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F 000	INITIAL COMMENTS A complaint investigation for intake # NC00159289 was conducted from 01/02/20 - 01/04/20. Past non compliance was identified at CFR 483.12 at tag F600 at a scope and severity (J). A partial extended survey was completed. A complaint investigation for intake #'s NC00159402, NC00157694 and NC00159034 was conducted from 01/02/20 - 01/04/20. There were 5 allegations. 1 of the 5 allegations was subtantiated with deficiency and 1 of the 5 allegations was subtantiated with deficiency for another resident and 3 of the 5 allegations were unsubstantiated.	F 000	Past noncompliance: no plan of correction required.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interviews and record review the facility failed to honor the preference of the resident and the resident's family to maintain a beard for 1 of 3 residents surveyed, Resident #1. The family expressed that the resident loved his beard and would be very upset if it was shaved off because he kept it all his adult life. Resident #1 was admitted to the facility on 08/05/19 with diagnoses that included, in part:	F 558	F588 Resident # 1 no longer resides in the facility. On 1/23/2020, 100% of all alert & oriented residents were interviewed regarding grooming preferences to include shaving by the social worker. On 1/23/2020, 100% of all non-alert and oriented resident's representatives were	2/3/20

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

Electronically Signed | 01/24/2020

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F 558	Continued From page 1 Acute respiratory failure with hypoxia, acute on chronic diastolic congestive heart failure and chronic obstructive pulmonary disease. He had a prognosis of less than 6 months to live and was receiving Hospice services. He expired at the facility on 10/28/19. Review of the Nursing 24-hour report sheet dated 10/12/19 revealed the following note: Resident #1-Responsible Party wants beard maintained at the beauty shop bi-monthly. A facility witness statement written on 10/27/19 by the Director of Nursing (DON) documented: "The (family) had requested two weeks ago that no one should shave Resident #1 except the beautician who could shape his beard up. This morning Aide #3 shaved this resident leaving his mustache. The family is upset because the resident is actively dying, and the family wants the resident to look normal." In an interview with the DON on 01/02/20 at 1:20 PM she stated she had learned Nurse #5 had spoken to the family and had been told not to shave Resident #1 two weeks prior to when the Aide shaved off the resident's beard. She commented Nurse #5 had not passed on the information to other staff members. She stated she educated Nurse #5 she should have put up a sign in the resident's room and told the assessment nurse so that the resident's care plan could have been updated. She said on the day Aide #5 shaved Resident #1 the aide was not aware of the family's wishes. She reported the family was upset and crying because the resident had a beard most of his life and they wanted him to look normal when he passed. She commented all she could do was apologize to the family	F 558	interviewed regarding grooming preferences to include shaving by the social worker. This audit is to ensure that all residents grooming preferences to include shaving are being honored. Any identified grooming preferences to include shaving will be reflected by updating the care plan and care guide. The Clinical Coordinators, Nursing Supervisor, Quality Assurance Nurse, Staff Development Coordinator, or Social Worker addressed all areas of concerns identified during the audit. On 01/02/2020 an in-service was initiated by the Staff Development Coordinator with all nursing staff in regards to residents preferences on grooming to include shaving. If any certified nursing assistant is made aware of a resident preferences to include grooming from the resident, residents family member or resident representative the preference will be communicated to the nurse. If any nurse is made aware of a resident preference on grooming to include shaving from the certified nursing assistant, resident, resident's family member or resident representative the care guide and care plan will be updated to reflect the resident's preference. The in-service was completed on 1/24/2020. All newly hired nursing staff will be in-serviced by the Staff Development Coordinator during orientation in regards to resident grooming preferences to include shaving. On 1/24/2020 an in-service was initiated by the Staff Development Coordinator with all nursing staff regarding reading the care	

