STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345314	A. BUILDING _____ B. WING _____	C 12/12/2019

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FAIR HAVEN OF FOREST CITY, LLC	830 BETHANY CHURCH ROAD FOREST CITY, NC 28043

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E 000	Initial Comments An unannounced Recertification and Complaint Investigation survey was conducted on 12/09/19 through 12/12/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 6WCX11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and Complaint investigation survey was conducted from 12/09/19 through 12/12/19. There was one complaint allegation investigated and it was substantiated. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J). CFR 483.12 at tag F607 at a scope and severity (J). The tags F600 and F607 constituted Substandard Quality of Care. Immediate Jeopardy began on 12/06/19 and was removed on 12/12/19. An extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		12/23/19

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

Electronically Signed | 01/09/2020

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F 600	Continued From page 1 §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 observations, staff interviews and record review, the facility failed to protect a resident's right to be free from abuse for 1 of 1 resident (Resident # 68). Immediate jeopardy began on 12/6/19 when three nurse aides provided personal care to a severely cognitively impaired agitated resident in a manner that resulted in the resident and staff behaviors escalating to the point of staff using foul language, threatening with fists, and imposing physical abuse to the resident, without staff intervening or discontinuing the care, or reporting the abuse to licensed staff immediately. Immediate Jeopardy was removed on 12/12/19 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: Resident #68 was admitted to the facility on 07/19/19 with diagnosis including non-Alzheimer's dementia, seizure disorder, anxiety and psychotic disorder (schizophrenia). Resident #68's care plan dated 07/20/19 revealed	F 600	Disclaimer: The following information is provided by request, in follow up to the survey conducted, and does not represent the facility admitting to, or agreeing to the alleged deficient practice. "Nurse Aide (NA) #2 was assigned rooms 106-111 from 7am until 3pm. Those in her care were potentially affected. NA #2 did not have an assignment from 3pm until she was removed from the floor. She was assisting another NA with care rounds and a shower. "NA #2 was working with an orientee (NA #1) from 7am to 3pm the date the alleged incident was reported. NA #1 confirmed that she was with NA #2 for the entire day, during care and breaks, and NA #2 did not provide care alone from the time of the reported incident until the end of the shift. NA #1 denied any other mistreatment / abuse of residents during the care. "NA #2 assisted another NA from 3pm until she was removed from the floor at around 4:50pm. The other NA stated that they performed incontinence rounds and were giving a shower when NA #2 was called off the floor. The other NA stated she was with NA #2 the entire time and	

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F 600	Continued From page 2	F 600		

he was care planned for combativeness and becoming resistant to staff when trying to provide care. The goal was for Resident #68 to communicate with others without swearing or being verbally abusive and allow staff to provide appropriate care through the next review date of 01/30/20. Interventions included encouraging participation in personal care, not arguing with the resident, speaking in a calm voice and reducing environmental stimuli.

Resident #68's quarterly minimum data set (MDS) assessment dated 10/23/19 revealed he was assessed as severely cognitively impaired. He was assessed to have no behaviors or refusal of care. He required extensive assistance with bed mobility, dressing and personal hygiene. Resident #68 was totally dependent on staff for bathing and able to make his needs known.

An observation of Resident #68 conducted on 12/10/19 at 2:39 PM revealed the resident to be in his wheelchair sitting in the hallway eating a snack. Staff were observed interacting with Resident #68 during this observation as well as another resident.

A second observation of Resident #68 was conducted on 12/11/19 at 8:56 AM. Resident #68 was observed with his eyes closed resting in bed.

An interview conducted on 12/10/19 at 1:46 PM with NA #1 revealed she had been working in the facility for 3 days on 12/06/19. She stated she was paired with NA#2 on that day for orientation. NA #1 stated a Hospice NA (NA #3) was in the facility and requested assistance with giving Resident #68 a bed bath. The interview revealed NA #2 had gotten on Resident #68's eye level and

denied any mistreatment / abuse of residents during the care.
"NA #2 was not alone from the time the incident occurred until the time she was removed from the floor.

"The potential for serious bodily injury was not likely to resident #68, or residents in rooms 106-111 due to witnesses being present during the entire shift.

Resident #68 assessed for physical injury at 6:30pm on 12/6/19. Head to toe skin assessment completed by the wound nurse revealed no redness, swelling, bruising, or abnormality. Resident #68 demonstrated no lasting mental anguish as evidence by no recollection of the alleged incident.

Residents on NA#2□s assignment, and the surrounding assignments (rooms 100-119) received head to toe skin assessments on 12/11/19. The remainder of residents (rooms 120-156) received head to toe skin assessments on 12/12/19. The skin assessments were completed by the unit managers and the wound nurse. No evidence of abuse noted on any residents. No new bruising when compared to the previous weekly skin assessments.

Alert and oriented residents from rooms

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F 600	Continued From page 3 asked him if the staff could get him dressed and give him a bed bath, Resident #68 became aggressive grabbing NA#3's hand, sinking his nails into her skin, trying to kick and hit. NA #2 then stated to the resident "stop, quit being a bxxxx" and popped him in the right upper chest area (not hard but a small tap) which made the resident more agitated hitting and kicking resisting care. NA #3 then stated to NA #2, "I don't believe smacking him helps the situation". NA #1 stated the staff continued to provide care and dress Resident #68 stating he did not become calm until he was placed in his wheelchair. Once the resident was placed in his wheelchair, he became approachable and calm. The interview revealed NA #1 did not see any red marks on Resident #68's skin from where NA #2 had popped him. NA #1 stated the incident happened on 12/06/19 at 7:30 AM. A second interview with NA #1 conducted on 12/10/19 at 2:48 PM revealed once the NAs began providing Resident #68 with a bed bath NA #2 was holding Resident #68's hands so NA #3 could wash his side. She stated Resident #68 got one of his hands loose from NA #2 and had grabbed NA #3's hand. NA #2 then popped him on the upper chest area to get the resident to stop fighting. On 12/10/19 at 1:58 PM an interview was conducted with NA #3. She stated Resident #68 would often become agitated and aggressive during a bed bath hitting, pinching and cursing at staff. NA #3 said she never gave Resident #68 a bath alone, he required someone else to assist and one of the NAs from the facility always helped her on Fridays. The interview revealed NA #3 asked NA #2 to assist her in giving Resident	F 600	100-119 were interviewed on 12/11/19 by the social worker and assistant administrator. All residents interviewed denied abuse or mistreatment from staff. Alert and oriented residents from rooms 120-156 were interviewed on 12/12/19 by the social worker and assistant administrator. All residents interviewed denied abuse or mistreatment by staff. Education began on the evening of Friday, December 6, 2019. This included the abuse policy, reporting abuse immediately, as well as approach with resident□s with dementia/ aggressive behaviors. This education was started by the assistant administrator to the direct care staff. The education continued throughout the weekend, on all shifts, and will continue until it is completed by all staff employed by Fair Haven of Forest City, as well as therapy staff working at Fair Haven of Forest City and staff working from Hospice. The assistant administrator, DON, ADON, and unit managers will continue the education until completion. All staff will require this education to be completed before they are allowed to work. All staff includes, nursing (nurses and CNAs), activities, dietary, housekeeping, laundry, maintenance, therapy and hospice. Completion date: 12/23/2019 Abuse education will continue to be provided upon hire, annually, and as	

