

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345501</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/10/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CROASDAILE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CROASDAILE FARM DURHAM, NC 27705</b>		
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F 157 SS=D	<p>483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon record review and staff and nurse practitioner interviews, the facility did not notify the physician, the nurse practitioner, or the family after an allegation of abuse was made for one of</p>	F 157	<p>#1 Corrective Action for affected residents</p> <p>Resident's responsible party was notified</p>	12/28/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/28/2015

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>three residents who were reviewed for abuse allegations, Resident #1. Findings included:</p> <p>A review of the admission assessment dated 10/06/2015 indicated that Resident #1 was re-admitted to the facility on 09/22/2015 from the hospital with diagnoses which included hypertension, cerebral vascular accident, and chronic obstructive pulmonary disease. The same assessment revealed Resident #1 had short term and long term memory problems, had moderate impairment for making decisions regarding her daily tasks of life, and that she required extensive assistance with most of her activities of daily living. An updated assessment for Resident #1 dated 11/19/2015 revealed that she required limited assistance with eating, that she had no difficulties with swallowing, and that she had exhibited behavioral symptoms which included rejection of care.</p> <p>A review of the nursing care plan initiated on 11/19/2015 revealed Resident #1 had a measurable goal and interventions in place related to her behavior problems. One of the interventions included, "Please approach me calmly, speak slowly, smile, and give me personal space when I appear to be upset."</p> <p>A review of the facility's 24-Hour Report to the Health Care Personnel Registry revealed that an allegation of abuse was made regarding an incident that occurred on 12/05/2015 at 9:00 AM. The description of the allegation was as follows: "It was reported on 12/06/2015 that [Nurse #1] forced the resident to take her medications on 12/05/2015. It was also reported that the nurse asked the [Nursing Assistant Name] to hold the resident's hands so she could give her</p>	F 157	<p>by Licensed Nurse on 12/07/15. The resident's Nurse Practioner was notified verbally by the Health Care Administrator on 12/10/15. Resident was assessed by DON on 12/07/15 in relation to allegation of abuse and no signs or symptoms of abuse or any negative outcomes were identified.</p> <p>#2 Corrective Action for all residents' affected</p> <p>All residents have the potential to be affected and situations will be monitored by QAPI team.</p> <p>#3 Prevention Measures</p> <p>100% education provided by DON to entire nursing administration team on notification of resident's responsible party and physician after any allegation of abuse 12/08/15. Random audits of physician notifications will be completed by Healthcare Administrator/DON.</p> <p>#4 Method of Monitoring</p> <p>All allegations of abuse and neglect will be audited by the Director of Social Services/ designee to ensure that the policy was followed including notification of MD and RP of allegation.</p> <p>Audits will be submitted monthly by the Director of Social Services to the QAPI committee for 6 months, time frame may be increased based upon findings.</p> <p>#5 Completion Date:</p>		

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F 157	<p>Continued From page 2</p> <p>medications." There was no indication on the report that the physician, family nurse practitioner, or family was notified of the allegation.</p> <p>A review of the nursing progress notes revealed there were no notes from 12/05/2015 through 12/07/2015 to indicate the physician, nurse practitioner, or family had been notified regarding the abuse allegation.</p> <p>An observation of the resident on 12/08/2015 at 8:40 AM revealed Resident #1 had a red scratch to her forehead about 1 inch long, 3 light greenish yellow bruises around the left wrist and on her right forearm and right wrist.</p> <p>In an interview with the facility's administrator on 12/09/2015 at 4:20 PM, she stated that she received a telephone call on 12/06/2015 at 11:36 AM from Nurse #3, who made the allegation of staff to resident abuse by Nurse #1. The administrator stated she had just suspended both Nurse #3 and Nurse #1 because of another issue, and she was so focused on the suspension that she did not report the abuse allegation to the physician on-call or the nurse practitioner. The Administrator stated in retrospect, she should have reported the allegation to the physician or the nurse practitioner after she received the allegation.</p> <p>In an interview with the Campus Administrator on 12/10/2015 at 12:25 PM, she stated that Resident #1's family had not been notified regarding the abuse allegation at all since the incident had been reported. She explained that a nurse had left a message with her physician on 12/07/2015, but that the physician was away for that week and probably did not receive the message.</p>	F 157		12/28/15	