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F 558	Continued From page 2 because she could not fix what had happened. In a telephone conversation with a family member of Resident #1 on 01/03/20 at 12:30 PM she stated Resident #1 had a beard all his adult life and she had instructed the facility not to shave the resident. She remarked when Resident #1 died he didn't even look like himself which was very upsetting to the family. In an interview with the facility Administrator on 01/02/20 at 4:22 PM she stated the family was upset because Resident #1 had a beard his whole life and was now unrecognizable to them. She said she apologized to the family who was crying because she couldn't fix the problem. In an interview with Nurse #5 on 01/03/20 at 9:00 AM she reported she cared for the Resident #1. She stated the family had reported to her during a telephone conversation not to shave the resident's beard. She remembered she had placed a note on the Nursing 24-hour report sheet instructing staff not to shave the resident but could not remember the date. In a telephone interview with Aide #3 on 01/03/20 at 3:30 PM she stated she had provided care to Resident #1. She commented he had hair all over his face and she shaved him during morning care. She reported she had previously worked for Hospice and it was the normal practice to try to make patients look "less sick" for the family during their final days of life by keeping them well groomed. She reported the family was in Resident #1's room when she began care but had left to make phone calls while she provided care. She said no one had told her not to shave the resident because had she known the family's	F 558	guide prior to providing care to ensure that all residents preferences to include shaving are honored. This in-service will be completed by 2/3/2020. All newly hired nursing staff will be in-serviced by the Staff Development Coordinator during orientation in regards to reading the care guide prior to providing care to ensure that all resident preferences to include shaving are honored. 10% of all residents will be observed weekly by the Social Worker or Assistant Director of Nursing weekly x 8 weeks and then monthly x 1 month utilizing the resident grooming preference audit tool. This audit is to ensure that all residents grooming preferences to include shaving are being honored. The nursing assistant will be reeducated for any identified areas of concerns. The Director of Nursing will review and initial the Resident Grooming Preference Audit Tool weekly x 8 weeks and then monthly x 1 month to ensure that all areas of concerns were addressed. The Administrator will present the findings of the Resident Grooming Preference Audit Tool to the Executive QA Committee x 3 months. The Executive QA Committee will meet monthly for 3 months and review the Resident Grooming Preference Audit Tool to determine trends and/or issues that may need further interventions and to determine need for further frequency of monitoring.	

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F 558	Continued From page 3 wishes she would not have shaved him.	F 558		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews and Adult Protective Services (APS) interview the facility failed to protect a resident ' s right to be free of sexual and physical abuse for 1 of 2 residents (Resident #6) reviewed for abuse. Resident #4 was observed naked while standing over Resident #6 ' s bed with both of his hands between her legs and inside her brief. Resident #6 said Resident #4 grabbed her vagina and slapped her face and the incident made her scared and very angry. Findings included: Resident #4 was admitted to the facility on 12/12/19. Diagnoses included dementia with behavioral disturbance.	F 600	Past noncompliance: no plan of correction required.	1/24/20

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Resident #4 ' s hospital expected discharge record written on 12/12/19 revealed a note by the hospital Social Worker which specified the resident no longer required a tele sitter (a computer camera device used to monitor a resident who required continued observation) at the hospital since 11/27/19 at 8:34 PM.

An interview was conducted with the Administrator on 01/02/20 at 4:20 PM. The Administrator reported she and the Admissions Coordinator went to the hospital just prior to Resident #4 being discharged and observed the resident in his hospital room sitting up in a recliner and he was noted to be pleasant. The Administrator reported he was not on 1 to 1 (staff to resident monitoring) and he seemed appropriate to be admitted to the facility. The Administrator reported the Director of Nursing (DON) reviewed the resident ' s admission record, and the DON felt the resident was appropriate for this facility. The Administrator and the Admissions Coordinator could not provide documentation to support why Resident #4 was requiring a tele sitter while hospitalized. The Administrator stated according to the discharge records, the tele sitter was discontinued on 11/27/19.

Resident #4 ' s baseline care plan dated 12/12/19 revealed a plan of care was in place for chronic/progressive decline in intellectual functioning characterized by deficit in memory, judgment, decision making and thought process related to dementia. The intervention included to allow and encourage resident to make choices. Additionally, a plan of care was in place for at risk for falls characterized by history of falls/actual

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falls, injury, multiple risk factors related to impaired balance, impaired cognition, impaired mobility and wandering.

The Minimum Data Set (MDS) dated 12/15/19, 5-day assessment revealed Resident #4 was severely cognitively impaired. Resident #4 presented with moods and behaviors such as physical behaviors including hitting, kicking, pushing, scratching and abusing others sexually for 1-3 days, refused care and wandered. The resident required limited assistance with one staff physical assistance with toileting and walked in and out of his room. Resident #4 received 4 days of antipsychotic medication and 3 days of antidepressant medication.