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F 600	Continued From page 4 #68 a bed bath on 12/06/19. NA #2 was training NA #1 so all three of the staff entered the room. Once in the room she stated she was on one side of the bed, NA #2 was on the other side and NA #1 was standing at the foot of the bed observing. NA #3 stated at first Resident #68 wasn't hitting, he was holding NA #2's hands while she washed his side. Resident #68 began to become aggressive hitting at NA #2 and NA #3. NA #3 stated NA #2 began making smacking gestures with her hands in the air at Resident #68 and he was becoming more aggressive. NA #3 stated the resident had grabbed her hand and was pinching her fingers, so she turned the other way and closed her eyes. NA #3 stated she did not see nor hear NA #2's hand come into contact with Resident #68's skin. NA #3 said she told NA #2 that she was agitating him and making the situation worse which NA #2 did not acknowledge. She stated she did not hear NA #2 curse at Resident #68. She stated Resident #68 would usually become combative when she started his bed bath however if she spoke to him in a calm manner he would calm down. On 12/10/19 at 2:11 PM an interview was conducted with NA #2. NA #2 stated on 12/06/19 at 7:30 AM she assisted NA #3 give Resident #68 a bed bath. She also had a new employee (NA #1) in the room observing care. The interview revealed Resident #68 was very combative so she held his hands so he didn't swing or hit NA #3 and turned his body towards her so NA #3 could wash his side and back. Resident #68 started becoming combative getting one of his arms loose and digging his nails into her hand trying to hurt her and cursing at her. NA #2 stated she popped his hand with her right opened hand one time. NA #2 stated Resident #68 continued to	F 600	needed throughout the year. Dementia education will continue to be provided upon hire, annually, and as needed throughout the year. Audits will consist of staff interviews to ensure competence of the abuse policy, including immediate reporting of suspected abuse, and approach with dementia/ aggressive behaviors. Staff interviews will be completed on RNs, LPNs, CNAs, activities, dietary, housekeeping, laundry, maintenance, therapy, and well as contract staff, such as hospice. Audits will be conducted by the administrator, assistant administrator, DON, and/ or ADON. Audits will be completed weekly for four weeks, and then every other week for four weeks, and then randomly. The audits will be presented by the assistant administrator and/or DON for review and monitoring in the facility's quality assurance meeting include a minimum of five employees each week of the audit. The next meeting is 1/21/2020. Completion date: 12/23/2019	

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remain agitated until he was placed in his wheelchair.

On 12/12/19 at 10:33 AM an interview was conducted with the ADON. She stated on 12/06/19 she was at a function with the DON and received a text message from NA #1 to call her and she returned the call to NA#1 around 4:30 PM. The ADON was with the DON when she received the information about the incident from NA#1 and the DON took over the investigation at that time.

On 12/10/19 at 3:03 PM an interview was conducted with the Director of Nursing (DON). She stated she had received a phone call from NA #1 on 12/06/19 at 4:30 PM regarding the incident. The DON said NA #1 reported NA #3 and NA #2 were completing a bed bath for Resident #68 earlier in the day and NA #2 had smacked Resident #68 on his arm/shoulder area. NA #1 reported to her that NA #3 had told NA #2 she was only making the situation worse. The interview revealed she had spoken with NA #2 who said she was holding Resident #68's hand to distract him while NA #3 washed his side. NA#2 had stated to the DON she had lightly popped the resident's hand to get him to let go of NA #3. The DON stated NA #2 had demonstrated to her how she had popped his hand. The DON stated she had interviewed NA #3 who said she had turned away from the incident but had seen NA #2 making a smacking motion in the air before she turned away. She stated following the incident a skin assessment was completed for Resident #68 which revealed no skin abnormalities.

On 12/11/19 at 11:47 AM an follow-up interview was conducted with NA #1, NA #2 and NA #3.

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NA#1 and NA #3 were in the facility and NA #2 was included in the interview via phone. NA #3 stated she sees the resident twice a week and had to have help because Resident #68 was combative. The NAs on the hall would assist her giving the resident a bath. NA #1 was in training with NA#2 so she asked them for help. NA #2 asked Resident #68 if he would take a bath and he didn't respond the first time, so she asked again, and he said yes. NA #3 got the supplies together and began giving Resident #68 a bath. Resident #68 grabbed her hands and put his nails into her skin. She stated NA #1 had a better view of the situation because she was at the foot of the resident's bed. NA #2 held the resident's hands during care while she washed the resident. Then they switched sides, Resident #68 grabbed her by both hands and dug his nails into her while NA #2 was washing him. She stated she pulled her hands down and turned around. She stated she didn't hear NA #2 hit him. When she turned back NA #2 was making hand gestures at him without touching the resident. She stated to NA #2 that doesn't help the situation. NA #1 stepped up to the left side to help fasten his brief. Once the resident sat up on the side of the bed, he was calm and got into his chair.

During the interview NA #1 stated when NA #3 turned her back, NA #2 was on the left side and the resident continued to flail around. NA #1 stated NA #2 popped the resident's chest area. She stated during the incident the resident had balled his fist up at NA #2 and NA #2 balled her fist up and faced them towards the resident and NA #2 stated to the resident, "Do you want to fight". NA #1 stated her nerves were shot when she left the situation and that's why she didn't report that NA #2 had her fist balled at the resident initially. NA#1 was scared feeling like she

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was in a bad situation on her third day of training. Stated her thought if NA #2 did this with other NAs in the room what does she do when she's alone. She stated the incident was very overwhelming.

During the interview NA #2 stated she lightly popped his hand because the resident had grabbed her hand and she tapped it to get him to let her hand go. She stated she lightly popped his hand and did not touch his chest area. The only time she touched his chest area was when she was putting his shirt on which was when he was sitting up on the side of the bed. She stated his hand was located near his chest area when she popped it so that is probably what NA #1 saw when she thought his chest was hit.

The Administrator was notified of the Immediate Jeopardy on 12/11/19 at 2:30 PM. On 12/12/19 at 4:30 PM the facility provided the following credible allegation of Immediate Jeopardy removal.

F 600 Removal Plan

Identify those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of noncompliance:

· On December 6, 2019 at around 4:30 pm, NA #1 reported that during her orientation earlier that day (before breakfast), she witnessed NA#2 popped resident #68 "in the right upper chest area" while telling him to "stop and quit being a bitch" during personal care. NA #1 stated that the hospice nurse aide (NA #3) was also in the room, and she commented "that will only make it worse". NA #2 was removed from the floor at

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4:50 pm and an investigation started.

· Around 4:50 pm, spoke with NA #3 on the phone. She stated that during care resident #68 gets combative at times. NA #2 was assisting her with his care, trying to distract him and hold his hands. NA #3 stated she witnessed NA #2 smack at his hands but did not actually see her come into contact with the resident. NA #3 felt it was inappropriate because resident #68 could see what NA #2 was doing. NA #3 stated "that will not help, it will only make it worse" and NA #2 did not acknowledge that she had spoken to her.

· Around 5:15 pm, interviewed NA #2. Asked her to explain any interactions she had with resident #68 during her shift. She stated that during her bathing, she assisted NA #3 like she does every Friday. She stated that she was holding his hands and providing distraction to prevent him from hitting NA #3 while she washed him. Resident #68 dug his nails into her hand, and NA #2 stated she "lightly popped" his hand to get him to stop. She demonstrated. It was not physically painful but gave the feeling of being disciplined.

· Around 6:30pm on December 6, 2019, resident #68 was assessed, as he was in the dining room for dinner when the investigation began. A head to toe skin assessment was complete. No physical injury was noted and he did not recall the incident. He was calm with no distress noted.

· The incident did not cause injury or lasting mental anguish as evidence by no redness, or bruising on physical assessment, and no recollection of the incident. NA #1 was with NA#2 throughout her shift to include breaks and did not witness any other resident at any time to be at

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risk of any type of abuse.

· The RP was informed on Monday, December 9, 2019 of the incident.

· The medical director was informed of the incident on Tuesday, December 10, 2019.

· Local law enforcement notified on 12/17/19.

· NA #2 employment was terminated on Tuesday, December 10, 2019 because she admitted to "lightly popping" resident #68 on the hand when he was combative. She was remorseful, stated she knew the policy, and knew it was wrong. NA #2 stated she did not intend to harm the resident but was attempting to get him to let go of her hand. Fair Haven has a zero tolerance policy for abuse, warranting termination of employment.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

· All residents on NA #2's assignment, and the surrounding assignments (rooms 100-119) received skin assessments on 12/11/19. (Rooms 120-156) were completed on 12/12/19 Skin assessments were completed by the unit managers and wound nurse. No evidence of abuse on any residents. No new bruising when compared to the previous weekly skin assessments. NA #2 consistently works on the same assignment, and her last day worked prior to the alleged incident was December 1, 2019.

· Alert and oriented residents from rooms 100-119

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were interviewed on 12/11/19 by the social worker and assistant administrator. All residents interviewed denied abuse or mistreatment from staff.

· Alert and oriented residents from rooms 120-156 were interviewed on 12/12/19 by the social worker and assistant administrator. All residents interviewed denied abuse or mistreatment from staff.

