

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

PRINTED: 11/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345405	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/21/2017
NAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		
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{F 000}	<p>INITIAL COMMENTS</p> <p>A complaint investigation survey was conducted from 09/07/17 through 09/08/17.</p> <p>Immediate Jeopardy was identified at:</p> <p>CFR 483.12 F 223 at a scope and severity level J. CFR 483.12 F 225 at a scope and severity level J. CFR 483.12 F 226 at a scope and severity level J. CFR 483.70 F 490 at a scope and severity level J.</p> <p>The tags F 223, F 225 and F 226 constituted substandard quality of care.</p> <p>Immediate Jeopardy began on 08/31/17 and is ongoing.</p> <p>A partial extended survey was conducted.</p> <p>The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable Allegation for the removal of the Immediate Jeopardy on 09/14/17.</p> <p>A revisit survey was conducted on 09/21/17 for verification of the facility's Allegations for the removal of the Immediate Jeopardy and to determine the status of the ongoing Immediate Jeopardy. The facility provided evidence the Immediate Jeopardy was removed on 09/14/17. At the time of exit on 9/21/17 the facility remained out of compliance for F 223, F 225, F 226 and F 490 at a lower scope and severity (D) isolated, no actual harm with potential for more than minimal</p>	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

09/29/2017

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 000}	Continued From page 1 harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of their corrective actions.	{F 000}			
{F 223} SS=D	<p>483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>483.12 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 symptoms.</p> <p>483.12(a) The facility must- (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, nurse practitioner and Law Enforcement interviews and record review, the facility failed to protect a resident from being assaulted by an unknown male for 1 of 3 sampled residents (Resident #2). The unknown male was arrested and charged on 09/05/17 with two 2nd degree sex offenses against Resident #2.</p> <p>Immediate Jeopardy began on 08/31/17 when Nurse #2 had to use force to open Resident # 2's barricaded door and observed an unknown male in Resident #2's room, the sheets were off the bed and the resident's brief had been removed. The Immediate Jeopardy is present and ongoing.</p>	{F 223}	<p>This allegation of compliance is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following credible allegations constitutes the center's allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated.</p> <p>F223</p> <p>How the corrective action will be accomplished for those residents found to have been affected by the deficient</p>	9/22/17	

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{F 223}	<p>Continued From page 2</p> <p>The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation for the removal of the Immediate Jeopardy on 09/14/17.</p> <p>A revisit survey was conducted on 09/21/17 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following:</p> <ul style="list-style-type: none"> - Systematic changes implemented to ensure visitors are identified before being allowed inside the facility. - Evidence of staff, resident and family education on abuse, emergency response and resident protection. - Documentation of audits for the in-servicing and procedures implemented related to abuse prohibition, protection of residents and emergency response procedures. <p>Observations of the facility's new security procedures for visitation were made and interviews with staff, residents and visitor were aware of the systemic changes implemented. The facility provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F 223 at a lower scope and severity (D) isolated, no actual harm that is not immediate jeopardy while the facility continues the process of monitoring and implementation of the corrective action.</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on 07/20/17 with diagnoses that included acute</p>	{F 223}	<p>practice:</p> <p>" On the evening of August 31, 2017, at or around 9:30 pm, Nurse 2 observed Resident 2's door closed. Nurse 2 opened Resident 2's door and found an unknown male in the room with Resident 2. Resident 2 was found with her covers down and brief off. When questioned, the unknown male told Nurse 2 that he was the nephew of Resident 2 and he was changing his aunt's brief. Nurse 2 then approached House Coordinator, who was in an office and on the phone with a family member of a resident. House Coordinator heard Nurse 2 ask House Coordinator to call 911, but House Coordinator directed Nurse 2 to ask Nurse 1 to call 911 while House Coordinator finished her call. Nurse 1 overheard Nurse 2's request to call 911, but did not hear House Coordinator's response and therefore assumed House Coordinator called 911.</p> <p>" Nurse 1 then joined Nurse 2 in Resident 2's room, and continued to question the unknown male. The unknown male insisted he was Resident 2's nephew and provided a first name and a last name that matched Resident #2's last name. At this point, the unknown male began to show signs of aggression and Nurse 1 instructed Nurse 2 to leave the room. Nurse 2 stationed herself in the hallway just outside Resident 2's room while Nurse 1 explained to the unknown male that she was going to call Resident 2's daughter to confirm his identity. Nurse 1 left Resident 2's room for privacy while she called Daughter and Nurse 2 remained</p>		

