. The interviews were conducted on 12/05/2018 and there were no residents who had experienced or witnessed any abuse. 2. The facility performed ongoing audits of Incident reports, since October, 2018. However, this process was escalated further to include 24 hour nursing shift reports as well, which are reviewed for incidents involving possible resident to resident altercations, and or abuse. This new process was initiated by Administrator following the resident to resident altercation on 11/28/2018. To date, there have been no injuries of unknown origin or resident to resident	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

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F 607	Continued From page 31 Review of NS #3's written statement (undated) and timed 10:00 AM revealed the Sitter approached her and stated Resident #1 needed an Ativan. NS #3 asked the Sitter what Resident #1 was doing and the Sitter stated that he kept trying to get up and that he punched her in the jaw. NS #3 stated she wanted to assess Resident #1 before she gave him an Ativan and observed him from his doorway smiling and seemed okay. A minute later the Sitter approached NS #3 and said Resident #1 had a skin tear that he had punched her and she grabbed his arm to push him away and (caused a) skin tear. On 12/04/18 at 10:04 AM during an interview with NS #3, she stated that on 08/18/18 the Sitter came up to her (NS) and told her (NS) that Resident #1 was trying to stand up and she (Sitter) tried to restrain him and he punched her (Sitter) in the face. NS #3 stated she called the Interim Director of Nursing (IDON) and was instructed to get a statement from the Sitter then send the Sitter home. Review of Nurse #2's written statement (undated and untimed) revealed in part that while she was treating Resident #1's skin tear he stated that she (Sitter) grabbed his arm with her nails then he punched her. Resident #1 continued to state the Sitter tempted him to hit her saying "hit me, hit me" so Resident #1 said he hit her. Resident #1 said they were initially scuffling and that she always does this with him. On 12/03/18 at 5:31 PM during a telephone interview with Nurse #2 she stated she was asked by NS #3 to come and note a skin tear on Resident #1. Nurse #2 stated that it didn't look	F 607	abuse to investigate. The Morning Meeting Signature Agenda reflects the Administrative and the Clinical Team attendance. Thus all non-interview able residents have not had any noted incidents. a. The Administrator, Director of Nursing and Corporate Nurse Consultant conducted In-services with all staff beginning on 12/05/2018 and completed the majority on 12/07/2018. For anyone else they were required to complete the education prior to returning to work; on the following; and all new hires will be required to complete the following training in orientation prior to working with the resident. b. ABUSE - Resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. c. Types of abuse, i.e., (physical, verbal, chemical, sexual, and resident to resident abuse. d. What to do if abuse is witnessed, who to report the abuse to, e. How to react to combative behavior from residents; how to provide care and services to combative residents to prevent abuse to resident(s) or harm to the care giver; and f. Dementia training. g. Reporting of ANY SUSPICION of abuse of any type, neglect, exploitation and misappropriation of resident property. h. Notification of the incident to the Administrator and the Director of Nursing IMMEDIATELY. Failure to notify will	

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F 607	Continued From page 32 like a normal skin tear and described it as deep, tunneling, and had a crescent shaped skin flap. The Nurse also stated there was a moderate amount of bleeding. After NS #2 treated the skin tear, she documented the measurements and what Resident #1 stated happened in her nurses' notes and reported it to NS #3 and called the IDON. Review of the Investigation Timeline written by IDON and dated 08/24/18 and signed by Administrator on 08/24/18 revealed the IDON was called on 08/18/18 at approximately 10:45 AM and informed that Resident #1 had swung at his Sitter while being redirected to sit down. While attempting to sit Resident #1 down he swung at the Sitter striking her in the right side of her face/jaw and that while the Sitter was trying to move his hands away a skin tear was caused on the left forearm of Resident #1. The IDON told NS #3 to assess both Resident #1 and the Sitter for injuries and get a written statement from the Sitter then send her home. The Sitter was noted with red mark on the right side of her face/jaw. Resident #1 had a skin tear on his left forearm. The skin tear was treated with normal saline and dressed with an occlusive gauze and dry dressing. The Physician's On-Call was notified of the situation and the family was notified via message. The IDON completed a 24-Hour Initial Report and faxed it to the state agency. The IDON also spoke with Resident #1 and asked him how he hurt his arm in which he replied "I punched her." however Resident #1 was not a reliable source due to the diagnosis of LBD. The Investigative Timeline continued to indicate on 08/22/18 at 1:30 pm the Sitter was brought in to meet with the IDON and the Administrator to provide a verbal statement of the incident. The	F 607	result in disciplinary action. 3. The Administrator and the Director of Nursing received additional training on the Abuse policy and regulations, the investigation process and the regulations regarding timely notification by staff, and then timely reporting of the abuse to the required agencies and Dementia Training. This was completed on 12/06/2018 by the Corporate Nurse Consultant. Address What Measures Will Be Put Into Place Or Systemic Changes Made To Ensure That The Deficient Practice Will Not Recur: 1. Due to the safety needs of the residents the Interdisciplinary Care Team and Physician decided that Resident #3 was evaluated on 12/06/2018 for a traditional wheelchair and placed in chair after the evaluation. 2. All staff has been made aware of the resident□s behavior and for potential of future behaviors and the need to be hyper vigilant with observation. The Director of Nursing has completed QA rounds ensure resident does not exhibit any further behaviors/abuse. If this does occur to report immediately any concerning resident behaviors to the Director of Nursing and Administrator. 3. All interviewable residents were interviewed by the facility Social Worker and Director of Nursing to determine if they had been a recipient of, or witnessed abuse by a staff member, family member,	