· All residents/families may file a grievance with the facility or state agency concerning resident abuse, neglect, exploitation, and misappropriation of resident property in the facility. This information is provided upon admission and is available on the resident information board.

· Education began on the evening of Friday, December 6, 2019. This included the abuse policy, reporting abuse immediately, as well as approach with resident's with dementia/aggressive behaviors.

· Education began on the evening of Friday, December 6, 2019. This included the abuse policy, reporting abuse immediately, as well as approach with resident's with dementia/aggressive behaviors. This education was started by the assistant administrator to the direct care staff. The education continued throughout the weekend, on all shifts, and is ongoing until it is completed by all staff employed by Fair Haven of Forest City, as well as therapy staff working at Fair Haven of Forest City. The assistant administrator, DON, ADON, and unit managers will continue the education until completion. All staff will require this education to be completed before they are allowed to work. All

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staff includes, nursing (nurses and CNAs), activities, dietary, housekeeping, laundry, maintenance, and therapy.

· The approach education included:

10 tips for dealing with aggressive behavior in dementia

1. Be prepared with realistic expectations
Reminding yourself that challenging behavior and aggressive outbursts are normal symptoms of dementia helps you respond in a calm and supportive way.

· Knowing that these episodes are a common part of the disease reduces your shock and surprise when it does happen and may also make it a little easier to not take the behavior personally.

2. Try to identify the immediate cause or trigger
Think about what happened just before the aggressive outburst started. Something like fear, frustration, or pain might have triggered it.

· For example, your resident might start yelling at empty areas of the room and telling people to get out. Looking around, you might notice that the room is starting to get darker because it's early evening. The dim light causes shadowing in the corners of the room, making it seem like there are people in the corner.

· After identifying that potential trigger, turn on the lights to get rid of the shadowy corners. That will hopefully help the resident calm down. And, in the future you'll know to turn on the lights before the room gets too dim.

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· In another example, you could have unintentionally approached them from behind and startled them. In a sensitive moment, that could make them feel attacked and so they lash out in what they perceive as self-defense.

3. Rule out pain as the cause of the behavior

Pain and physical discomfort can trigger aggressive behavior in someone with dementia.

· Many older adults with dementia aren't able to clearly communicate when something is bothering them. Instead, being in pain or discomfort could cause them to act out.

· Check to see if they need pain medication for existing conditions like arthritis or gout, if their seat is comfortable, or if they need to use the toilet.

4. Use a gentle tone and reassuring touch
When your older adult gets upset, take a deep breath and stay as calm as possible. If you're upset, that unintentionally continues escalating the tense emotions in the situation.

· Staying calm and breathing slowly helps to reduce everyone's anger and agitation. Speak slowly and keep your voice soft, reassuring, and positive.

· If appropriate, use a gentle and calming touch on the arm or shoulder to provide comfort and reassurance.

5. Validate their feelings

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If your resident is being aggressive and there isn't an obvious cause, it could be because they're having strong negative feelings like frustration, sadness, or loneliness and don't know how to properly express themselves.

· Try to look for clues to their emotions in their behavior and speak in a calm and comforting way. Reassure them that it's ok to feel that way and that you're there to help.

6. Calm the environment

A noisy or busy environment could also trigger aggressive dementia behavior.

· If your older adult starts behaving aggressively, take notice of the environment to see if you can quickly calm the room. Turn down music volume, turn off the TV, and ask other people to leave the room.

7. Play their favorite music

Music has an amazing effect on mood.

· Sometimes, singing an old favorite song, humming a soothing tune, softly playing relaxing classical music, or playing their favorite sing-a-long tunes can quickly calm someone down.

8. Shift focus to a different activity

If the current or previous activity caused agitation or frustration, it could have provoked an aggressive response.

· After giving your resident a minute to vent their

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feelings, try to shift their attention to a different activity - something they typically enjoy.

9. Remove yourself from the room

In some cases, nothing works to calm the person.

· If that happens, it may be best to leave the room to give them some space and to give yourself time to calm down and regain balance. They may be able to calm themselves or might even forget that they're angry.

· Before leaving, check to see that the environment is safe and that they're not likely to hurt themselves while you're gone.

10. Make sure you and your resident are safe and call for help in emergencies

If your resident can't calm down and is becoming a danger to you or to themselves, you'll need help from others.

· If the situation isn't extreme and there's a nearby staff member usually responds well to, call and ask them to come over to help immediately.

· Always notify a supervisor if the resident is unable to be calmed, and remove yourself from the situation if you feel you are getting aggravated.

· It is never acceptable to pop, smack, punch, hit, punish or inflict harm as a response to a combative resident.

· Resident #68's is care planned for disruptive

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behaviors and combative episodes with care.
The education provided for this alleged incident includes some of the approaches consistent with resident #68's care plan. However, his name was not included in the education for his privacy and protection. The 10 tips are appropriate for any disruptive / combative behaviors exhibited, and appropriate for resident #68's daily care.

· Abuse education is provided to new hires, annually, and as needed throughout the year.

· Dementia education is provided to new hires, annually, and as needed throughout the year. The virtual dementia tour is also provided annually.

· Education will be conducted with Hospice staff before they are allowed to work in the facility. This education will be conducted by the assistant administrator, DON, and/or ADON. The hospice supervisor was informed of this requirement on December 11, 2019 at 5:45 pm. A list of all hospice staff assigned to the facility was requested to ensure completion of education before they provide care to residents in the facility.
This plan has been implemented and all staff providing care has received the needed education. The administrator and DON will be responsible for continuing and maintaining the plan.

The facility alleges IJ removal date of Thursday, December 12, 2019.

The credible allegation for Immediate Jeopardy removal was validated on 12/12/19 at 4:30 PM, as evidenced by staff interviews, in-service record reviews and observation. The in-services

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F 600	Continued From page 16 included information on caring for aggressive residents with dementia, abuse and neglect policies and procedures, types of abuse and reporting incidents of abuse. Interview's were conducted with alert and oriented residents residing in rooms which NA#2 had worked regarding mistreatment from staff or abuse. None of the residents interviewed reported being abused or mistreated by NA #2 or any other staff member.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, Nurse Aide (NA) #1 failed to report abuse immediately after observing NA #2 impose abuse to a resident and which allowed NA #2 to continue to work the rest of her shift for 1 of 1 resident reviewed for abuse (Resident #68). Immediate jeopardy began on 12/6/19 when NA #1 observed NA #2 pop Resident #68 in the chest at 7:30 AM and did not report the incident to the Assistant Director of Nursing (ADON) until after	F 607	Disclaimer: The following information is provided by request, in follow up to the survey conducted, and does not represent the facility admitting to, or agreeing to the alleged deficient practice. Resident #68 assessed for physical injury at 6:30pm on 12/6/19. Head to toe skin assessment completed by the wound	12/23/19

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F 607	Continued From page 17 3:30 PM on 12/6/19, which allowed NA #2 to work the rest of the shift. Immediate Jeopardy was removed on 12/12/19 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: Review of the facility's Abuse Prohibition policy which was revised August 1st, 2017 included the following in part: Under protocol for reporting abuse: A. If you have reason to believe, as a reasonable person, that abuse, neglect, or misappropriation of resident property has occurred you are responsible to immediately notify a person in charge, Administrator or designee. B. Safety of the resident shall be protected at all times while the investigation is in progress. Resident #68 was admitted to the facility on 07/19/19. An interview conducted on 12/10/19 at 1:46 PM with NA #1 revealed she had been working in the facility for 3 days on 12/06/19. She stated she was paired with NA#2 on that day for orientation. NA #1 stated a Hospice NA (NA #3) was in the facility and requested assistance with giving Resident #68 a bed bath. The interview revealed NA #2 had gotten on Resident #68's eye level and	F 607	nurse revealed no redness, swelling, bruising, or abnormality. Resident #68 demonstrated no lasting mental anguish as evidence by no recollection of the alleged incident. Residents on NA#2□s assignment, and the surrounding assignments (rooms 100-119) received head to toe skin assessments on 12/11/19. The remainder of residents (rooms 120-156) received head to toe skin assessments on 12/12/19. The skin assessments were completed by the unit managers and the wound nurse. No evidence of abuse noted on any residents. No new bruising when compared to the previous weekly skin assessments. Alert and oriented residents from rooms 100-119 were interviewed on 12/11/19 by the social worker and assistant administrator. All residents interviewed denied abuse or mistreatment from staff. Alert and oriented residents from rooms 120-156 were interviewed on 12/12/19 by the social worker and assistant administrator. All residents interviewed denied abuse or mistreatment by staff. Education began on the evening of Friday, December 6, 2019. This included the abuse policy, reporting abuse	