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{F 223}	<p>Continued From page 3</p> <p>respiratory failure with hypoxia, seizures, tracheostomy, gastrostomy and dementia. Resident was currently being treated with antibiotics for a urinary tract infections and an over the counter medication for a yeast infection. The admission Minimum Data Set (MDS) dated 07/27/17 specified the resident had short and long term memory impairment with severely impaired cognitive skills for daily decision making. The MDS also specified the resident was not comatose, but had no speech and the rare ability to make herself understood. The resident required two person physical assistance with activities of daily living.</p> <p>A nurse's entry made by Nurse #1 dated 08/31/17 at 11:38 PM specified 911 was called and police arrived at the facility in relation to an unknown male observed in Resident #2's room.</p> <p>Review of Resident #2's medical record revealed a medical transportation report dated 08/31/17. The report specified the medical transport unit was dispatched at 11:38 PM and arrived to Resident #2 at 11:52 PM. The report specified the chief complaint was assault and they arrived on scene to find an 85 year old "semi-flower" in bed. The report also revealed family of Resident #2 reported the resident may have been sexually assaulted by an unknown male that barricaded himself in the room and had removed the resident's brief. The unknown male had been allowed to leave the facility. Staff reported to the medical transport unit that the resident had not been changed or cleaned since the assault.</p>	{F 223}	<p>stationed in the hallway just outside the room. However, the unknown male closed Resident 2's door which prompted Nurse 1 to reopen the door and instruct the unknown male not to close the door. This occurred several more times until the unknown male was instructed to exit Resident 2's room and remain in the hallway. Nurse 1 called Daughter at 9:51 pm from Nurse 1's cell phone. However, Daughter did not pick up the call. Nurse 1 returned to the area outside of Resident 2's room where the unknown man and Nurse 2 were waiting. Daughter returned the phone call at 9:52 pm so Nurse 1 stepped away again and explained to Daughter what had transpired and that the unknown male claimed he was a family member and provided a first name. Daughter advised Nurse 1 that they did have a family member by that first name and that she was going to drive to the Center to confirm whether the unknown male was a family member.</p> <p>" Around 9:52 pm, when Nurse 1 stepped away to speak to Daughter, House Coordinator went to find Nurse 2 to see if she could be of assistance. Not knowing yet what had transpired, House Coordinator found the unknown male and questioned whether he had signed in at the front desk. When the unknown male responded that he had not signed in, House Coordinator escorted him to the front desk and observed him sign in. The unknown male and House Coordinator returned to the hallway at which point House Coordinator asked Nurse 2 what was going on. Nurse 1 advised Nurse 2</p>		