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F 157	Continued From page 3  On 12/10/2015 at 1:15 PM, an interview was conducted with the nurse practitioner (NP) who provided care for Resident #1. During the interview, she stated she had not received a report that an allegation of abuse to Resident #1 had been made. The NP stated she was taking care of the resident while Resident #1's regular physician was away that week, and that she had not received any notification regarding the allegation or about any new bruising until 12/10/2015. The NP stated she was in the facility to see Resident #1 and her family member on 12/07/2015 at around 4:00 PM to discuss her medications and she could have assessed the resident for bruises and any other issues at that time if she had been aware of the abuse allegation.  In a telephone interview with Nurse #2 on 12/10/2015 at 4:45 PM, she stated she notified a family member on 12/07/2015 about some new bruises that were noted on the resident's forearms and wrists, but did not report any allegations of abuse to the physician or family.	F 157			
F 223 SS=D	483.13(b) ABUSE  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility did not prevent a staff member from making a verbally threatening statement to 1 of 3 residents reviewed for abuse allegations, Resident #1. Findings included:	F 223	#1 Corrective Action for affected resident  100% education provided to all Pavilion team members on the abuse and neglect policy including what constitutes abuse	12/28/15	

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F 223	<p>Continued From page 4</p> <p>A review of the admission assessment dated 10/06/2015 indicated that Resident #1 was re-admitted to the facility on 09/22/2015 from the hospital with diagnoses which included hypertension, cerebral vascular accident, and chronic obstructive pulmonary disease. The same assessment revealed Resident #1 had short term and long term memory problems, had moderate impairment for making decisions regarding her daily tasks of life, and that she required extensive assistance with most of her activities of daily living. An updated assessment for Resident #1 dated 11/19/2015 revealed that she required limited assistance with eating, that she had no difficulties with swallowing, and that she had exhibited behavioral symptoms which included rejection of care.</p> <p>A review of the nursing care plan initiated on 11/19/2015 revealed Resident #1 had a measurable goal and interventions in place related to her behavior problems. One of the interventions included, "Please approach me calmly, speak slowly, smile, and give me personal space when I appear to be upset."</p> <p>On 12/09/2015 at 10:30 AM, an interview was conducted with the Nursing Assistant #1 (NA #1), who was present during part of the alleged medication event of 12/05/2015. NA #1 stated that on 12/05/2015 she was seated in the common area where residents often sit to play games or watch television, and that she witnessed Nurse #1 attempt to give Resident #1 her medications from a cup using a spoon, but the resident refused, stating she was not going to take them. NA stated she could not remember exactly what Nurse #1 said to the resident after she refused the medicine, but that she was</p>	F 223	<p>and neglect and the different types of abuse, as well as notification of physician and responsible party. Resident was assessed by DON on 12/08/15 and no signs and symptoms of abuse or negative outcomes were identified.</p> <p>#2 Corrective action for all residents <input type="checkbox"/> affected</p> <p>All residents have the potential to be affected. Administration identified random residents to be interviewed by Social Work. Interviews were conducted and other residents having the potential to be affected did not identify any additional concerns.</p> <p>#3 Prevention Measures</p> <p>100% education provided to all Pavilion team members on the abuse and neglect policy including what constitutes abuse and neglect and the different types of abuse, as well as notification of physician and responsible party. Staff Development will also provide education on the abuse and neglect policy during orientation for new team members including what constitutes abuse and neglect and the different types of abuse. Director of Nursing or designee will complete at least 5 random audits of unannounced medication administration of nursing staff each month that will include observation of residents rights and dignity during medication administration.</p> <p>#4 Method of Monitoring</p>		