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F 607	Continued From page 18 asked him if the staff could get him dressed and give him a bed bath, Resident #68 became aggressive grabbing NA#3's hand, sinking his nails into her skin, trying to kick and hit. NA #2 then stated to the resident "stop, quit being a bxxxx" and popped him in the right upper chest area (not hard but a small tap) which made the resident more agitated hitting and kicking resisting care. NA #3 then stated to NA #2, "I don't believe smacking him helps the situation." NA #1 stated the staff continued to provide care and dress Resident #68 stating he did not become calm until he was placed in his wheelchair. Once the resident was placed in his wheelchair, he became approachable and calm. The interview revealed NA #1 did not see any red marks on Resident #68's skin from where NA #2 had popped him. NA #1 stated the incident happened on 12/06/19 at 7:30 AM and she did not report the incident to the Assistant Director of Nursing (ADON) until after 3:30 PM on 12/06/19. NA #1 said she did not report the incident immediately because she was a new staff member to the facility and was concerned to tell on NA #2. The interview revealed NA #1 had received an orientation on abuse on the Tuesday before the incident regarding how to handle an abuse situation and to report the allegation to administrative staff immediately. NA #1 stated she did not tell the nurse on duty because she had previously worked with the Assistant Director of Nursing (ADON) and felt more comfortable notifying her. On 12/10/19 at 1:58 PM an interview was conducted with NA #3. She stated Resident #68 would often become agitated and aggressive during a bed bath hitting, pinching and cursing at staff. NA #3 said she never gave Resident #68 a	F 607	immediately, as well as approach with resident□s with dementia/ aggressive behaviors. This education was started by the assistant administrator to the direct care staff. The education continued throughout the weekend, on all shifts, and will continue until it is completed by all staff employed by Fair Haven of Forest City, as well as therapy staff working at Fair Haven of Forest City. The assistant administrator, DON, ADON, and unit managers will continue the education until completion. All staff will require this education to be completed before they are allowed to work. All staff includes, nursing (nurses and CNAs), activities, dietary, housekeeping, laundry, maintenance, therapy, and hospice. Completion date: 12/23/2019 Abuse education will continue to be provided upon hire, annually, and as needed throughout the year. Dementia education will continue to be provided upon hire, annually, and as needed throughout the year. Audits will consist of staff interviews to ensure competence of the abuse policy, including immediate reporting of suspected abuse, and approach with dementia/ aggressive behaviors. Staff interviews will be completed on new hires and current employees, including	

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F 607	Continued From page 19 bath alone, he required someone else to assist and one of the NAs from the facility always helped her on Fridays. The interview revealed NA #3 asked NA #2 to assist her in giving Resident #68 a bed bath on 12/06/19. NA #2 was training NA #1 so all three of the staff entered the room. Once in the room she stated she was on one side of the bed, NA #2 was on the other side and NA #1 was standing at the foot of the bed observing. NA #3 stated at first Resident #68 wasn't hitting, he was holding NA #2's hands while she washed his side. Resident #68 began to become aggressive hitting at NA #2 and NA #3. NA #3 stated NA #2 began making smacking gestures with her hands in the air at Resident #68 and he was becoming more aggressive. NA #3 stated the resident had grabbed her hand and was pinching her fingers, so she turned the other way and closed her eyes. NA #3 stated she did not see nor hear NA #2's hand come into contact with Resident #68's skin. NA #3 said she told NA #2 that she was agitating him and making the situation worse which NA #2 did not acknowledge what NA #3 had told her. She stated she did not hear NA #2 curse at Resident #68. She stated Resident #68 would usually become combative when she started his bed bath however if she spoke to him in a calm manner he would calm down. NA #3 stated she reported the incident to her Hospice nurse on the afternoon of 12/06/19 and had not reported the incident to anyone in the facility. She stated the Director of Nursing (DON) had called her around 4:30 PM to receive a statement of what had happened. On 12/10/19 at 2:25 PM an interview was conducted with Hospice Nurse #1. She stated on 12/06/19 NA #3 reported to her she was writing a statement about something that had happened	F 607	RNs, LPNs, CNAs, activities, dietary, housekeeping, laundry, maintenance, therapy, and well as contract staff, such as hospice. Audits will be conducted by the administrator, assistant administrator, DON, and/ or ADON. Audits will be completed weekly for four weeks, and then every other week for four weeks, and then randomly. The audits will be tracked and presented by the assistant administrator and/or DON for review and monitoring in the facility's quality assurance meeting include a minimum of five employees each week of the audit, including new employees when possible. The next meeting is 1/21/2020. Completion date: 12/23/2019	

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that morning while she was in the facility giving a resident a bath. Hospice Nurse #1 stated she could not recall the exact details of the incident and did not contact the facility because she knew an investigation was being completed since the DON had asked NA #3 for a statement.

On 12/10/19 at 2:11 PM an interview was conducted with NA #2. NA #2 stated on 12/06/19 at 7:30 AM she assisted NA #3 give Resident #68 a bed bath. She also had a new employee (NA #1) in the room observing care. The interview revealed Resident #68 was very combative so she held his hands so he didn't swing or hit NA #3 and turned his body towards her so NA #3 could wash his side and back. Resident #68 started becoming combative getting one of his arms loose and digging his nails into her hand trying to hurt her and cursing at her. NA #2 stated she popped his hand with her right opened hand one time. NA #2 stated Resident #68 continued to remain agitated until he was placed in his wheelchair. NA #2 stated she did not report the incident to her nurse because it was in her opinion normal behavior for Resident #68 because he was known to hit and kick at staff while providing care.

On 12/12/19 at 10:33 AM an interview was conducted with the ADON. She stated on 12/06/19 she was at a function with the DON and received a text message from NA #1 to call her and she returned the call to NA#1 around 4:30 PM. The ADON was with the DON when she received the information about the incident from NA#1 and the DON took over the investigation at that time.

On 12/10/19 at 3:03 PM an interview was

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conducted with the Director of Nursing (DON). She stated she had received a phone call from NA #1 at 4:30 PM regarding the incident. The DON said NA #1 reported NA #3 and NA #2 were completing a bed bath for Resident #68 earlier in the day at 7:30 AM and NA #2 had smacked Resident #68 on his arm/shoulder area. NA #1 reported to her that NA #3 had told NA #2 she was only making the situation worse. The interview revealed she had spoken with NA #2 who said she was holding Resident #68's hand to distract him while NA #3 washed his side. NA#2 had stated to the DON she had lightly popped the resident's hand to get him to let go of NA #3. The DON stated NA #2 had demonstrated to her how she had popped his hand. The DON stated she had interviewed NA #3 who said she had turned away from the incident but had seen NA #2 making a smacking motion in the air before she turned away. She stated following the incident a skin assessment was completed for Resident #68 which revealed no skin abnormalities. The DON explained that NA #3 had told her she didn ' t report the incident immediately because she had turned away from Resident #68 and did not see NA #2 hit the resident however when she saw the smacking motion towards the resident it had made her feel uncomfortable. The interview revealed 12/06/19 made NA #1's third day working in the facility and she did not know all of the staff working in the building. She stated NAs should report to their supervisor immediately if they have a concern regarding abuse and not wait an entire shift. The DON confirmed NA #1 had received abuse training during orientation and had been told to report allegations immediately per facility policy.

On 12/12/19 at 10:01 AM an interview was

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conducted with Nurse Manager #1. She stated she was responsible for competency training in the facility and in-servicing. Nurse Manager #1 stated staff receive abuse training upon hire, annually and as needed throughout the year. She stated staff are trained to immediately report any allegation or suspicion of abuse immediately.

The Administrator was notified of the Immediate Jeopardy on 12/11/19 at 2:30 PM. On 12/12/19 at 4:30 PM the facility provided the following credible allegation of Immediate Jeopardy removal.