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F 607	Continued From page 33 Sitter reported she was attempting to redirect Resident #1 to sit back down and he began to get agitated with her and swung at her hitting her in the right side of her face/jaw. In response to him swinging at her she reacted by forcefully pushing his arm away from her face. She left the room to notify the nurse of the increase in agitation. Upon returning to the room with the nurse she and the nurse noted blood on the sleeve of his left forearm. When the sleeve was rolled up a skin tear was observed. The Sitter was asked to demonstrate how she reacted when he hit her since she used the word "forcefully." Both the IDON and the Administrator witnessed her reaction and felt that it was a reaction to being hit and she did not mean to cause a skin tear to his arm. The Sitter was told by the Administrator that she was being suspended until Monday, August 27th at which time they would call her and let her know about returning to work once the facility's investigation was complete. At that time they felt it was not appropriate for her to work as a Resident Companion. The Timeline stated, "we did not feel this was abuse and therefore were not able to substantiate abuse since there were no witnesses and the resident was not a reliable source due to the diagnosis of Lewy Body Dementia". During an interview with the IDON on 12/04/18 at 11:47 AM she reported that she was notified of the incident between Resident #1 and the Sitter in the morning of 08/18/18 and arrived at the facility in the early afternoon. The IDON stated she was told by NS #3 that Resident #1 became combative with the Sitter and punched her in the face after they got into a scuffle. The IDON stated she instructed NS #3 to get a statement from the Sitter then send her home. The IDON stated that when she got to the facility Resident #1's skin	F 607	visitor or another resident. The interviews were conducted on 12/05/2018 and there were no residents who had experienced or witnessed any abuse. 4. Staff interviews were conducted by outside RN Consultant on 12/5/2018-12/6/2018. The interviews involved detail questioning pertaining to resident abuse awareness, prevention and reporting process of all facility staff. Interview results were reviewed by Administration on December 10, 2018 for possible concerns. There were no incidents of abuse reported in these interviews. 5. All staff members were in-serviced on 12/06/2018 as to the abuse prohibition policy with emphasis on not only reporting direct knowledge of any incident, but also immediately reporting knowledge of any rumor or hearsay of abuse (of any type), thereby promoting investigation as to the validity of the rumor/hearsay. Failure to do so will warrant disciplinary action. Additionally, staff members were addressed as to the revised policy which clearly specified the educational training on dementia, during orientation. As a means to ensure ongoing compliance, the orientation process has been amended to fully integrate dementia training for CNA□s and Nurses, to ensure care givers are receiving tools to care for combative residents, as per facility policy. Additionally, immediate reporting of any rumor or hearsay which could indicate any type of abuse will be addressed during orientation of newly hired employees to ensure enforcement of facility policy No concerns were revealed based on staff	

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tear was already dressed and she did not remove the dressing to assess his skin tear. The IDON stated she interviewed Resident #1 but because of his progressive LBD he could not remember the incident. The IDON stated she reviewed the Sitter's statement and read it as when Resident #1 went up to hit her she pushed his hand out of the way and caused the skin tear. She added she did not consider the incident as abuse which was why it was not reported to the police. The IDON continued to state that they (Administration) brought the Sitter in to act out of incident and they did not feel the act was intentional or abusive.

During an interview with the Administrator on 12/04/18 at 3:45 PM she stated the Sitter received the same training on residents with agitation as the other direct care staff and she (Sitter) did what she should have done by reporting the incident which she did right away. The Administrator stated the facility informed the state abuse the incident but did not inform law enforcement about the incident because she did not see it as abuse.

2. Resident #3 was admitted to the facility on 05/14/18 with diagnoses that included: encounter for orthopedic aftercare following surgical amputation, unspecified dementia without behaviors, and cognitive communication deficit among others. A review of Resident #3's most recent MDS Assessment revealed Resident #3 was moderately cognitively impaired with no noted behaviors during the look back period.

A. Review of Resident #3's nurse's notes revealed a noted dated 11/25/18 at 1:25 PM that reported Resident #3 was leaving the dining room and had an altercation with Resident #1 in which

interviews. An observation of the overall environment and at risk residents is ongoing and is being conducted by the Champion designated licensed nurse (Nurse Managers), and documented on Behavior monitoring flow sheets. The flow sheets will be submitted to DON and discussed by IDT at daily stand up meeting.

6. Incident Reports and (24-Hour Nursing Report) will be reviewed Monday through Friday in morning meetings for any unusual incident to include bruises, skin tears and injuries of unknown origin and resident to resident abuse. An immediate investigation will be started for all bruises or unknown origin, skin tears of unknown origin or any other incident or injury of unknown origin and any occurrence that is suspected abuse will be reported immediately to the Huntersville Police Department and the North Carolina Health Care Personnel Registry. The incident reports are completed electronically by the staff nurses and the nurse supervisors are responsible to print the incident report(s) for their unit before the morning meeting and are responsible to bring them to the morning meeting. In addition they will bring the 24-Hour Nursing Report to the meeting and two documents will be compared to ensure incidents of unknown origin are investigated and interventions put into place. In the event the nursing supervisor is absent the responsibility of printing the incident reports and the 24-Hour Nursing Report is assigned to the ADON and then to the DON.

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F 607	Continued From page 35 Resident #3 utilized his motorized wheelchair to roll over Resident #1's feet. Per the nurse's note, the altercation was a result of Resident #1 being in the way of Resident #3 and not moving out of the way as fast as Resident #3 wanted. The nurse's note revealed Resident #3 reported that he rolled over Resident #1's feet because Resident #1 did not move out of his way so "he had to teach him a lesson." Further review of the progress note revealed Resident #3 appeared to have "no remorse and stated again that he had to teach him a lesson." Resident #1 was admitted to the facility on 01/04/18 with diagnoses that included: Dementia with Lewy bodies, dementia with behaviors, cognitive communication deficit, major depressive disorder, muscle weakness, history of falling and unspecified fracture of lower leg among others. Review of Resident #1's most recent quarterly Minimum Data Set (MDS) Assessment revealed Resident #1 to be cognitively impaired with no noted behaviors. Resident #1 was coded as requiring extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. Resident #1 was coded as requiring limited assistance with locomotion on & off the unit and he was totally dependent of others in bathing. A review of Resident #3's nurse's notes revealed a noted dated 11/25/18 at 1:25PM that reported Resident #3 was leaving the dining room and had an altercation with Resident #1 in which Resident #3 utilized his motorized wheelchair to roll over Resident #1's feet. Per the nurse's note, the altercation was a result of Resident #1 being in the way of Resident #3 and not moving out of the way as fast as Resident #3 wanted. The nurse's	F 607	7. The Corporate Compliance Nurse will be responsible to review the Administrative Nursing Staff rounds Sheets on a weekly basis for three (3) months; a bi-monthly basis for three (3) months and then monthly for six (6) months to determine that facility is in compliance with the credible allegation of compliance and interventions have been put into place. If there are discrepancies in the monitoring tool, the Corporate Compliance Nurse will be responsible to inform the Administrator and conduct an investigation to determine why the discrepancy is there and if needed to assist in correcting the issue. 8. The Corporate Compliance Nurse will also conduct rounds on a weekly basis for three (3) months; a bi-monthly basis for three (3) months and then monthly for six (6) months and conduct interviews with the staff and residents to ensure that all incidents have been reported and compare with the Clinical Teams reviews and interventions. 9. Resident to resident abuse monitoring will be conducted every shift on the flow sheet logs, by the appointed licensed nurse (Nurse Managers), termed Champion nurse. These logs are reviewed daily by DON and IDT. 10. For any resident with combative behaviors, only Nurses or CNAs will be allowed to provide any direct care to include sitting with a resident if this is indicated in the resident care plan. During the Orientation training the Nurses and CNA□s will receive dementia training and	