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{F 223}	<p>Continued From page 4</p> <p>Further review of the medical record revealed a document titled "Sexual Assault Nurse Examination" dated 09/01/17 at 1:42 AM performed in the Emergency Department. The exam revealed that Resident #2 had no physical injuries from the assault. The exam report revealed the resident had a 4 millimeter excoriation on her labia. Evidence was collected and provided to Law Enforcement.</p> <p>A nurse's entry made by Nurse #3 dated 09/01/17 at 5:15 AM revealed Resident #2 was returning to the facility from the Emergency Department after having had a sexual assault exam. The nurse documented, "Report was received from the hospital that according to assessment and testing in appeared the unidentified male was interrupted before he could do anything to the resident."</p> <p>On 09/07/17 at 9:50 AM Resident #2 was observed in bed and her eyes were closed.</p> <p>On 09/07/17 at 10:35 AM Nurse #1 was interviewed and reported the facility had one entrance for visitors that automatically locked at 9:30 PM. She stated that after 9:30 PM when the door was locked, visitors were dependent on a staff member to let them in and out of the facility. The Nurse described that on 08/31/17 she was working 3 PM to 11 PM and was preparing to start her 9 PM medication pass on the 200 A Hall. The Nurse explained that at 9:15 or 9:20 PM she was at the top of the 200 A Hall standing at her medication cart when she noticed an unknown male walk past her to the end of the 200 A Hall, opened a door, looked in the room, shut the door</p>	{F 223}	<p>and House Coordinator that Daughter was on her way to identify the unknown male. Nurse 2 called the DON at 9:59 pm to explain what had transpired.</p> <p>" Nurse 1, Nurse 2, and House Coordinator then worked together to keep an eye on the unknown male, keep in contact with Daughter, care for and protect the residents, alert the DON, and try to alert other staff members of the situation while attempting to keep the unknown male calm and not alert him as to their actions. It was around this time that Nurse 1, Nurse 2, and House Coordinator realized that no one had called 911. Nurse 1 then called Daughter at 10:09 pm to obtain her status. Daughter advised that she was on her way and in close proximity to the center. The nurses would call 911 if the unknown male was not identified by Daughter as a family member.</p> <p>" At 10:18 pm, Daughter called Nurse 1's cell phone and advised that she had arrived at the Center and had looked through the window to observe the unknown male. Daughter confirmed what the unknown male was wearing with Nurse 1 and then Daughter stated that the unknown male was not her family member. At this point, Nurse 1 hung up with Daughter and immediately called 911 at 10:20 pm. Per telephone interview with Detective assigned to case on 9/13/17 by Administrator, the 911 call was confirmed at 10:20pm, and dispatched at 10:22pm. Around the same time, CNA 1 unlocked (by swiping her badge) the front door to allow the unknown male out of the</p>		

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{F 223}	<p>Continued From page 5</p> <p>and walked back up the hall. She stated she felt this was "odd" because she didn't know who the male was and why he would have been visiting that Resident. The Nurse added that when the unknown male walked back up the hall, she said, "Hi" and the unknown male waved and stated, "Good night." The Nurse reported that she remained in the same location at the top of the 200 A Hall and assumed the unknown male exited the building. Nurse #1 explained that she proceeded with her medication pass and approximately "5 minutes later" she heard a "boom" and Nurse #2 yelling for the House Coordinator to, "Call 911! He's trying to rape her (Resident #2)." Nurse #1 described that she stopped her medication pass, grabbed an umbrella and went to Nurse #2 on the 200 B Hall. Nurse #1 asked what was going on and Nurse #2 reported that she found Resident #2's door closed and when she opened it she saw an unknown male in the room and he had taken the Resident's bed sheets off and removed her brief. Nurse #1 stated that it was the same unknown male she saw 5 minutes earlier that she assumed had left the building. The unknown male told the nurses he was visiting his "aunt" and needed to provide incontinence care because the nursing staff were not doing their jobs of providing care to Resident #2.</p> <p>Nurse #1 stated she asked the unknown male his identity and after stating the question he provided his name. She stated she wanted to try to diffuse the situation because she could tell the unknown male was angry with Nurse #2, so she asked the unknown male to have a seat in Resident #2's room while she called the family to verify his identify. Nurse #1 stated she realized when she walked away from the room, the unknown male</p>	{F 223}	<p>building at 10:19 pm. CNA 1 had no knowledge as to what had transpired related to the unknown male.</p> <p>" Based on information provided by Detective, the police arrived at the Center at 10:23 pm. Nurse 1 and Daughter spoke with police outside the Center, at which time Nurse 1 provided a description of the unknown male and Daughter provided a description of the vehicle he fled in. Based on information and belief, per interview of Detective, the event was closed by the police at 10:42pm.</p> <p>" Visual assessment of resident body done by Nurse #2 for any signs of bruising, redness, bleeding, agitation/anxiety-none found. The decision was made to not change or clean resident prior to sending for possible sexual assault examination.</p> <p>" Daughter visited with Resident 2, facility staffed consoled the family, and was counseled by the nurses about sending Resident 2 to hospital to be evaluated. Decision was made to send resident to hospital to rule out sexual assault. While family was questioned by Nurse #1 whether they wanted the assessment done, the nurse stated she did this only to include them since it was a significant event, but intentioned to send her anyway to protect the resident, herself and the center.</p> <p>" As a result of this second call to 911, both EMS and law enforcement officers were dispatched to the center. EMS unit dispatched per 911 call at 11:38pm, and reached patient's room at 11:52pm. Arrived to Hospital at 12:24AM.</p>		