F 607 Removal Plan

Identify those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of noncompliance:

· Nurse Aide (NA) #1 messaged the ADON at around 3:30pm when she had left the facility. The ADON did not receive the message and call NA #1 until around 4:30pm. NA #1 stated she was scared to report the abuse allegation earlier because she was a new and still in training. She felt the need to report it but waited until after her shift because of this fear. She stated she was more comfortable talking to the ADON because they worked together in previous years. NA #1 reported the following to the ADON:

· On December 6, 2019 at around 4:30pm, NA #1 reported that during her orientation earlier that day (before breakfast), she witnessed NA#2 popped resident #68 "in the right upper chest area" while telling him to "stop and quit being a bitch" during personal care. NA #1 stated that the hospice nurse aide (NA #3) was also in the room,

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and she commented "that will only make it worse". This was reported to the ADON and DON at the same time. NA #2 was removed from the floor at 4:50pm.

· 24-hour report was submitted on December 6, 2019 at 5:58pm. Investigation started immediately.

· Local law enforcement notified on 12/17/19.

· NA #1 was on her third day of orientation. She received abuse education upon hire.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

· Education began on the evening of Friday, December 6, 2019. This included the abuse policy, reporting abuse immediately, as well as approach with resident's with dementia / aggressive behaviors. This education was started by the assistant administrator to the direct care staff. The education continued throughout the weekend, on all shifts, and is ongoing until it is completed by all staff employed by Fair Haven of Forest City, as well as therapy staff working at Fair Haven of Forest City. The assistant administrator, DON, ADON, and unit managers will continue the education until completion. All staff will require this education to be completed before they are allowed to work. All staff includes, nursing (nurses and CNAs), activities, dietary, housekeeping, laundry, maintenance, and therapy.

· The re-education was focused on the

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F 607	Continued From page 24	F 607		

importance to report immediately to remove the potential threat and provide resident protection from any further potential incidents. This focus on the abuse policy will be a process improvement for education provided to new hires, annually, and as needed.

· Abuse education is provided to new hires, annually, and as needed throughout the year.

· Education will be conducted with Hospice staff before they are allowed to work in the facility. This education will be conducted by the assistant administrator, DON, and/or ADON. The hospice supervisor was informed of this requirement on December 11, 2019 at 5:45pm. A list of all hospice staff assigned to the facility was requested to ensure completion of education before they provide care to residents in the facility.

· NA #1 will receive written discipline on December 12, 2019 due to not immediately reporting the allegation in addition to the verbal counseling and education that was completed on December 6, 2019.

This plan has been implemented and all staff providing care has received the needed education. The administrator and DON will be responsible for continuing and maintaining the plan.

The facility alleges IJ removal date of Thursday, December 12, 2019.

The credible allegation for Immediate Jeopardy removal was validated on 12/12/19 at 4:30 PM, as evidenced by staff interviews and in-service

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F 607	Continued From page 25 record reviews. The in-services included information on caring for aggressive residents with dementia, abuse and neglect policies and procedures, types of abuse and reporting incidents of abuse.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit the Minimum Data Set (MDS) death in facility tracking record for 1 of 2 sampled closed records (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/8/18 with diagnoses that included diabetes, Alzheimer's disease, and cerebrovascular accident. The most recent transmitted MDS for Resident #1 was dated 6/14/19 and coded for a significant change in status assessment. No further MDS assessments had been transmitted. A review of the progress notes revealed that Resident #1 had expired (died) in the facility on 7/4/19. On 12/11/19 at 4:18 PM an interview was conducted with the MDS Nurse. The MDS Nurse verified that Resident #1 had expired in the facility on 7/4/19 and that a MDS death in the facility	F 641	Disclaimer: The following information is provided by request, in follow up to the survey conducted, and does not represent the facility admitting to, or agreeing to the alleged deficient practice. The MDS for death in the facility was completed, submitted, and accepted for resident #1 on 12/14/19 at 2:27pm. This was completed as soon as the missing assessment was identified. Residents who expire while in the facility potentially affected by the alleged deficient practice. An audit was completed by the MDS nurse on 12/16/19 on residents who expired in the facility over the past six	1/10/20

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F 641	Continued From page 26 tracking record had not been completed. She reported that one should have been completed and transmitted, and that it was an oversight. An interview was completed with the Director of Nursing (DON) on 12/12/19 at 2:36 PM. The DON reported that she expected the MDS assessments to be coded and transmitted timely. In an interview with the Administrator on 12/12/19 at 3:06 PM he indicated that the MDS assessments should be submitted in a timely manner.	F 641	months. No other MDS assessments missing. No systemic issues identified. No systemic changes necessary in the MDS scheduling process, as this alleged deficient practice was human error, with no systemic issues identified. The MDS nurse was re-educated on 1/2/2020 by the assistant administrator. the education included the requirement of completing an MDS when a resident expires in the facility. For three months, the DON or ADON will complete a monthly audit of residents who expire in facility to ensure the MDS are complete. These audits will be presented by the DON or ADON for review and monitoring in the facility's quality assurance meetings for three months. The next meeting is 1/21/2020. Completion date: 1/10/2020	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		1/10/20

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resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation and staff

Disclaimer: The following information is

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F 656	Continued From page 28 interviews, the facility failed to develop a care plan regarding communication for 1 of 1 sampled resident for communication (Resident #14) and failed to implement a care plan intervention for monitoring the use of psychotropic medications for 1 of 5 sampled residents for unnecessary medications (Resident #22). The findings included: 1. Resident #14 was admitted to the facility on 3/13/15 with diagnoses that included dementia, psychotic disorder and mood disorders. A review of the annual Minimum Data Set (MDS) assessment dated 8/28/19 revealed Resident #14 was moderately cognitively impaired and had unclear speech with slurred or mumbled words. Resident #14 had difficulty communicating some words or finishing thoughts but was able to make himself understood if prompted or given time. His ability to understand others was coded as having clear comprehension. He did not have a diagnosis that involved stuttering. The Care Area Assessment (CAA) for communication indicated Resident #14 had difficulty communicating in a manner that was understood. Resident #14 had constant tremors which resulted in stuttering when he attempted to speak and made his speech unclear. The CAA further indicated that the facility would proceed to care plan to address Resident #14's communication. A review of Resident #14's care plan which was last updated on 12/7/19 revealed no care plan interventions to address Resident #14's communication issues. On 12/9/19 at 4:34 PM, an observation was	F 656	provided by request, in follow up to the survey conducted, and does not represent the facility admitting to, or agreeing to the alleged deficient practice. A communication care plan was completed and placed on chart for resident #14□s on 12/12/19 by MDS nurse. Revision made to Resident #22□s care plan to reflect AIMS assessment to be completed per policy in place of quarterly and as needed for psychotropic medication use. Completed on 12/13/19 by DON. Every resident currently residing, and all admitted to skilled nursing potentially affected by alleged deficient practice due to care plan requirements. Education to be completed with the interdisciplinary team (IDT) on the importance of accuracy with care plans and follow through from the MDS CAA to the care plan. This education will be done by the assistant administrator, DON and/or ADON. The IDT consists of the MDS nurse, dietary director, activities	

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F 656	Continued From page 29 made, and an interview was attempted with Resident #14. When asked questions, Resident #14 just stared at the surveyor, smiled and did not answer any questions. On 12/11/19 at 8:35 AM, an interview with nurse aide (NA) #1 revealed she had assisted Resident #14 with lunch one time and was not sure if Resident #14 could talk because she had not heard him speak and Resident #14 did not talk back to her. On 12/11/19 at 4:22 PM, an interview with the MDS nurse revealed Resident #14's CAA for communication was completed by the Social Worker and after reviewing Resident #14's current care plan, the MDS nurse stated the Social Worker should have also completed a care plan addressing his communication issues. On 12/11/19 at 5:10 PM, an interview conducted with the Social Worker revealed Resident #14 had trouble communicating and stuttered sometimes. The Social Worker shared that Resident #14 should be given time to respond and sometimes he would not talk to people whom he didn't like or didn't know. The Social Worker agreed that a care plan for communication should have been developed for Resident #14 and was unsure why she missed it. The Social Worker stated she must have overlooked it and would fix Resident #14's care plan to include communication. On 12/12/19 at 2:38 PM, an interview conducted with the Director of Nursing (DON) revealed that if Resident #14 triggered for communication in his CAA, then he should have had a care plan for communication. The DON was unsure how	F 656	director, social worker, and therapy director. Completion date: 1/10/2020 Care plan meetings will continue to be held weekly by the IDT to review care plans for accuracy and completion. Audits will be completed on care plans that have had recent MDS or admission care plan completed. Audits will include two care plans per week and consist of checking for accuracy, and to ensure all CAA have the needed care plan in place. The audits will be conducted by the assistant administrator, DON, and/or ADON. Audits will be presented by the assistant administrator or DON for review and monitoring in the facility's quality assurance meetings for three months. Audits will be completed weekly for four weeks, and then every other week for four weeks, and then as needed. The next meeting is 1/21/2020. Completion date: 1/10/2020	

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Resident #14's care plan for communication was missed.