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note revealed Resident #3 reported that he rolled over Resident #1's feet because Resident #1 did not move out of his way so "he had to teach him a lesson". Further review of the progress note revealed Resident #3 appeared to have "no remorse and stated again that he had to teach him a lesson."

A review of facility provided incident logs revealed no filed reported/documented incidents regarding Resident #1 or Resident #3.

An interview with Medication Aide #1 on 12/04/18 at 3:41 PM revealed on 11/25/18 she was out in the hall and heard Resident #3 state "get out of my way" angrily. She reported she noted Resident #3 had the control stick to his motorized wheelchair pushed as far to the left as it would go towards Resident #1. She stated Resident #3 reported to her that Resident #1 should have moved out of his way. She reported Resident #1 appeared frightened and scared, staring off into space. She stated Resident #3's motorized wheelchair to be off balance at times due to Resident #3 continuing to try and traverse up and over Resident #1's feet. She stated she was surprised Resident #3 did not tip the motorized wheelchair over. She stated she separated the residents she immediately reported the incident to her supervisor and that she had not been asked by administration to provide a statement in regards to what she witnessed.

During an interview with Nurse #1 on 12/04/18 at 10:12 AM she revealed that she did not witness Resident #3 running over Resident #1's feet first hand on 11/25/18 and that it was reported to her by Nurse Aide #1. She continued, reporting that she documented the incident in the nurse's notes

have to demonstrate the ability to work with combative residents, to de-escalate the behaviors, and provide care in a manner and way that protects the resident from abuse. They will receive additional training at least annually but as needed as well. The decision to implement this procedure was made on October 17, 2018 and then re-evaluated on 12/05/2018.
The staff was educated about this procedure which is required to be completed prior to returning to work; on 12/06/2018 by the Director of Nursing, Administrator.
11. As a means of quality assurance, the Administrator shall be responsible to report all allegations and investigations initiated, as per policy, to the President of the company, on a daily basis when received, in an effort to review and confirm appropriate immediate action taken, including thorough investigation as per facility policy.
12. All investigations, with summary of findings and resolution, shall be presented ongoing and reviewed by the QA Committee on a monthly basis to ensure adherence with facility policy, with frequency of review revised only should the Committee deem appropriate.
13. The Corporate Compliance Nurse will be responsible to review the Administrative Nursing Rounds Sheet on a weekly basis for three (3) months; a bi-monthly basis for three (3) months and then monthly for six (6) months to determine that facility is in compliance with the credible allegation of compliance and interventions have been put into

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F 607	Continued From page 37 as Nurse Aide #1 reported it to her. She stated after the incident was reported to her, she completed only a visual assessment of Resident #1's feet and noted no injuries and she observed no broken skin or bruising with no complaints of pain from Resident #1. She reported notifying the DON through a text message and received a response of "OK, thanks" in a return text message. The Nurse stated she did not set up any monitoring systems for Resident #3 to prevent him from exhibiting this inappropriate behavior again. An interview with Nurse Supervisor #1 on 12/04/18 at 10:45AM revealed she was informed of the incident by Nurse #1. She stated she reported the incident to Nurse Supervisor #2 on 11/26/18 who reported she would notify the Director of Nursing. The NS indicated she was not aware of any monitoring systems that were put into place to prevent Resident #3's behavior from happening again. An interview with Nurse Supervisor #2 on 12/04/18 at 1:35PM revealed she was notified of the incident on 11/26/18 during her morning report that Resident #3 had run over two different resident's feet the day before. She stated she instructed Nurse #1 to complete an incident report and document the incident and pass the information on during her report. She stated she spoke with the Director of Nursing (DON) that morning and asked the DON about the incidents. She reported the DON informed her that she was already aware of the incident and the facility was ordering a urinalysis for Resident #3. During an interview with the Director of Nursing (DON) on 12/04/18 at 11:45 am it was revealed	F 607	place. She will also conduct rounds on a weekly basis for three (3) months; a bi-monthly basis for three (3) months and then monthly for six (6) months and conduct interviews with the staff and residents to ensure that all incidents have been reported and compare with the Clinical Teams reviews and interventions. 14. Resident to resident abuse monitoring will be conducted every shift on the flow sheet logs, by the appointed licensed nurse, termed Champion nurse. These logs are reviewed daily by DON and IDT. 15. If there are discrepancies in the monitoring tool, the Corporate Compliance Nurse will be responsible to inform the Administrator and conduct an investigation to determine why the discrepancy is there and if needed to assist in correcting the issue. 16. For any resident with combative behaviors, only Nurses or CNAs will be allowed to provide any direct care to include sitting with a resident if this is indicated in the resident care plan. During the Orientation training the Nurses and CNA□s will receive dementia training and have to demonstrate the ability to work with combative residents, to de-escalate the behaviors, and provide care in a manner and way that protects the resident from abuse. They will receive additional training at least annually but as needed as well. The decision to implement this procedure was made on October 17, 2018 and then re-evaluated on 12/05/2018. The staff was educated about this procedure on 12/06/2018 by the Director of Nursing, Administrator.	