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F 223	<p>Continued From page 5</p> <p>concerned about the situation because Nurse #1 told NA #2 to come across the hall to a vacant room to assist her with giving the medications. NA #1 stated that when NA #2 got up to assist Nurse #1, she told NA #2, "Don't touch the resident, we do not hold hands." NA #1 explained she made the statement to NA #2 because only the nurse should give medications, and that a nursing assistant should not assist with meds or holding the resident's hands. NA #1 stated she did not report the incident to anyone on 12/05/2015.</p> <p>During an interview on 12/09/2015 at 11:19 AM with the nursing assistant who was asked to assist Nurse #1 with the medication administration, NA #2, she stated that while she and 2 other nursing assistants were in the common area, she witnessed Nurse #1 attempt to give Resident #1 her medications which were crushed and mixed with food. NA #2 stated the resident was a little agitated that day and that she refused to take her medications. NA #2 stated that Nurse #1 then said to the resident, "We can take it the easy way or the hard way." NA #2 explained that Nurse #1 asked her (NA#2) to come across the hall and hold the resident's hands while she gave the medications. NA #2 stated she then went with Nurse #1 and Resident #1 into a vacant room across the hall from common area. NA #2 confirmed that NA #1 told her not to hold the resident's hands down because that would be abuse.</p> <p>In an interview conducted with Nurse #1 on 12/09/2015 at 12:21 PM, she stated that on 12/05/2015, Resident #1 was seated in the common area when she was going to administer her medications around 9:00 AM. Nurse #1 explained that she crushed Resident #1's</p>	F 223	<p>QAPI will monitor corrective actions to ensure compliance during monthly meetings. Director of Nursing or designee will complete at least 5 random audits of unannounced medication administration of nursing staff each month that will include observation of residents rights and dignity during medication administration for 6 months timeframe may be extended based on findings. Audits will be submitted to the QAPI committee monthly by the DON. Social Worker will complete 5 interviews with alert, oriented, and reliable residents each month in relation to abuse and neglect allegations. Interviews will be submitted monthly by the Director of Social Services to the QAPI committee for 6 months, time frame may be increased based upon findings.</p> <p>#5 Completion Date 12/28/15</p>		

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F 223	Continued From page 6 medications, mixed them with applesauce, and then used a spoon to attempt to administer the medications to her. Nurse #1 added that the resident was agitated that day and that she refused to take her medications, making a face and saying, "Yuck." Nurse #1 stated the resident never said, "No." Nurse #1 stated that she said something to the resident similar to, "I know this isn't easy," or, "I know this is hard for you." Nurse #1 stated that after Resident #1 refused the medications, she left her in the commons area a while, then returned to try to administer the medications again. Nurse #1 stated the common area was very chaotic, so she asked NA #2 to take the resident to the vacant room across the hall to assist her as she gave the medications. Nurse #1 added that she did not say, "We can do this the easy way or the hard way," and that those who witnessed that she made this statement might have misunderstood her or misconstrued her statement. In an interview with NA #3 on 12/09/2015 at 2:21 PM, she stated that she was present in the common area on 12/05/2015 when Nurse #1 attempted to give medications to Resident #1. NA #3 stated that Nurse #1 crushed the resident's medication at the medication cart and mixed it with a food item, perhaps pudding (unsure which type of food) then approached Resident #1 with the medications and told her it was time to take them. NA #3 explained that Resident #1 shook her head side to side (to indicate "no") and said clearly, "I'm not going to take it." NA #3 stated that Nurse #1 tried again to give a spoonful of the medications to her, but the resident was agitated and that she refused to take them again, shaking her head, "no" and stating she was not going to take them. NA #3 stated Resident #1 refused at least twice, perhaps three times. NA #3 stated	F 223			