On 12/12/19 at 3:05 PM, an interview with the Administrator revealed he agreed that communication should have been added to Resident #14's care plan after he reviewed his CAA and his current care plan.

2. Resident #22 was admitted to the facility on 3/12/19 with diagnoses that included paranoid personality disorder and psychotic disorder with delusions. She was last re-admitted to the facility on 11/22/19 after hospitalization with pneumonia.

A review of Resident #22's care plan dated 6/7/19 revealed Resident #22 was at risk of adverse effects of psychotropic medications. One of the approaches listed was Abnormal Involuntary Movement Scale (AIMS) quarterly and as needed with changes.

Further review of Resident #22's medical record revealed an AIMS assessment dated 6/7/19 which indicated no abnormal involuntary movements were observed.

A review of the quarterly minimum data set (MDS) assessment dated 9/11/19 revealed Resident #22 was moderately cognitively impaired, had no behaviors and received a psychotropic medication routinely.

On 12/12/19 at 1:01 PM, an interview conducted with Unit Manager #1 revealed an AIMS assessment was done within 7 days of starting an antipsychotic medication and then every 6 months thereafter. Unit Manager #1 stated the third shift nurses were responsible for completing

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the AIMS assessment, but she was not sure who kept track of when Resident #22's AIMS assessment was due.

On 12/12/19 at 1:20 PM, an interview was conducted with the Director of Nursing (DON) who stated that the facility had identified a problem regarding AIMS assessment not being completed timely. The facility did not have a designated staff member to keep up with the schedule of when AIMS assessments were due. The DON further stated that she thought the AIMS assessment was included in a group of assessments called user-defined assessments for which the unit managers were responsible for. She recently realized that it was not and agreed that an AIMS assessment should have been completed for Resident #22 when she had an increase in her antipsychotic medication in October. The DON said the statement that AIMS should be done quarterly in Resident #22's care plan was inaccurate and should have read every 6 months and as needed with any changes.

On 12/12/19 at 2:14 PM, an interview with the MDS Nurse revealed she had not been aware that AIMS assessments were not being done quarterly on Resident #22. The MDS Nurse shared that AIMS assessments were supposed to be done every 6 months and not quarterly as what was stated in Resident #22's care plan, and that she needed to make a correction in Resident #22's care plan.

On 12/12/19 at 3:05 PM, an interview with the Administrator revealed that he recognized that Resident #22's AIMS assessment not being completed timely was a problem and the facility was working on a plan to correct this deficiency.

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to update a care plan for 1 of 1 resident (Resident #49) to reflect the nothing by mouth (NPO) status of the resident. Findings included:	F 657	Disclaimer: The following information is provided by request, in follow up to the survey conducted, and does not represent the facility admitting to, or agreeing to the alleged deficient practice.	1/10/20

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F 657	Continued From page 33 Resident #49 was admitted to the facility on 07/26/16. Her diagnoses included food in respiratory tract causing asphyxiation, diabetes and cerebral vascular accident. A review of Resident #49's quarterly Minimum Data Set (MDS) dated 10/02/19 revealed she was cognitively intact for daily decision making and required extensive assistance of 1 staff member for eating due to her feeding tube. Resident #49 received 51% or more of her calories through tube feeding and average fluid intake of 501 cubic centimeters (cc) through her tube feedings. A review of Resident #49's care plan dated 10/09/19 revealed she had a PEG tube related to her inability to swallow food without aspirating all consistency. The resident is receiving bolus feedings and water flushes as ordered by physician. The goal was for the resident to receive feedings and flushes as indicated along with maintaining weight through the next review date of 01/09/2020. The interventions included to administer bolus feedings and flushes as prescribed by physician, administer medications via feeding tube, maintain NPO status, insure tube is inserted and secured properly for feeding purposes, secure feeding tube to prevent dislodgement, check position of tube prior to giving feeding, check for residual gastric contents prior to each feeding, Nursing to withhold feeding if residual is 200 cc or greater as ordered by physician, document and notify physician, maintain resident in upright position after each feeding as indicated, observe skin condition around insertion site and document per protocol, report increased redness, temperature at site to physician, change tube site dressing as ordered by physician, document and report any	F 657	Revision made to Resident #49□s care plan to reflect NPO status. Completed on 1/6/20 by the MDS nurse. Any residents receiving tube feedings potentially affected by the alleged deficient practice. Only one other resident receiving tube feedings currently residing in facility. Care plan reviewed and reflects resident centered care, specific to the resident. No widespread issues identified. Education to be completed with the interdisciplinary team (IDT) on the importance of accuracy with care plans. This education will be done by the assistant administrator, DON and/or ADON. The IDT consists of the MDS nurse, dietary director, activities director, social worker, and therapy director. Completion date: 1/10/20 Care plan meetings will continue to be held weekly by the IDT to review care plans for accuracy and completion. Audits will be completed on care plans	

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F 657	Continued From page 34 abnormalities to physician, report any significant fluid balance discrepancy to physician including decreased output, weigh resident as indicated, document and report any significant variance to physician, dietician to review resident dietary regimen and document as indicated. Further review of Resident #49's care plan dated 10/09/19 revealed she had a care plan for being edentulous with top dentures, and she was NPO related to new PEG tube placement. The goal was for the resident to be able to chew food sufficiently to swallow without difficulty through the next review of 01/09/2020. The interventions included provide dental services per protocol and as needed, dietician to evaluate per protocol, determine resident food likes/dislikes, provide oral care per protocol and as needed, monitor food intake at each meal, record and report decline in intake to physician and dietician. A review of Resident #49's physician orders dated 10/10/19 revealed she was NPO with Percutaneous Esophageal Gastrostomy (PEG) tube feedings and flushes before and after medications with all medications and feedings to be given via tube. Resident #49 was hospitalized from 11/23/19 through 11/26/19 for dyspnea, coughing, hypoxemia and aspiration pneumonia. She was treated for the aspiration pneumonia with intravenous (IV) antibiotics and switched to oral antibiotics and transferred back to the facility to continue care. It was recommended the resident remain NPO (nothing by mouth) due to swallowing exam revealing all food and liquids swallowed went into the resident's lungs. Orders were written for tube feedings via Resident #49's	F 657	that have had recent MDS or admission care plan completed. Audits will include two care plans per week and consist of checking for accuracy, and resident specific interventions. The audits will be conducted by the assistant administrator, DON, and/or ADON. The assistant administrator or DON will present the audits for review and monitoring in the facility's quality assurance meetings for three months. Audits will be completed weekly for four weeks, and then every other week for four weeks, and then as needed. The next meeting is 1/21/2020. Completion date: 1/10/2020	

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feeding tube.

A review of Resident #49's physician orders dated 11/26/19 revealed she was again NPO with PEG tube feedings and flushes before and after medications with all medications and feedings to be given via tube.

An interview with Resident #49 on 12/11/19 at 1:43 PM revealed she was not eating anything by mouth and resident stated she could not remember the last time she had something to eat.

An interview on 12/11/19 at 3:50 PM with Nurse #2 revealed Resident #49 was NPO due to aspiration pneumonia. She stated the resident had just recently been hospitalized for aspiration and pneumonia and as a result was no longer allowed to have food.