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F 607	Continued From page 38 she had been made aware of Resident #3 running over Resident #1's feet on the morning of 11/26/18 and reported she was scheduled to monitor the hall where Resident #1 and Resident #3 for other quality assurance measures that the facility was currently monitoring. She reported she spoke to both residents involved in the incident about their general wellbeing but denied specifically asking about the incident with the motorized wheelchair. The DON stated both resident denied having any issues or complaints at that time and Resident #1 voiced no complaints of lingering pain. She reported informing the Administrator of Resident #3 running over Resident #1's feet on 11/26/18. An interview with the Administrator on 12/04/18 at 11:45 am revealed she had been made aware of the incident involving Resident #3 running over Resident #1's feet with his motorized wheelchair on 11/26/18 and reported she re-educated Nurse #1 on making sure she contacted administrative staff until someone was reached. She stated she did not start an abuse investigation, contact local law enforcement, local adult protective services or the state agency due to her belief that the incident was not abuse. She reported not completing an internal investigation due to her belief that the incident was not abuse, stating it was a resident to resident incident and that it was not reportable. B. Review of Resident #3's nurse's notes revealed a note dated 11/25/18 at 7:18PM, written by Nurse #1, stated Resident #3 had an incident with Resident #2 while leaving the dining room. Further review of the nurse's note revealed Resident #3 ran over Resident #2's feet with his motorized wheelchair reportedly because	F 607	17. All residents who desire to use a Motorized Wheelchair will have to be assessed by the therapy department prior to use of the chair. The therapy department will use a standardized Electric Wheelchair Assessment on the residents. If at any time the resident is considered unsafe, the Interdisciplinary Care Team will review the assessment and make any recommendations necessary. The family will be notified and the therapy will evaluate for another chair. Indicate How The Facility Plans To Monitor It□s Performance To Make Sure That Solutions Are Sustained. The Facility Must Develop A Plan For Ensuring That Correction Is Achieved And Sustained: 1. The resident care unit rounds will be presented at weekly QA meetings and monthly to the QAPI Committee for evaluation to determine if the system is adequate and if not to devise and re-implement a system to ensure that the alleged deficient practice does not occur again. 2. All incident reports will be reviewed monthly at the QAPI Committee Meeting for any bruises, skin tears and injury of unknown origin and investigations of incidents of unknown origin to determine if any patterns or practices exist that may be considered abuse. 3. All investigations, with summary of findings and resolution, shall be presented	

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F 607	Continued From page 39 Resident #2 was in his way. Additional review of the nurse's note indicated this was the 2nd incident of Resident #3 running over another resident's feet due to the other residents reportedly being in Resident #3's way. The nurse's note also revealed the nurse stated she would continue to monitor Resident #3's behavior and passed the information of the incident onto the 3rd shift Nurse Supervisor. Resident #2 was admitted to the facility on 5/26/18 with diagnoses that included: major depressive disorder, chronic kidney disease, pain in right and left knee and restless leg syndrome among others. A review of Resident #2's most recent MDS Assessment dated 11/24/18 and coded as a quarterly assessment revealed Resident #2 to be cognitively impaired with noted physical and verbal behaviors directed towards others occurring 1-3 days during the look back period. Resident #2 was coded as requiring extensive assistance with bed mobility, locomotion on the unit, dressing and was coded as being totally dependent with transfers. A review of facility provided incident logs revealed no filed reported/documented incidents regarding Resident #2 or Resident #3. An interview on 12/04/18 at 10:12 am with Nurse #1 who completed the nurse's note on 11/25/18 revealed she did not witness Resident #3 running over Resident #2's feet with his motorized wheelchair first hand. She reported Dietary Aide #1 reported the incident to her and she wrote her nurse's note as a reflection of the incident as it was reported to her. She stated she visually assessed Resident #2's feet and noted there to be no injuries and reported no lingering pain. She	F 607	ongoing and reviewed by the QA Committee on a monthly basis to ensure adherence with facility policy, with frequency of review revised only should the Committee deem appropriate 4. If any patterns or practices are noted, the QAPI Committee will begin an immediate investigation to ensure that solutions are put into place to ensure corrective action is achieved and sustained. 5. The QA Committee, QAPI Committee and the Medical Director have been apprised of this plan and commit their support to assisting the facility with achieving and sustaining compliance with this alleged citation. The QAPI Committee was notified on 12/06/2018.	

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stated she reported the incident to the Director of Nursing after the incident by text message and reportedly received a response of "OK, thanks" by text.

An interview with Dietary Aide #1 on 12/04/18 at 11:15 AM revealed she was in the dining room assisting residents when she heard Resident #2 yell out "oh, oh, he ran over my foot." She stated she turned around and observed Resident #3 continuing to try and engage his wheelchair over Resident #2's feet. She reported observing Resident #2 attempt to grab Resident #3 but by that time Resident #3 had already run over Resident #2's foot. She reportedly ran over to the two residents to separate them and informed a nurse, whom she could not identify, walking down the hall with whom she asked for help. Dietary Aide #1 reported she was asked to write a statement about the incident but reported she had forgotten and did not complete it until 12/04/18.

An interview with Nurse Supervisor #1 on 12/04/18 at 10:45AM revealed she was informed of the incident by Nurse #1. She stated she reported the incident to Nurse Supervisor #2 on 11/26/18 who reported she would notify the Director of Nursing.

An interview with Nurse Supervisor #2 on 12/04/18 at 1:35PM revealed she was notified of the incident on 11/26/18 during her report that Resident #3 had run over two different resident's feet. She stated she instructed Nurse #1 to complete an incident report and document the incident and pass the information on during her report. She stated she spoke with the Director of Nursing (DON) that morning and asked the DON about the incidents. She reported the DON

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informed her that she was already aware of the incident and the facility was ordering a urinalysis for Resident #3.