An interview was conducted with Nurse #7 on 01/03/20 at 12:42 PM. Nurse #7 indicated on 12/12/19 when the resident was admitted around 1:30 PM from the hospital, she did not receive any report or information from the nurse at the hospital about Resident #4. Nurse #7 stated the Nursing Assistants (NAs) put the resident in bed because she was in the middle of a medication pass when he arrived. Nurse #7 stated, after a short while, she went to Resident #4 ' s room to introduce herself and let him know that she would be back shortly to assess him. The nurse reported while she was at her medication cart, she noticed he had come into the hallway wearing only a brief and she redirected him back to his bed. Nurse #7 stated this happened a couple more times and she knew she was going to need to get some help with this resident. Nurse #7 reported Resident #4 was easily directed, however, he was persistent with disrobing and coming out to the hallways. Nurse #7 stated she went to the Quality Assurance (QA) Nurse and

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together they observed the resident, and he was, again, wearing only his brief and wandering in the hallway. Nurse #7 stated she asked the QA nurse to get a staff member to sit with him until she was able to get her med pass done and try to get the resident more settled. Nurse #7 stated she obtained an order for a one time dose of Seroquel (an antipsychotic medication) 25 milligrams which she administered to Resident #4 without difficulty while NA #4 sat with Resident #4. Nurse #7 stated she went back to Resident #4 ' s room to complete her assessment and obtain vital signs and she indicated the resident was not mean in demeanor, but pleasant, but he was calling out he needed help, refusing care when you tried to help, and became sexually inappropriate verbally. Nurse #7 stated NA #4 left at 4:00 PM and reported to her he was sleeping. Nurse #7 reported she went back to his room about 4:45 PM, assisted him into a Geri chair (reclining chair on wheels) and brought him to the nurse ' s station where the Evening Nurse Supervisor watched him until 7:00 PM. Nurse #7 reported she would not have considered the resident to be an actual 1 to 1, but she just needed sometime to help get him situated and keep him safe.

An interview was conducted with NA #4 on 01/03/20 at 11:15 AM. NA #4 stated when she went into Resident #4 ' s room on 12/12/19 he was pleasant, but he was saying sexually inappropriate things to her and Nurse #7 and making sexual hand gestures while touching his private areas. NA #4 stated he settled down and she covered him up and went to sleep. NA #4 stated she was in the room for about 2 hours and at 4:00 PM he was sleeping and it was time for her to leave. She stated Nurse #7 was down the

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end of the hall and she told Nurse #7 she was leaving, but she did not know if she heard her. NA #4 stated that no other staff member relieved her, but she felt safe leaving him at that time. NA #4 stated Resident #4 was just admitted and very disoriented and she was told she would be sitting with him until he settled down.

An interview with the Evening Nursing Supervisor (ENS) was conducted on 01/03/20 at 12:56 PM via phone. The ENS reported on the evening of 12/12/19, Nurse #7 brought Resident #4 to him in a Geri chair and asked that he keep an eye on him and explained that the was disrobing, getting out of bed and wandering upon admission. The ENS reported Resident #4 was confused and called out for help during the time he monitored him, but he was not combative, wandering or uncooperative and he was easily reassured and redirected. The ENS stated he monitored the resident from about 5:00 PM to 7:00 PM and at that time, NA #5 took him to his room to do care.

An interview was conducted with NA #5 via phone on 01/03/20 at 1:20 PM. NA #5 revealed when she arrived on 12/12/19 at 3:00 PM, she was told Resident #4 had been disrobing, wandering out of his room and being verbally sexually inappropriate with staff. NA #5 reported the resident was sitting with the ENS until about 7:00 PM when she took him to his room to do care. NA #5 stated he was verbally sexually inappropriate to her but she ignored what he was saying. NA #5 indicated she assisted the resident back into the Geri chair and placed him at the nurse ' s station so the staff could keep an eye on him. NA #5 reported at about 9:30 PM, she brought the resident to his room to complete incontinent care and get him ready for bed. NA

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#5 stated the resident continued to be verbally sexually inappropriate toward her and she reported that to the ENS. NA #5 reported he went to sleep and there were no further issues for the remainder of the 3:00 PM - 11:00 PM shift.