An interview with the MDS Coordinator on 12/12/19 at 2:14 PM revealed she had not done Resident #49's Care Area Assessment (CAA) summary or care plan for nutrition but said it had been completed by the Dietary Manager.

An interview with the Dietary Manager on 12/12/19 at 2:49 PM revealed he had completed the nutritional and feeding tube CAA summary and care plan for Resident #49. He stated he had not discontinued the care plan regarding her being able to chew her food and swallow because the resident had hoped she would be able to have comfort foods. The Dietary Manager stated he was aware that any food or drink the resident swallowed would go into her lungs and stated he was aware the physician had written orders for the resident to remain NPO as a result of her swallowing exam. He was not able to answer

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F 657	Continued From page 36 why the care plan had not been updated. An interview was conducted on 12/12/19 at 2:25 PM with the Director of Nursing (DON). She stated she would have expected Resident #49's care plan to have been updated to reflect that she could not have any food or drink by mouth. According to the DON, she would have expected if the resident was getting comfort foods interventions be in place to address the consequences of her swallowing food or drink and the family be aware of all the consequences. She stated the care plan should have been more specific to Resident #49 and address her desires versus the physician orders and specific interventions to address her desires for food and drink. An interview on 12/12/19 at 3:09 PM with the Administrator revealed he would have expected Resident #49's care plan to have reflected her NPO status and interventions more specific to her and her care.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide supervision	F 689	Disclaimer: The following information is provided by request, in follow up to the	1/17/20

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F 689	Continued From page 37 to a prevent a fall from occurring for 1 of 3 residents who was left leaning to one side while in bed. (Resident #31). Resident #31 was admitted to the facility on 10/29/18 with diagnosis which included diabetes mellitus and cerebrovascular disorder (CVA). The quarterly minimum data set (MDS) dated 09/25/19 revealed Resident #31 was severely cognitively impaired. Resident #31 was assessed as requiring extensive assistance with bed mobility and dependent on staff members for transfers. His balance was assessed as unsteady, only able to stabilize with staff assistance. Resident #31 was assessed as having no behaviors. He had experienced two or more falls since the last assessment resulting in no injury and one fall resulting in a minor injury. The care plan dated 09/25/19 revealed a focus area for fall risk related to hemiplegia, epilepsy, and impaired mobility. The goal was for Resident #31 to experience no serious injuries related to falls through the next review to be completed on 01/02/20. Interventions included documenting all falls and surrounding circumstances, call light within reach, mechanical lift for all transfers, fall precautions in place, drop seat to wheelchair, concave mattress, fall mat at bedside and the bed against the wall. The resident incident report dated 09/04/19 revealed Resident #31 was on his bed and the nurse noted he was starting to lean to one side when the nurse left the room to get a nurse aide (NA) to help adjust Resident #31 in bed. When the nurse and NA returned to the room less than 30 seconds later the resident was noted to be on	F 689	survey conducted, and does not represent the facility admitting to, or agreeing to the alleged deficient practice. Resident # 31 will continue with interventions for fall reduction and prevention of fall related injuries, as they have been effective in preventing injuries related to falls. These interventions include a concave overlay on the air mattress, keeping the bed in low position, dycem underneath the mattress to prevent sliding, and fall mat at bedside. These interventions have been in place on the care plan, the CNA care guide, and staff is competent in person centered needs of resident #31. All residents identified as being affected by the risks of falling, which gives them the potential of being affected by the alleged deficient practice. Re-education to be completed with all staff on fall reduction and prevention. The education will include ensuring the resident is in a safe position, with interventions in place before leaving the room. This education will be done by the assistant administrator, DON and/or	

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F 689	Continued From page 38 the floor. The note revealed Resident #31 stated he was not hurt and did not know how the fall had happened. Immediate actions taken included assessing the resident for injuries, assisting the resident back into bed using a mechanical lift. Resident #31's fall mat was in place during the incident in which the resident landed on. The bed was in low position. A follow up assessment was completed 24 hours after the fall. Resident #31 had no signs of injury related to the recent fall. The nursing note dated 09/04/19 at 10:29 PM by Nurse #1 revealed at 5:30 PM he had noticed Resident #31 leaning to one side of the bed, so he left the room to go and get a NA, 30 seconds later when the two reentered the room Resident #31 was laying in the floor. A total lift was used to place the resident back into bed and his concave mattress was adjusted to better fit the resident. The resident experienced no injuries from the fall. On 12/12/19 at 9:08 AM an interview was conducted with Nurse #1. Nurse #1 stated he usually worked on the rehabilitation hall and not the hall in which Resident #31 resided. He stated on the evening of 09/04/19 he walked into the room and saw Resident #31 laying in the bed leaning to his side near the edge of the bed. Nurse #1 stated he then left the room to find a NA to assist him reposition the resident. The interview revealed by the time the nurse and NA got back into the room Resident #31 had experienced a fall and was on the floor lying on his right side. Nurse #1 said the residents call light was in place and working however he did not think to use the call light and just walked out of the room figuring that would be the quickest way to get help because he felt like the resident was falling out of his bed. He stated looking back at	F 689	ADON or unit managers. All staff consists of nursing (RN, LPN, CNA), dietary, activities, social worker, therapy, admissions, medical records, housekeeping, laundry, and maintenance. Completion date: 1/17/2020 Falls will continue to be a focus for staff, using games such as No Falls Bingo and Last Man Standing, as these have been successful. No systemic changes necessary, as an extensive fall program is in place, and working effectively. The alleged deficient practice is the result of a nursing judgement call made before the fall occurred, not a process failure. Falls will continue to be reviewed during morning meeting, and resident specific interventions placed as needed. The team members present in morning meeting are representatives from administration, nursing, dietary, therapy, social, activities, housekeeping, and maintenance. Falls interventions will continue to be reviewed for effectiveness in at risk meeting, which includes the DON, ADON, and MDS, and wound nurse. Audits to be conducted by the Administrator, assistant administrator, and/ or DON will ensure compliance with fall reviews in morning meeting, at risk	

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F 689	Continued From page 39	F 689		

the incident he would have stayed in the room to assist in preventing Resident #31 from falling. Nurse #1 stated following the fall he assessed the resident for any injuries in which he did not have any and assisted in transferring him back into the bed using a mechanical lift. He could not recall the NAs name who he went to get on 09/04/19.

On 12/12/19 at 9:27 AM an interview was conducted with NA #4 who was working with Nurse #1 on 09/04/19. NA #4 stated she remembered assisting a nurse get Resident #31 out of the floor but could not recall the nurse or date of the incident. The interview revealed NA #4 did not remember any details of the incident.

On 12/12/19 at 10:33 AM an interview was conducted with Nurse Manager #1. She stated she was responsible for competencies and training in the facility. The manager stated staff were trained to never leave a resident alone if they're at risk of a fall. When reviewing the incident report, she stated the nurse should have yelled for assistance or used the call light from inside of the room. The interview revealed all nurses attend yearly competency training.

On 12/12/19 at 10:36 AM an interview was conducted with Nurse Manager #2. She stated she was responsible for competencies and training in the facility. She stated the staff were trained that resident safety is the number one priority and to never leave a resident alone if you felt like they might experience a fall. When reviewing the incident report, she stated the nurse should have used the call bell or yelled for assistance in repositioning the resident for safety.

On 12/12/19 at 10:01 an interview was conducted

meeting held weekly. Falls will continue to be presented by the ADON or DON for review in the monthly quality assurance meeting. Audits will be completed weekly for four weeks, and then every other week for four weeks, and then as needed. The next quality assurance meeting is 1/21/2020.

Completion date: 1/17/2020

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F 689	Continued From page 40	F 689		

with the Assistant Director of Nursing (ADON). The ADON stated she reviewed all incident reports to ensure there was enough information and follows up on falls. She stated she puts interventions in place to prevent falls from reoccurring. When reviewing the incident from 09/04/19 with Resident #31 she stated the resident was considered a special situation because he had a history of leaning and getting into the floor and she did not see anything wrong with what Nurse #1 had done by leaving the resident. The ADON stated normally employees are told to always stay with the resident for safety and yell for assistance. She stated Resident #31's concave overlay was not secured on the bed and had to be placed back onto the bed after the fall.