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F 223	Continued From page 7 Nurse #1 said, "We can take it the easy way or the hard way." NA #3 stated she felt the statement was disturbing to her, so she reported it on 12/06/2015. In an interview with the facility's campus administrator (CA) on 12/10/2015 at on 12/09/2015 at 11:50 AM, she stated that the alleged statement by Nurse #1, "We can take it the easy way or the hard way," was disturbing to her and that it could be taken as a threat to a resident or to others who heard the statement.	F 223			
F 226 SS=D	483.13(C)(1)(i) STAFF TREATMENT OF RESIDENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  (Use F226 for deficiencies concerning the facility's development and implementation of policies and procedures.)  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and nurse practitioner interviews, the facility failed to follow its Abuse and Neglect Policy when, a) the facility did not identify a reported incident as suspected abuse or perform an assessment of the resident after an allegation of abuse was made, and b) staff members failed to recognize and report suspected abuse, for one of three residents reviewed in an abuse investigation, Resident #1. Findings included:  A review of the facility's Abuse and Neglect	F 226	#1 Corrective Action for affected Residents  Resident was assessed by DON on 12/08/15 and no signs or symptoms of abuse or negative outcomes were identified.  #2 Corrective Action for all residents affected  All residents have the potential to be	12/28/15	



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F 226	<p>Continued From page 8</p> <p>Policy, effective January 14, 2014 and revised on May 13, 2014, revealed the following in Section II B. on page 3, "Employees are instructed during new hire orientation, periodic in-services, ...on the importance of immediate reporting witnessed or suspected instances of abuse/neglect." In Section IV A., page 4, the policy stated, "All employees need to be able to detect potential abuse or neglect: unexplained open wounds, cuts, bruises, welts, or discoloration..." Section V, page 4 of the policy revealed: "The Community internal investigation shall include: Examination and interview of resident by risk manager/designee coordinator and by two qualified professionals (i.e., interdisciplinary team)."</p> <p>A review of the admission assessment dated 10/06/2015 indicated that Resident #1 was re-admitted to the facility on 09/22/2015 from the hospital with diagnoses which included hypertension, cerebral vascular accident, and chronic obstructive pulmonary disease. The same assessment revealed Resident #1 had short term and long term memory problems, had moderate impairment for making decisions regarding her daily tasks of life, and that she required extensive assistance with most of her activities of daily living. An updated assessment for Resident #1 dated 11/19/2015 revealed that she required limited assistance with eating, that she had no difficulties with swallowing, and that she had exhibited behavioral symptoms which included rejection of care.</p> <p>A review of the nursing care plan initiated on 11/19/2015 revealed Resident #1 had a measurable goal and interventions in place related to her behavior problems. One of the</p>	F 226	<p>affected. Administration identified random residents to be interviewed by Social Work. Interviews were conducted and other residents having the potential to be affected did not identify any additional concerns.</p> <p><b>#3 Prevention Measures</b></p> <p>100% education provided to all Pavilion team members on the abuse and neglect policy including what steps to follow after any allegation of abuse or neglect. Staff Development Coordinator will also provide education on the abuse and neglect policy during orientation for new team members including the steps to follow after any allegation of abuse or neglect. Director of Nursing or designee will complete at least 5 random audits of unannounced medication administration of nursing staff each month that will include observation of resident rights and dignity during medication administration.</p> <p><b>#4 Method of Monitoring</b></p> <p>QAPI will monitor corrective actions to ensure compliance during monthly meetings. Director of Nursing or designee will complete at least 5 random audits of unannounced medication administration of nursing staff each month that will include observation of resident rights and dignity during medication administration for 6 months and time frame may be extended based on findings. Audits will be submitted to QAPI committee monthly by DON. All allegations of abuse and neglect</p>		