During an interview with the Director of Nursing (DON) on 12/04/18 at 11:45 am it was revealed she had been made aware of Resident #3 running over Resident #1's feet on the morning of 11/26/18 and reported she was scheduled to monitor the hall where Resident #2 and Resident #3 for other quality assurance measures that the facility was currently monitoring. She reported she spoke to both residents involved in the incident about their general wellbeing but denied specifically asking about the incident with the motorized wheelchair. The DON stated Resident #2 voiced no complaints of pain or injury. She reported informing the Administrator of Resident #3 running over Resident #2's feet on 11/26/18.

An interview with the Administrator on 12/04/18 at 11:45 am revealed she had been made aware of the incident involving Resident #3 running over Resident #2's feet with his motorized wheelchair on 11/26/18 and reported she re-educated Nurse #1 on making sure she contacted administrative staff until someone was reached. She stated she did not start an abuse investigation, contact local law enforcement, local adult protective services or the state agency due to her belief that the incident was not abuse. She reported not completing an internal investigation due to her belief that the incident was not abuse, stating it was a resident to resident incident and that it was not reportable.

The Administrator was informed of Immediate Jeopardy on 12/05/18 at 11:00 am. The facility provided an acceptable credible allegation of

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F 607	Continued From page 42 Immediate Jeopardy removal on 12/06/18 at 11:41 am which specified the following: CORRECTIVE ACTION PLAN F- 607 Facility must develop and implement written policies and procedures that; Prohibit and prevent abuse, neglect and exploitations of residents and misappropriation of resident property, Establish policies and procedures to investigate any such allegations, and Include training as required. Address How Corrective Action (S) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: 08/18/2018 INCIDENT 1. The facility did not substantiate the abuse of Resident #1 on 08/18/2018 when Resident Companion was struck by Resident #1 and Resident Companion grabbed his arm resulting in a skin tear, based on the witness statement and the facilities' investigation at that time. Based on the Resident Companion's statement we immediately removed the employee and suspended her until the investigation was complete. Based on our investigation and interview with the employee the decision was made to move the employee to the Dietary department as a Dietary Aide where she will not be able to provide care with the residents. Thus we were in compliance as of the 08/18/2018 date. 2. However due to the complaint survey citing the facility for failure to prevent abuse due to the employee's statement on 12/03/2018 the facility	F 607		

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has decided to re-open the investigation.

3. The Police were notified on 12/05/2018 at 10:00 am and they came to the facility around 10:30 am at which time we made a report.

4. The facility sent in a 24 Hour Report to NCDHSR to indicate that they had re-opened the investigation.

5. The employee in question was notified of the need to come in for another interview on 12/05/2018 and she arrived at 12:30 pm at which time an interview was conducted. Per our policy the employee is suspended now pending another investigation. If the investigation supports bringing her back to work she will have go through another orientation at which time she will receive training on Abuse, How to react to combative behavior from residents, and Dementia Training. Therefore the facility has provided an environment free from abuse.

6. For Resident #1 his care plan was updated on 08/30/2018 by the MDS Nurse to reflect how to approach him when providing care and services to minimize his behaviors and to gain his cooperation; to always have two staff members when providing his care; to explain in a calm voice what is going to be done to the resident before starting care and to stop care if resident becomes combative and to re-approach after he has become calm and cooperative to finish care.

11/25/2018 INCIDENT

1. November 25, 2018 there was an incident where Resident #3 ran over the feet of Resident #1 and Resident #2. The staff intervened with

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Resident #1 and Resident #3 by removing Resident #1 from the area and monitoring Resident #3, per #1 Nurse LPN witness statement and nurse's note. After the incident with Resident #2 and #3 the staff in the dining room intervened by assisting Resident #3 from the dining room which was his intent when running over resident #2's feet. The #1 Nurse LPN evaluated the resident #1 and #2's feet at the time and there were no injuries or complaints from the residents per the nurse's notes. The facility did not identify the root cause of the incident as an abusive act. At the time of incident, the resident's intent was not clear. Though Resident #3 stated he meant to run over the resident's feet when asked by staff, upon further consideration by administration, this admission could be erroneous due to resident's acute mental status related to Urinary Tract Infection. Resident #3 does not have a history of aggression or altercation and was being treated for acute UTI. The Resident to Resident Altercation resulting in no physical harm to Resident #1 and #2. The facility did not submit report, as per resident to resident abuse.

2. On November 26, 2018 the DON completed a thorough skin assessment on Resident # 1 and Resident #2 involved in the 11/25/2018 incident and there were no noted areas of bruising, discoloration, scratches and or injury. Resident #1 and #2 did not appear to have any mental or emotional distress as a result of the incident as they mentally appeared to be at their baseline and did not express any signs of physical or mental distress.

3. Resident #3 was evaluated by Physical Therapy on 12/03/2018 to determine if the

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resident has the capability of maneuvering a motorized chair independently. It was determined that resident has great difficulty when decreased space is available. He is unable to see his feet or immediately by his sides due to decreased visual field. He tends to use the wheelchair to increase his visual field as opposed to turning his head. Required cues to turn his head instead, he would turn the chair. Due to the safety needs of the residents the Interdisciplinary Care Team and Physician has decided the resident will be evaluated on 12/06/2018 for a traditional wheelchair and placed in chair after the evaluation.

Address How Corrective Action Will Be Accomplished For Those Residents Having Potential To Be Affected By The Same Deficient Practice:

1. All interview able residents were interviewed by the facility Social Worker and Director of Nursing to determine if they had been a recipient of, or witnessed abuse by a staff member, family member, visitor or another resident. The interviews were conducted on 12/05/2018 and there were no residents who had experienced or witnessed any abuse.

2. The facility performed ongoing audits of Incident reports, since October, 2018. However, this process was escalated further to include 24 hour nursing shift reports as well, which are reviewed for incidents involving possible resident to resident altercations, and or abuse. This new process was initiated by Administrator following the resident to resident altercation on 11/28/2018. To date, there have been no injuries of unknown origin or resident to resident abuse to investigate.