An observation of Resident #31 conducted on 12/09/19 at 2:37 PM revealed the resident to be laying in the middle of the bed, the bed was in a low position with a fall mat at bedside. Resident #31's concave mattress was secured to the bed at that time.

A second observation of Resident #31 was conducted on 12/11/19 at 8:54 AM. Resident #31 was observed laying on his back in the middle of the bed, the bed was in a low position with a fall mat at bedside. Resident #31's concave mattress was secured to the bed at that time.

On 12/12/19 at 2:36 PM an interview was conducted with the Director of Nursing (DON). The DON stated Resident #31 leaned frequently over the side of the bed and they had interventions in place such as his fall mat. She stated she was not there during the incident and could not give a definite answer of what correct actions should have taken place stating it

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F 689	Continued From page 41 depended on nursing judgement. On 12/12/19 at 3:14 PM an interview was conducted with the Administrator. The Administrator stated he wanted to trust the judgement in his staff and trusted his nurses. He stated resident falls were a high focus in the facility and could not say exactly what the nurse should have done because he wasn't there during the fall.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		1/17/20

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F 758	Continued From page 42 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS) assessment after an increase in dose of an antipsychotic medication on 1 of 5 residents reviewed for unnecessary medications (Resident #22). The findings included: Resident #22 was admitted to the facility on 3/12/19 with diagnoses that included paranoid personality disorder and psychotic disorder with delusions. A review of Resident #22's Medication Administration Record for June 2019 revealed	F 758	Disclaimer: The following information is provided by request, in follow up to the survey conducted, and does not represent the facility admitting to, or agreeing to the alleged deficient practice. AIMS assessment completed on resident #22 on 12/13/19 by DON. Any resident receiving antipsychotic	

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F 758	Continued From page 43 she received Risperdal 0.5 mg (milligrams) one tablet by mouth at bedtime. An AIMS assessment dated 6/7/19 in Resident #22's medical record indicated no abnormal involuntary movements were observed. A review of Resident #22's care plan dated 6/7/19 revealed Resident #22 was at risk of adverse effects of psychotropic medications. The approaches listed included AIMS quarterly and as needed with changes, monitoring for possible medication dosage reductions and monitoring for changes in gait or tremors. A review of the quarterly minimum data set (MDS) assessment dated 9/11/19 revealed Resident #22 was moderately cognitively impaired, had no behaviors and received an antipsychotic medication routinely. A review of Resident #22's Physician Orders revealed orders on 10/18/19 for Risperdal 0.25 mg take one tablet by mouth every morning and Risperdal 0.5 mg take one tablet by mouth daily at 5 PM. An AIMS assessment had not been completed when Resident #22's anti-psychotic medication dose had been increased on 10/18/19. The AIMS assessment was used to check for abnormal involuntary movements due to possible side effects from the use of the antipsychotic medication. On 12/12/19 at 12:57 PM, an interview conducted with Nurse #2 revealed an AIMS assessment was usually done on admission and at regular intervals by the third shift nurses. Nurse #2	F 758	medications potentially affected by the alleged deficient practice. Audit completed on all residents on antipsychotic medications to ensure AIMS assessment has been completed timely. Completion date: 12/13/19 Education to be completed with nurses (RN and LPN) on completing AIMS assessments quarterly, using the same schedule as MDS due dates, and as needed with antipsychotic medication new orders and order changes. This education will be done by the DON and/or ADON, assistant administrator, or unit managers. Completion date: 1/17/20. Medication orders will continue to be reviewed in clinical meetings. The DON, ADON, MDS, and unit managers are present during these meetings. When new antipsychotic orders, and antipsychotic order changes are reviewed, an AIMS assessments will be scheduled by the DON, ADON, or MDS nurse. Audits will be completed on timely completion of AIMS assessments, which is quarterly, the start of therapy, and with dosage changes. The audits will include three residents receiving antipsychotic medications each week.	

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F 758	Continued From page 44 stated she was not sure how often it should have been done or who kept track of when Resident #22's AIMS assessment was due. On 12/12/19 at 1:01 PM, an interview conducted with Unit Manager #1 revealed an AIMS assessment was done within 7 days of starting an antipsychotic medication and then every 6 months thereafter. Unit Manager #1 stated the third shift nurses were responsible for completing the AIMS assessment, but she was not sure who kept track of when Resident #22's AIMS assessment was due. On 12/12/19 at 1:20 PM, an interview was conducted with the Director of Nursing (DON) who stated that the facility had identified a problem regarding AIMS assessment not being completed timely. The facility did not have a designated staff member to keep up with the schedule of when AIMS assessments were due. The DON further stated that she thought the AIMS assessment was included in a group of assessments called user-defined assessments for which the unit managers were responsible for. She recently realized that it was not and agreed that an AIMS assessment should have been completed for Resident #22 when her anti-psychotic medication dose was increased on 10/18/19. The DON shared an AIMS assessment should be completed on admission or re-admission, with any changes in the anti-psychotic medication dose and every 6 months thereafter. On 12/12/19 at 3:05 PM, an interview with the Administrator revealed that he recognized that Resident #22's AIMS assessment not being completed timely was a problem and the facility	F 758	The audits will be conducted by the DON, ADON, and/ or unit managers and reviewed in the weekly at risk meetings. The audits will be presented by the DON or ADON at the monthly quality assurance meetings for three months. Audits will be completed weekly for four weeks, and then every other week for four weeks, and then as needed. The next quality assurance meeting is scheduled for 1/21/2020. Completion date: 1/17/2020	

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F 758	Continued From page 45 was working on a plan to correct this deficiency.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard an opened and undated vial of Lantus insulin on 1 of 4 medication carts. Findings included: On 12/12/19 at 10:13 AM, an observation of	F 761	Disclaimer: The following information is provided by request, in follow up to the survey conducted, and does not represent the facility admitting to, or agreeing to the alleged deficient practice.	1/17/20

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F 761	Continued From page 46 Medication Cart A was conducted with Nurse #3 and revealed an opened and undated vial of Lantus insulin that was available for resident use. A pharmacy label on the vial revealed it was received by the facility on 9/5/19. On 12/12/19 at 10:15 AM, an interview was conducted with Nurse #3 who stated the Lantus insulin vial should have been dated when opened per facility policy and because the insulin had not been dated when opened there was no way to determine when the insulin had expired. Nurse #3 further stated Lantus insulin should be discarded after 28 days of being opened and the undated/opened Lantus insulin was last administered to a resident the evening prior. Nurse #3 discarded the opened and undated vial of Lantus. On 12/12/19 at 10:47 AM, an interview was conducted with Unit Manager #2 who verified the Lantus insulin vial was opened and undated and was available for resident use. Unit Manager #2 stated that the Lantus vial should have been dated when it was opened and was not sure how the vial was left in Medication Cart A available for resident use because the pharmacist had inspected all the medication carts the day before. She further stated the nurses were responsible for making sure all the insulin vials were dated and third shift nurses checked all the medication carts daily for outdated and expired medications. On 12/12/19 at 2:45 PM, an interview was conducted with the Director of Nursing (DON) who stated insulin should be dated when opened per facility policy. The DON shared the nurse assigned to the medication cart was responsible for making sure all insulin vials were dated but	F 761	Undated insulin was not administered to the resident. It was removed from the cart and discarded. Residents receiving injectable medications potentially affected by the alleged deficient practice. Education to be completed with nurses (RN and LPN) on dating bottles of insulin and other injectable medications when the bottle is opened. This education will be done by the DON, ADON, assistant administrator, or unit managers. Completion date: 1/17/20 Audits will be completed on medication carts for properly dated insulin and injectable medications. Audits will include checking all four medication carts. The audits will be conducted by the DON, and/or ADON or unit manager. The audits will be presented by the DON or ADON for review in the facility's quality assurance meetings for three months. Audits will be completed weekly for four weeks, and then every other week for four weeks, and	

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F 761	Continued From page 47 the unit managers also checked the medication carts daily. She further stated that the pharmacist had inspected all the medication carts the day before and was surprised that an undated and opened Lantus insulin vial was observed. On 12/12/19 at 3:16 PM, an interview was conducted with the Administrator who stated that staff should have followed the facility policy and dated the Lantus insulin vial when it was opened.	F 761	then as needed. The next quality assurance meeting is 1/21/2020. Completion date 1/17/2020	