A behavior monitoring sheet for Resident #4 revealed there were no behaviors during the night shift starting on 12/13/19 and throughout the day on 12/13/19. Behaviors were documented on 2nd shift on 12/14/19.

A nursing behavior note, written by Nurse #4 on 12/14/19 at 4:40 PM revealed, in part, Resident #4 wandered into Resident #6 ' s room. Resident #4 was redirected and a wander guard was placed on Resident #4 ' s left ankle.

Resident #6 was admitted to the facility on 01/08/19. Diagnoses included diabetes, anxiety, and chronic kidney disease, above the knee right amputation, depression, high blood pressure, chronic obstructive pulmonary disease and atrial fibrillation.

The MDS quarterly assessment dated 10/17/19 revealed the resident was cognitively aware and she did not exhibit any behaviors. Resident #6 required extensive assistance with one staff physical assistance with bed mobility. She had impairment to one side to the lower extremity and used a wheelchair.

A review of the physician orders revealed there were no orders for scheduled or as needed antianxiety medications to be administered and a psychiatric consult was ordered on 12/20/19 due to recent resident to resident altercation.

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An interview was conducted with Resident #6 on 01/03/20 at 3:15 PM. Resident #6 revealed on the afternoon of 12/14/19 she was sitting up in her wheelchair when a man came into her room wearing just a brief, walked around her wheelchair and sat on her bed and began to eat her popcorn. Resident #6 stated she told the man he did not belong there, and he stated he was cold. Resident #6 stated a visitor had arrived to see her and asked who was this man sitting on her bed? Resident #6 reported she called out to Nurse #4 that there was a man in her room in her bed. Resident #6 stated NA #5 came in and escorted him out of the room. Resident #6 reported Resident #4 did not say anything inappropriate to her and she and the visitor thought it was kind of funny that he came into the room and sat on the bed and ate her popcorn. Resident #6 stated she had never seen Resident #4 before and she did not see him again until the early morning hour the next day (about 5:00 AM or so). Resident #6 reported she woke up to this man standing naked next to her bed who pulled back her covers and stated "I want to see your old pussy." Resident #6 stated she tried to push him away and he slapped her in the face. Resident #6 reported Resident #4 put his hands under her brief and felt her vagina, but he did not penetrate her. Resident #6 stated she yelled for help and Nurse #3 came in and took Resident #4 out of the room. Resident #6 stated Nurse #2 also came into the room to talk with her and reassured her everything was okay and she was safe. Resident #6 reported she was scared after the incident occurred and very angry and she reported her face hurt. Resident #6 stated the police came and took a report and Nurse #2 asked if she could contact anyone for her, but she declined at this time to have family notified

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because she needed to process what just happened and she was embarrassed.

An interview was conducted with NA #5 via phone on 01/03/20 at 1:20 PM. NA #5 reported on 12/14/19 at around 3:45 PM she had heard Resident #6 yelling "help me, there is a man in my bed." NA #5 stated she went into Resident #6 ' s room and noted Resident #6 was sitting in her wheelchair while Resident #4 was sitting on her bed wearing only a brief and eating popcorn. NA #5 reported Resident #6 rolled her wheelchair to the doorway and notified Nurse #4. NA #5 redirected Resident #4 out of Resident #6 ' s room and brought him to his room which was located directly beside Resident #6 ' s room. NA #5 stated Resident #4 did not say anything to Resident #6 while she escorted him out of the room and he remained in his room for the rest of the evening shift and she checked on him every 30 minutes. NA #5 reported he was not wandering throughout the shift, but he was demonstrating behaviors by being verbally sexually inappropriate with her (NA #5) when she was providing care throughout the evening. NA #5 stated she reported the behaviors to Nurse #2.

A review of a written statement by Nurse #4 revealed at 3:45 PM at 12/14/19, Nurse #4 and NA #5 were alerted by Resident #6 that a man was in her room. NA #5 redirected Resident #4 out of the room. The written statement indicated Nurse #4 applied a wander guard to Resident #4 at this time. Nurse #4 indicated in her statement Resident #6 was sitting in her wheelchair when Resident #4 entered the room and sat on her bed.

An interview was attempted with Nurse #4 via

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phone, but she was unable to be reached after 2 attempts on 01/03/20 and 01/04/20.