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F 226	<p>Continued From page 9</p> <p>interventions included, "Please approach me calmly, speak slowly, smile, and give me personal space when I appear to be upset."</p> <p>In an interview with the Director of Nursing (DON) on 12/08/2015 at 10:03 AM on 12/08/2015, she stated that the facility had submitted a 24-Hour Report to the Health Care Personnel Registry dated 12/07/2015 at 11:51 AM regarding an allegation of abuse to Resident #1.</p> <p>The facility's 24-Hour Report to the Health Care Personnel Registry revealed that an allegation of abuse was made regarding an incident that occurred on 12/05/2015 at 9:00 AM. The description of the allegation on the report was as follows: "It was reported on 12/06/2015 that [Nurse #1] forced the resident to take her medications on 12/05/2015. It was also reported that the nurse asked the [Nursing Assistant Name] to hold the resident 's hands so she could give her medications."</p> <p>a) A review of the medication administration record dated December 2015 revealed Resident #1 was receiving Xarelto (an anti-coagulant medication), 15 milligrams by mouth daily with breakfast. (A side effect of Xarelto is increased risk of bleeding.)</p> <p>A Skin Assessment Form for Resident #1 dated 12/07/2015 at 11:59 AM included the following description of the resident 's skin condition: "Has three bruises going up her right forearm, bruise to inner arm close to wrist 0.5 inches long and 0.2 inches wide, bruise to outer forearm on top of wrist 1 inch long and 0.5 inches wide, bruise to outer forearm 1.5 inches long and 0.5 inches wide. All pink in color."</p>	F 226	<p>will be audited by the Director of Social Services/ designee to ensure that the abuse and neglect policy was followed. Audits will be submitted monthly to the QAPI committee by the Director of Social Services for 6 months, time frame may be increased based upon findings.</p> <p>#5 Completion Date 12/28/15</p>		

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F 226	<p>Continued From page 10</p> <p>Review of an Inter-Disciplinary Team (IDT) Note dated 12/08/2015 at 12:04 PM revealed the following: "... Res (resident) reviewed by IDT committee related to discolored areas to bilateral hands and red abrasion to resident's forehead. Areas to right hand is believed to be self-inflicted and area to left hand is consistent with watch placement. Red abrasion to forehead is believed to be from resident scratching area. Resident is on anticoagulation and has had multiple episodes of combative behaviors ..."</p> <p>A review of the nursing progress notes revealed there was no other documentation that an assessment of Resident #1 was made after the allegation of abuse was reported on 12/06/2015 at 11:36 AM.</p> <p>In an interview with the Director of Nursing (DON) on 12/09/2015 at 4:00 PM, she explained that she stated that she would have expected Resident #1 to have received a skin assessment after the allegation of abuse was made on 12/06/2015 if there was implied physical harm from the alleged abuse of 12/05/2016. She explained she was unaware of the abuse allegation until she came in to the facility on Monday, 12/07/2015, and that the investigation did not start until she was in the facility that day.</p> <p>In an interview with the Administrator on 12/09/2015 at 4:20 PM, she stated the investigation for abuse should have started on 12/06/2015 after she received the allegation of abuse on 12/06/2015 at 11:36 AM. The Administrator explained that a skin assessment was not completed by the nurse on duty or the staff supervisor on Sunday, 12/06/2015, and that the investigation and assessment of the resident did not begin until Monday, 12/07/2015. The Administrator also stated she was so focused on</p>	F 226			

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F 226	<p>Continued From page 11</p> <p>another urgent staff problem that she did not recognize the reported incident to be abuse when it was first reported to her on 12/06/2015 at 11:36 AM.</p> <p>b) On 12/09/2015 at 10:30 AM, an interview was conducted with the Nursing Assistant #1 (NA #1), who was present during part of the alleged medication event of 12/05/2015. NA #1 stated that on 12/05/2015 she was seated in the common area where residents often sit to play games or watch television, and that she witnessed Nurse #1 attempt to give Resident #1 her medications from a cup using a spoon, but the resident refused, stating she was not going to take them. NA stated she could not remember exactly what Nurse #1 said to the resident after she refused the medicine, but that she was concerned about the situation because Nurse #1 told NA #2 to come across the hall to a vacant room to assist her with giving the medications. NA #1 stated that when NA #2 got up to assist Nurse #1, she told NA #2, "Don't touch the resident, we do not hold hands." NA #1 explained she made the statement to NA #2 because only the nurse should give medications, and that a nursing assistant should not assist with meds or holding the resident's hands.</p> <p>An interview was conducted with the Unit Manager on 12/09/2015 at 10:56 AM. She explained that she was supervising the section of the facility where Resident #1 resided, and that no staff members reported to her any suspected abuse or a medication incident involving Resident #1 on 12/05/2015.</p> <p>During an interview on 12/09/2015 at 11:19 AM with the nursing assistant who was asked to</p>	F 226			