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The Morning Meeting Signature Agenda reflects the Administrative and the Clinical Team attendance. Thus all non-interview able residents have not had any noted incidents.

a. The Administrator, Director of Nursing and Corporate Nurse Consultant conducted In-services with all staff beginning on 12/05/2018 and completed on 12/07/2018 which is required to be completed prior to returning to work; on the following; and all new hires will be required to complete the following training in orientation prior to working with the resident.
b. ABUSE - Resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.
c. Types of abuse, i.e., (physical, verbal, chemical, sexual, and resident to resident abuse.
d. What to do if abuse is witnessed, who to report the abuse to,
e. How to react to combative behavior from residents; how to provide care and services to combative residents to prevent abuse to resident(s) or harm to the care giver; and
f. Dementia training.
g. Reporting of ANY SUSPICION of abuse of any type, neglect, exploitation and misappropriation of resident property.
h. Notification of the incident to the Administrator and the Director of Nursing IMMEDIATELY. Failure to notify will result in disciplinary action.

3. The Administrator and the Director of Nursing received additional training on the Abuse policy and regulations, the investigation process and the regulations regarding timely notification by staff, and then timely reporting of the abuse to the required agencies and Dementia Training. This

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was completed on 12/06/2018 by the Corporate Nurse Consultant.

Address What Measures Will Be Put Into Place Or Systemic Changes Made To Ensure That The Deficient Practice Will Not Recur:

1. Due to the safety needs of the residents the Interdisciplinary Care Team and Physician has decided the Resident #3 will be evaluated on 12/06/2018 for a traditional wheelchair and placed in chair after the evaluation

2. The Nursing Staff were informed by the Nurse Manager of the incident and instructed them to be hyper vigilant with observation of Resident #3) on 11/25/2018. All staff has been made aware of the resident's behavior and the need to be hyper vigilant with observation by 12/07/2018. The Director of Nursing has completed QA rounds ensure resident does not exhibit any further behaviors/abuse. If this does occur to report immediately any concerning resident behaviors to the Director of Nursing and Administrator.

3. All interview able residents were interviewed by the facility Social Worker and Director of Nursing to determine if they had been a recipient of, or witnessed abuse by a staff member, family member, visitor or another resident. The interviews were conducted on 12/05/2018 and there were no residents who had experienced or witnessed any abuse.

4. Staff interviews were conducted by outside RN Consultant on 12/5/2018-12/6/2018. The interviews involved detail questioning pertaining to resident abuse awareness, prevention and

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reporting process of all facility staff. Interview results were reviewed by Administration for possible concerns.

5. All staff members were addressed prior to their next tour of duty as to the abuse prohibition policy with emphasis on not only reporting direct knowledge of any incident, but also immediately reporting knowledge of any "rumor" or hearsay of abuse (of any type), thereby promoting investigation as to the validity of the rumor/hearsay. Failure to do so will warrant disciplinary action. Additionally, staff members were addressed as to the revised policy which clearly specified the educational training on dementia, during orientation. As a means to ensure ongoing compliance, the orientation process has been amended to fully integrate dementia training for CNA's and Nurses, to ensure care givers are receiving tools to care for combative residents, as per facility policy. Additionally, immediate reporting of any rumor or hearsay which could indicate any type of abuse will be addressed during orientation of newly hired employees to ensure enforcement of facility policy No concerns were revealed based on staff interviews. Observations of the overall environment and at risk residents is ongoing and is being conducted by the Champion designated licensed nurse, and documented on Behavior monitoring flow sheets. The flow sheets will be submitted to DON and discussed by IDT at daily stand up meeting.

6. Incident Reports and (24-Hour Nursing Report) will be reviewed Monday through Friday in morning meetings for any unusual incident to include bruises, skin tears and injuries of unknown origin and resident to resident abuse.

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An immediate investigation will be started for all bruises or unknown origin, skin tears of unknown origin or any other incident or injury of unknown origin and any occurrence that is suspected abuse will be reported immediately to the Huntersville Police Department and the North Carolina Health Care Personnel Registry. The incident reports are completed electronically by the staff nurses and the nurse supervisors are responsible to print the incident report(s) for their unit before the morning meeting and are responsible to bring them to the morning meeting. In addition they will bring the 24-Hour Nursing Report to the meeting and two documents will be compared to ensure incidents of unknown origin are investigated and interventions put into place. In the event the nursing supervisor is absent the responsibility of printing the incident reports and the 24-Hour Nursing Report is assigned to the ADON and then to the DON.

7. The Corporate Compliance Nurse will be responsible to review the Administrative Nursing Staff rounds Sheets on a weekly basis for three (3) months; a bi-monthly basis for three (3) months and then monthly for six (6) months to determine that facility is in compliance with the credible allegation of compliance and interventions have been put into place. If there are discrepancies in the monitoring tool, the Corporate Compliance Nurse will be responsible to inform the Administrator and conduct an investigation to determine why the discrepancy is there and if needed to assist in correcting the issue.

8. The Corporate Compliance Nurse will also conduct rounds on a weekly basis for three (3) months; a bi-monthly basis for three (3) months

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and then monthly for six (6) months and conduct interviews with the staff and residents to ensure that all incidents have been reported and compare with the Clinical Teams reviews and interventions.

9. Resident to resident abuse monitoring will be conducted every shift on the flow sheet logs, by the appointed licensed nurse, termed "Champion" nurse. These logs are reviewed daily by DON and IDT.

10. For any resident with combative behaviors, only Nurses or CNAs will be allowed to provide any direct care to include sitting with a resident if this is indicated in the resident care plan. During the Orientation training the Nurses and CNA's will receive dementia training and have to demonstrate the ability to work with combative residents, to de-escalate the behaviors, and provide care in a manner and way that protects the resident from abuse. They will receive additional training at least annually but as needed as well. The decision to implement this procedure was made on October 17, 2018 and then re-evaluated on 12/05/2018. The staff was educated about this procedure which is required to be completed prior to returning to work; on 12/06/2018 by the Director of Nursing, Administrator.

11. As a means of quality assurance, the Administrator shall be responsible to report all allegations and investigations initiated, as per policy, to the President of the company, on a daily basis when received, in an effort to review and confirm appropriate immediate action taken, including thorough investigation as per facility policy.