An interview was conducted with Nurse #2 via phone on 01/02/20 at 5:00 PM. Nurse #2 revealed on 12/14/19 when she arrived for her shift from 7:00 PM - 7:00 AM, she had been told by the day shift Nurse #4 Resident #4 had wandered into Resident #6 ' s room. Nurse #2 stated she was on a medication cart and was assigned to the hall that Resident #4 and Resident #6 resided on until 11:00 PM. Nurse #2 stated during the 7:00 PM - 11:00 PM shift, Resident #4 slept and had no further wandering behaviors on 12/14/19. Nurse #2 reported staff was keeping an eye on Resident #4 during rounds every 2 hours and as they passed his room from the hall.

An interview was conducted with Nurse #3 via phone on 01/03/20 12:30 PM. Nurse #3 revealed when she came in at 11:00 PM on 12/14/19, Nurse #2 reported to her that Resident #4 was sleeping. Nurse #3 stated she had no knowledge of what happened on 12/14/19 when Resident #4 entered Resident #6 ' s room during the day shift. Nurse #3 stated Resident #4 had no behaviors during the night shift until about 5:20 AM on 12/15/19 when she heard a scream from down the 400 hall. She stated she ran toward the scream and found Resident #6 ' s door closed, she opened the door and found Resident #4 naked, standing over Resident #6 ' s bed with both hands between her legs inside her brief and Resident #6 was trying to push Resident #4 away. Nurse #3 stated she removed Resident #4 from the room and instructed NA #6 to get him dressed, put him in a Geri chair, and to monitor him 1 to 1. Nurse #3 stated she assessed

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	345119	A. BUILDING _____ B. WING _____	C 01/04/2020

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Resident #6. She reported Resident #6 was nervous and scared and knew she had been violated and wanted to know why and how. Nurse #3 noted Resident #6 ' s face had redness to the left side of her face and Resident #6 reported to the nurse Resident #4 had slapped her when she told him to stop touching her and get out. Nurse #3 stated Resident #4 remained on 1 to 1 until she obtained an order by the physician to send him to the hospital for further evaluation. Nurse #3 stated Emergency Medical Services arrived at 11:51 AM on 12/15/19 and transferred him to the hospital.

An interview with NA #6 via phone on 01/03/20 at 1:15 PM revealed she was assigned to the hall that Resident #4 and Resident #6 resided on. NA #6 reported when she came on to her shift for the 11:00 PM - 7:00 AM shift on 12/14/19 going into 12/15/19, she did not get report from anyone and did not know Resident #4 had behaviors such as wandering. NA #6 stated she worked as an agency NA and usually did not get report from the previous NA when she worked at the facility. NA #6 reported she rounded on Resident #4 every 2 hours and the last round she completed was about 5:00 AM. NA #6 stated Resident #4 had no behaviors during the night. NA #6 stated when she saw Resident #4 come out of Resident #6 ' s room with Nurse #3, he had no brief on and she knew she had just put a clean one on him.

A review of the police report revealed the report was dated 12/15/19 at 6:15 AM. The crime incident noted on the report was "simple assault" with minor injury noted to Resident #6.

An attempt to interview the officer on scene was attempted on 01/04/20 at 9:55 AM. There was no

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answer and a voice mail message was left.

An interview was conducted with the Adult Protective Services (APS) staff member on 01/02/20 at 2:45 PM. The APS staff member stated the officer, who was on the scene at the facility on 12/15/19, reported to her that according to the Magistrate and the District Attorney, Resident #4 was not of sound mind and would be given a citation for assault on a female and was given a date to appear in court.

An interview was conducted with the Administrator on 01/04/20 at 9:20 AM. The Administrator reported what happened to Resident #6 while living in her "home was horrific." The Administrator stated Resident #4 was confused when he arrived at the facility on 12/12/19, and he ended up settling down once he was situated. The Administrator reported Resident #4 did not have any behaviors again until 12/14/19 when he wandered into Resident #6 ' s room and the nurse put a wander guard on him but no other interventions were put in place to keep him from entering other resident rooms. The Administrator stated after Resident #4 wandered into Resident #6 ' s room on 12/14/19, he slept until the following morning. The Administrator added, the facility had no way of knowing such a thing could happen and expected her staff to keep all the residents safe from harm and abuse.