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F 226	Continued From page 12 assist Nurse #1 with the medication administration, NA #2, she stated that while she and 2 other nursing assistants were in the common area, she witnessed Nurse #1 attempt to give Resident #1 her medications which were crushed and mixed with food. NA #2 stated the resident was a little agitated that day and that she refused to take her medications. NA #2 stated that Nurse #1 then said to the resident, "We can take it the easy way or the hard way." NA #2 explained that Nurse #1 asked her (NA#2) to come across the hall and hold the resident's hands while she gave the medications. NA #2 stated she then went with Nurse #1 and Resident #1 into a vacant room across the hall from common area. NA #2 confirmed that NA #1 told her not to hold the resident's hands down because that would be abuse. In an interview with NA #3 on 12/09/2015 at 2:21 PM, she stated that she was present in the common area on 12/05/2015 when Nurse #1 attempted to give medications to Resident #1. NA #3 stated that Nurse #1 crushed the resident's medication at the medication cart and mixed it with a food item, perhaps pudding (unsure which type of food) then approached Resident #1 with the medications and told her it was time to take them. NA #3 explained that Resident #1 shook her head side to side (to indicate "no") and said clearly, "I'm not going to take it." NA #3 stated that Nurse #1 tried again to give a spoonful of the medications to her, but the resident was agitated and that she refused to take them again, shaking her head, "no" and stating she was not to going to take them. NA #3 stated Resident #1 refused at least twice, perhaps three times. NA #3 stated Nurse #1 said, "We can take it the easy way or the hard way." NA #3 stated she felt the statement was disturbing, but she did not report	F 226			

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F 226	Continued From page 13 the statement to anyone at that time. In addition, NA #3 stated that she witnessed Nurse #1 and NA #2 come back out of the vacant room a short while later, and that Resident #1 had a pinkish stain on her sweater that had not been present when she was taken into the vacant room. NA #3 stated she was concerned about the resident because her behavior she did not look up as she was brought back into the common area. NA #3 stated she thought her expression was odd, so she went to the resident and asked her if she was okay, and the resident replied, "You just don't want to know." NA #3 stated she knew she should have recognized the incident as suspected abuse and should have reported the incident on 12/05/2015 right after it happened, but that she did report it the next day. In an interview with the Director of Nursing on 12/09/2015 at 4:00 PM. She stated that she would expect for a staff member to report suspected abuse immediately or within a timely manner.	F 226			
F 241 SS=D	483.15(a) QUALITY OF LIFE  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility did not provide medications in a dignified manner for 1 of 3 residents, Resident #1. Findings included:  A review of the admission assessment dated 10/06/2015 indicated that Resident #1 was	F 241	#1 Corrective Action for affected residents  Resident was assessed by DON on 12/08/15 and no signs and symptoms of abuse or negative outcomes were identified.	12/28/15	

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F 241	<p>Continued From page 14</p> <p>re-admitted to the facility on 09/22/2015 from the hospital with diagnoses which included hypertension, cerebral vascular accident, and chronic obstructive pulmonary disease. The same assessment revealed Resident #1 had short term and long term memory problems, had moderate impairment for making decisions regarding her daily tasks of life, and that she required extensive assistance with most of her activities of daily living. An updated assessment for Resident #1 dated 11/19/2015 revealed that she required limited assistance with eating, that she had no difficulties with swallowing, and that she had exhibited behavioral symptoms which included rejection of care.</p> <p>A review of the nursing care plan initiated on 11/19/2015 revealed Resident #1 had a measurable goal and interventions in place related to her behavior problems. One of the interventions included, "Please approach me calmly, speak slowly, smile, and give me personal space when I appear to be upset."</p> <p>During an interview on 12/09/2015 at 11:19 AM with the nursing assistant who was asked to assist Nurse #1 with the medication administration, NA #2, she stated that while she and 2 other nursing assistants were in the common area, she witnessed Nurse #1 attempt to give Resident #1 her medications which were crushed and mixed with food. NA #2 stated the resident was a little agitated that day and that she refused to take her medications. NA #2 stated that Nurse #1 then said to the resident, "We can take it the easy way or the hard way." NA #2 explained that Nurse #1 asked her (NA#2) to come across the hall and hold the resident's hands while she gave the medications. NA #2</p>	F 241	<p>#2 Corrective Action for all residents affected</p> <p>All residents have the potential to be affected. Administration identified random residents to be interviewed by Social Work. Interviews were conducted and other residents having the potential to be affected did not identify any additional concerns.</p> <p>#3 Prevention Measures</p> <p>Director of Nursing or designee will complete at least 5 random audits of unannounced medication administration of nursing staff each month that will include observation of residents rights and dignity during medication administration. 100% of nursing team educated on resident's dignity including respecting residents dignity.</p> <p>#4 Method of Monitoring</p> <p>QAPI will monitor corrective actions to ensure compliance during monthly meetings. Director of Nursing of designee will complete at least 5 random audits of unannounced medication administration of nursing staff each month that will include observation of residents rights and dignity during medication administration for 6 months, time frame may be extended based on findings. Audits will be submitted to the QAPI committee monthly by the DON. Social work will interview 5 alert, oriented, and reliable residents each</p>		