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	345541	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

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12. All investigations, with summary of findings and resolution, shall be presented ongoing and reviewed by the QA Committee on a monthly basis to ensure adherence with facility policy, with frequency of review revised only should the Committee deem appropriate.

13. The Corporate Compliance Nurse will be responsible to review the Administrative Nursing Rounds Sheet on a weekly basis for three (3) months; a bi-monthly basis for three (3) months and then monthly for six (6) months to determine that facility is in compliance with the credible allegation of compliance and interventions have been put into place. She will also conduct rounds on a weekly basis for three (3) months; a bi-monthly basis for three (3) months and then monthly for six (6) months and conduct interviews with the staff and residents to ensure that all incidents have been reported and compare with the Clinical Teams reviews and interventions.

14. Resident to resident abuse monitoring will be conducted every shift on the flow sheet logs, by the appointed licensed nurse, termed "Champion" nurse. These logs are reviewed daily by DON and IDT.

15. If there are discrepancies in the monitoring tool, the Corporate Compliance Nurse will be responsible to inform the Administrator and conduct an investigation to determine why the discrepancy is there and if needed to assist in correcting the issue.

16. For any resident with combative behaviors, only Nurses or CNAs will be allowed to provide any direct care to include sitting with a resident if

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F 607	Continued From page 52 this is indicated in the resident care plan. During the Orientation training the Nurses and CNA's will receive dementia training and have to demonstrate the ability to work with combative residents, to de-escalate the behaviors, and provide care in a manner and way that protects the resident from abuse. They will receive additional training at least annually but as needed as well. The decision to implement this procedure was made on October 17, 2018 and then re-evaluated on 12/05/2018. The staff was educated about this procedure which is required to be completed prior to returning to work; on 12/06/2018 by the Director of Nursing, Administrator . 17. All residents who desire to use a Motorized Wheelchair will have to be assessed by the therapy department prior to use of the chair. The therapy department will use a standardized Electric Wheelchair Assessment on the residents. If at any time the resident is considered unsafe, the Interdisciplinary Care Team will review the assessment and make any recommendations necessary. The family will be notified and the therapy will evaluate for another chair. Indicate How The Facility Plans To Monitor It's Performance To Make Sure That Solutions Are Sustained. The Facility Must Develop A Plan For Ensuring That Correction Is Achieved And Sustained: 1. The QA Committee, QAPI Committee and the Medical Director have been apprised of this plan and commit their support to assisting the facility with achieving and sustaining compliance with this alleged citation. The QAPI Committee was notified on 12/06/2018.	F 607		

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F 607	Continued From page 53 2. The resident care unit rounds will be presented at weekly QA meetings and monthly to the QAPI Committee for evaluation to determine if the system is adequate and if not to devise and re-implement a system to ensure that the alleged deficient practice does not occur again. 3. All incident reports will be reviewed monthly at the QAPI Committee Meeting for any bruises, skin tears and injury of unknown origin and investigations of incidents of unknown origin to determine if any patterns or practices exist that may be considered abuse. 4. All investigations, with summary of findings and resolution, shall be presented ongoing and reviewed by the QA Committee on a monthly basis to ensure adherence with facility policy, with frequency of review revised only should the Committee deem appropriate 5. If any patterns or practices are noted, the QAPI Committee will begin an immediate investigation to ensure that solutions are put into place to ensure corrective action is achieved and sustained. The facility's credible allegation of IJ removal was verified on 12/07/18 at 4:09 pm when the facility staff were interviewed and demonstrated they were in-serviced on the topic of abuse including; identification of abuse, investigating an allegation of abuse and their responsibility to report abuse in any form.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		12/12/18

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F 609	Continued From page 54 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to report an allegation of staff to resident abuse to the state agency within 2 hours for 1 of 3 residents (Resident #1) reviewed for abuse. The finding included: Resident #1 was admitted to the facility on	F 609	Address How Corrective Action (S) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: 1. In-services were conducted for all staff members on 12/5/2018 & 12/6/2018 to address the expectation and requirement that all suspected or actual	

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F 609	Continued From page 55 01/04/18 with diagnoses which included Lewy Body Dementia (LBD) (which is a progressive Parkinson like dementia). His most recent comprehensive Minimum Data Set (MDS) dated 06/01/18 revealed he had severe cognitive impairment and required extensive assistance with most of his activities of daily living. The MDS also indicated he had no behaviors within the look back period. Review of a Nurses Note, written by Nurse #2, dated 08/18/18 at 10:22 AM indicated in part that Resident #1 was alert and verbal with confusion. Resident #1 received a skin tear to the top of left forearm which measured 4 cm long by 1.5 cm wide with a flap of skin tunneling 0.5 cm to the left side of the skin tear. Resident #1 was calm and in good a mood while treatment was being given. Resident #1 stated "the Sitter and he were scuffling, and she tore a chunk of meat from his arm then he punched her." The note specified, Resident #1 also stated that the Sitter said "ha, ha, ha I won." Resident #1 stated he felt some soreness in his left arm. Telephone interview with Resident Companion (Sitter) on 12/03/18 at 3:05 PM she stated Resident #1 had started to stand up and she told him to sit back down then he reached up with his hand and hit her in the face. The Sitter stated out of instinct she grabbed Resident #1's left hand to keep him from hitting her again. By this time Resident #1 was sitting down so she immediately went to the nurses' station to report what had happened. The Sitter stated while she was holding an ice pack to her right jaw they brought Resident #1 to the desk and when he saw her he said "Oh, you did this" while pointing to his skin tear. The Sitter stated Resident #1 was not	F 609	violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property MUST be reported to Administration (Administrator and Director of Nursing) IMMEDIATELY so that a report made be made to the Health Care Personnel Registry, the State Survey Agency and adult protective services within two (2) hours after the allegation is made. 2. The facility Social Worker and Director of Nursing interviewed all alert an oriented residents to determine if they had been a recipient of or witnessed abuse by a staff member, another resident of anyone else. These interviews were completed on 12/05/2018. All interview able residents reported that they had not been the victims of any abuse or misappropriation of property and had not witness any other resident being the victim either. Staff interviews were conducted by an outside RN Consultant on 12/5/2018 □ 12/6/2018 concerning their awareness of what constitutes abuse or misappropriation, prevention of abuse and misappropriation and the reporting process if abuse or misappropriation occurs. Address How Corrective Action Will Be Accomplished For Those Residents Having Potential To Be Affected By The Same Deficient Practice: 1. Beginning 12/7/2018 the facility will perform ongoing audits of incident reports as well as 24 hour nursing shift reports for	