A corrective action plan for noncompliance dated 12/15/19 was as follows:

1. The immediate corrective action by the facility on 12/15/19 was Resident #4 was brought out of the Resident #6 ' s room by Nurse #3 and NA #6

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dressed the resident and put him in Geri chair and he was placed on 1 to 1 at the nurse ' s station. Resident #6 was assessed by the Nurse #3. A physician ' s order was obtained and Resident #4 was sent to the hospital for further evaluation on 12/15/19 at 11:51 AM.

The Administrator, Director of Nursing, and Assistant Director of Nursing were notified immediately after the incident and were in the facility within 30 minutes. Police were notified and completed a report. The facility completed the 24-hour initial report and submitted it to Department of Health Care Registry via fax within 2 hours and initiated the 5 -day investigation report.

The corrective action for the affected resident included notifying the physician, notifying the Social Worker at PACE (Program for All-inclusive Care for the Elderly) where the resident attended 3 times per week and was seen by the PACE Social Worker once per week, frequent visits from the facility ' s Social Worker to assess wellbeing and any post-traumatic stress, a psychiatric consult was ordered on 12/20/19 and family was notified when the resident allowed permission to do so.

The corrective action for residents with the potential to be affected included the DON, ADON and Staff Development Coordinator (SDC) Nurse completed 100% skin assessments of all non-alert and oriented residents for signs and symptoms of sexual abuse on 12/15/19. The facility Social Worker completed a 100% resident questionnaire for all alert and oriented residents regarding anyone wandering into their room on 12/15/19. The questionnaire was expanded on

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12/16/19 and completed by the Social Worker to include the question regarding has anyone touched you inappropriately that has not been reported and addressed.

2. Measures implemented to assure deficient practice would not reoccur included 100% audit of all progress notes for the last 30 days for any resident that had wandered into another resident ' s room unwanted or uninvited was completed on 12/15/19 by the DON. On 12/15/19, The DON also reviewed admissions for the past 30 days to ensure that no other residents had any documented inappropriate behaviors to include requiring a sitter, sexual behaviors, violent behaviors, or were given as needed antipsychotics without justifiable diagnoses.

The SDC Nurse completed 100% in services to staff to include nurses, nursing assistants, med aides, dietary staff, housekeeping staff, therapy staff, ancillary staff and the Administrator on 12/15/19 regarding resident abuse and residents that wander into other resident ' s rooms unwanted or uninvited which included how to intervene with residents who wander uninvited to other resident ' s room or make inappropriate sexual comments or display inappropriate sexual actions. In services were completed by 12/17/19.

3. The outcome of compliance with the plan of action will be monitored by the DON, ADON, Nursing Supervisors, QA Nurse and SDC Nurse and includes 100% review of progress notes 5 days per week for 4 weeks monitoring for wandering and inappropriate behaviors to include implementing interventions and updating the care plan to prevent reoccurrence by utilizing the Behavior Interdisciplinary (IDT) tool. The initial

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Quality Assurance (QA) meeting to review the plan of correction was held on 12/15/19. The Behavior IDT tool, which will aid in determining trends or concerns that required further interventions, will be utilized and forwarded to the executive QA committee monthly X 1 month. The executive QA committee will meet and review the Behavior IDT tool to determine the need for further and or frequency of monitoring.

The facility alleges full compliance with the plan of correction effective 12/18/19.

As part of the validation process on 01/04/20 the plan of correction was reviewed which included dates and content of the in services that were conducted, dates and content of the audits that were completed. A review of dates and content of the questionnaires for the alert and oriented residents regarding anyone wandering into their rooms or making inappropriate sexual comments or action, and the skin assessments for all non-alert and oriented residents for signs and symptoms or abuse and review of the Behavior IDT audit. The Abuse Prohibition Review was completed to determine if residents, direct care staff, and front line supervisors were provided education regarding the abuse policy and procedures to include screening potential new hires, training of employees, prevention policies and procedures, identification of possible incident or allegations which need investigation, investigation of incidents and allegations, protection of residents during investigation and the reporting of incidents, investigations, and the facility response to the results of their investigations. On 01/04/20, the facility ' s compliance date of 12/18/19 was validated.