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F 241	Continued From page 15 stated she then went with Nurse #1 and Resident #1 into a vacant room across the hall from common area. NA #2 added that when she was in the room observing the medication administration, Nurse #1 explained to the resident why she needed to take her medication, then drew up the medication from the medication cup using a syringe and administered the medication by pushing the plunger on the syringe into Resident #1's mouth. In an interview conducted with Nurse #1 on 12/09/2015 at 12:21 PM, she stated that on 12/05/2015, Resident #1 was seated in the common area when she was going to administer her medications around 9:00 AM. Nurse #1 explained that she crushed Resident #1's medications, mixed them with applesauce, and then used a spoon to attempt to administer the medications to her. Nurse #1 added that the resident was agitated that day and that she refused to take her medications, making a face and saying, Yuck. " Nurse #1 stated the resident never said, "No." Nurse #1 stated that she said something to the resident similar to, "I know this isn't easy," or, "I know this is hard for you." Nurse #1 stated that after Resident #1 refused the medications, she left her in the commons area a while, then returned to try to administer the medications again. Nurse #1 stated the common area was very chaotic, so she asked NA #2 to take the resident to the vacant room across the hall to assist her as she gave the medications. Nurse #1 added that she did not use a syringe to administer the medications. She explained that the medications were already mixed with applesauce in a medicine cup due to her earlier attempt to administer the medications, and that she added thickened cranberry juice to the medications at that time in order to administer	F 241	month in relation to dignity. Director of Social Work will submit audits monthly to the QAPI Committee for 6 months, time frame may be increased based upon findings.  Completion Date: 12/28/15		



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F 241	<p>Continued From page 16</p> <p>them.</p> <p>During an interview with Nurse #3 on 12/10/2015 at 2:38 PM, she explained that she provided care for Resident #1 frequently and that she had no problems with administering medications to Resident #1, and that she did not crush her medications because the resident had no problems with swallowing. Nurse #3 also added that the resident had documented behaviors, but that she did not have problems with Resident #1 refusing her medications.</p> <p>In an interview with the Director of Nursing on 12/09/2015 at 3:45 PM, she stated she would not expect a nurse to continue to attempt to give medication after it had been refused 2 or 3 times. She also stated that it was not the usual procedure to administer oral medications via syringe.</p> <p>A review of the 60-Day scheduled assessment revealed Resident #1 was re-admitted to the facility on 09/22/2015 from the hospital with diagnoses including hypertension, cerebral vascular accident, and chronic obstructive pulmonary disease. The same assessment revealed Resident #1 had short-term and long-term memory problems and had moderate impairment for making decisions regarding her daily tasks of life. The assessment also indicated that Resident #1 required limited assistance with eating and extensive assistance with most of her other activities of daily living, including personal hygiene, bathing, and locomotion on the facility</p>	F 241			

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F 241	Continued From page 17 unit. The resident was totally dependent upon staff for dressing, bed mobility, and transfers.	F 241			