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F 609	Continued From page 56 bleeding a lot. On 12/03/18 at 4:30 PM the interview with the Sitter continued in person with demonstration of incident. The Sitter stated she and Resident #1 were watching television when he started to stand up and she stood up in front of him and leaned down to him and said (Resident #1) you need to sit down and at that time he had already sat back down then he "hit me on the right side of my face with his left hand and out of instinct I grabbed his arm to keep him from hitting me again" and in doing so my fingernails caused a skin tear on his arm. The Sitter stated she did not know she caused the skin tear to Resident #1's arm until he came to the nurses' station later and showed the nurse and me his arm. The Sitter stated, "It (the resident's arm) clearly had the imprints of my fingernails and it was open with small drops of blood." The Sitter explained that she had not received training on what to do when a resident became agitated. Review of Nurse #2's written statement (undated and untimed) revealed in part that while she was treating Resident #1's skin tear he stated that she (Sitter) grabbed his arm with her nails then he punched her. Resident #1 continued to state the Sitter tempted him to hit her saying "hit me, hit me" so Resident #1 said he hit her. Resident #1 said they were initially scuffling and that she always does this with him. On 12/03/18 at 5:31 PM during a telephone interview with Nurse #2 she stated she was asked by NS #3 to come and note a skin tear on Resident #1. Nurse #2 stated that it didn't look like a normal skin tear and described it as deep, tunneling, and had a crescent shaped skin flap.	F 609	any possible abuse or resident to resident altercations that result in abuse. These will be reviewed in the morning meeting Monday thru Friday for any indication that any abuse has occurred. Staff has been in-serviced on the requirement to report any suspected or actual abuse to the Administrator and Director of Nursing IMMEDIATELY and the fact that if the policy is not followed, the employee will be disciplined by termination. In addition, beginning 1-1-2019 (after in-servicing nurse managers and charge nurses on the new procedure), the nurse manager for each shift seven days a week must call the Administrator at the end of their shift and report off on any resident behaviors or staff actions that could be interpreted as abuse or any suspicion of abuse in any form or manner. This will be done daily for 30 days, then ever other day for 30 days and will be reevaluated after 60 days for the need to continue. Address What Measures Will Be Put Into Place Or Systemic Changes Made To Ensure That The Deficient Practice Will Not Recur: 1. The facility began a Quality Improvement Performance Improvement Project on 12/13/2018 to address the issues with abuse in the facility and reporting of abuse timely. The Quality Assurance and Performance Improvement Committee has identified the following components to the Quality Performance Improvement Project and will assess these each week at the QAPI	

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F 609	Continued From page 57 The Nurse also stated there was a moderate amount of bleeding. After NS #2 treated the skin tear, she documented the measurements and what Resident #1 stated happened in her nurses' notes and reported it to NS #3 and called the Interim Director of Nursing (IDON). Review of the 24-Hour Initial Report revealed the date and time of the allegation/incident was 08/18/18 at 10:00 am. The allegation described in part "that a resident received a skin tear to his left forearm this morning post incident with the Sitter" (who was employed by the facility). The report continued "resident struck the Sitter in the right side of the face/jaw as she attempted to redirect him to sit back down. The Sitter reported she tried to get his arms away, a skin tear resulted. Resident stated she tore into his skin during a scuffle. The Sitter was removed from Resident #1 and facility pending investigation." Review of the Fax Transmittal Form the 24-Hour Initial Report was faxed to the state agency on 08/18/18 at 8:49 pm. During an interview with the IDON on 12/04/18 at 11:47 AM she reported that she was notified of the incident between Resident #1 and the Sitter during the morning of 08/18/18 and arrived at the facility in the early afternoon. The IDON stated she was told by NS #3 that Resident #1 became combative with the Sitter and punched her in the face after they got into a scuffle. The IDON stated she instructed NS #3 to get a statement from the Sitter then send her home. The IDON stated she did not report the altercation between Resident #1 and the Sitter within 2 hours to the state agency. The IDON stated she reported the incident to the state agency later that night.	F 609	sub committee meetings: 1. Identify root cause analysis, 2. identify residents with behaviors that are higher risk for abuse, 3. review all injuries of unknown source, 4. track any suspicions of abuse, actual abuse, injuries of unknown source, reporting times of any incident of suspicion or abuse or actual abuse 5. Develop a system to inform care givers of residents with behaviors or resistive to care 6. In-service incorporated into new hire orientation on timely reporting 7. All current staff were in-serviced on 12/05/2018 and 12/06/2018 concerning the requirement of timely reporting as outlined in the facility's policies and procedures. Staff engagement to improve morale and change general attitude towards ownership of job and responsibilities to residents. 2. The QAPI Subcommittee will monitor each of these components of the project and will assess and adjust the project to ensure that facility performance and solutions are achieved and sustained. The Subcommittee will report to the Monthly QAPI which has the responsibility to ensure that the Subcommittee is performing in a manner to ensure that facility performance and solutions are achieved and sustained. Indicate How The Facility Plans To Monitor It□s Performance To Make Sure	

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F 609	Continued From page 58	F 609	That Solutions Are Sustained. The Facility Must Develop A Plan For Ensuring That Correction Is Achieved And Sustained: The QAPI Subcommittee will monitor each of these components of the project and will assess and adjust the project to ensure that facility performance and solutions are achieved and sustained. The Subcommittee will report to the Monthly QAPI which has the responsibility to ensure that the Subcommittee is performing in a manner to ensure that facility performance and solutions are achieved and sustained.	