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{F 223}	<p>Continued From page 6</p> <p>had shut the door to the room. Nurse #1 opened the door and explained to the unknown male that he would need to sit in the room with the door open. Nurse #2 stood outside the room continuing her medication pass to watch the unknown male while Nurse #1 used the telephone. Nurse #1 reported that the unknown male attempted to shut the door 4 times until she finally told him he had to get out of the room. Nurse #1 stated she didn't realize at the time but when he was shutting the door, the unknown male was "fixing Resident #2" back. Nurse #1 explained the unknown male had reattached the resident's brief and put the covers back on her body.</p> <p>Nurse #1 described that she went to the nurses' station area and observed the House Coordinator on the telephone and assumed she was on the phone with 911 as Nurse #2 had called for her to do. The Nurse stated her goal became to keep Resident #2 safe and contact the family. The nurse stated she saw the House Coordinator and asked her if she had called 911 and she hadn't. The Nurse stated she was so confused and upset that 911 had not been called but she knew she had to protect Resident #2. Nurse #1 decided to contact the family because she knew the unknown male was locked inside the facility since it was after 9:30 PM. The nurse used her cell phone to track call times and revealed she spoke with Resident #2's daughter at 9:52 PM to ask if she had a family member with the name provided and the daughter said, "Yes." Nurse #1 provided a description of the unknown male and the descriptions did not match but the family stated she was on her way to the facility. Nurse #1 placed a second call to the daughter at 10:18 PM asking her where she was and she was pulling</p>	{F 223}	<p>" Per hospital report no evidence of break in skin, abrasions except for excoriation to labia, redness, bruising, swelling, or bleeding to the body. No evidence of semen, DNA pending at this time, and detective assigned to case unable to tell us when we will get it back, and undetermined time at this point. Per verbal transfer report from ED nurse to Nurse 3 at the time of discharge from the Emergency Department, it appeared unidentified male was interrupted before he was able to do anything to resident. Family updated by hospital.</p> <p>" Beginning 9/1, automatic front door lock system was moved from auto lock of 9:30pm to auto lock at 8PM and will remain locked until 9:00 AM; the receptionist hours are 9:00 AM -8:00 PM. The system does not allow any other doors to be used for entry by visitors, and never has. All other doors are and have always been locked continuously and require badge access for entry and exit.</p> <p>" Between the hours of 5pm and 9pm beginning 9/1/17, the patient received a sitter to ensure her safety.</p> <p>" The perpetrator/unknown male was apprehended/caught by law enforcement on 9/5/17. Sitter services were discontinued on 9/6/17.</p> <p>" Staff began to receive education immediately following the event on 8/31/17 by the DON, and designees on:</p> <ul style="list-style-type: none"> o Expectations for visitor identification after door lock times. All visitors will call facility or ring front door bell to identify who they are and who they want to see. 		

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{F 223}	<p>Continued From page 7</p> <p>into the parking lot. During the phone call the daughter sat in her vehicle and was able to see the unknown male through the window and front door of the facility. The daughter told Nurse #1 the unknown male was not family and to call the police. Nurse #1 ended the call with the daughter and called 911 at 10:20 PM. At the same time, Nurse #1 explained nurse aide #1 unlocked the front door for the unknown male and he left. Nurse #1 added the police arrived to the facility "less than 5 minutes" after she called.</p> <p>In the same interview with Nurse #1 she was asked if she had ever seen the unknown male prior to the incident. Nurse #1 explained that she had seen the unknown male 2 previous times and was not aware of who he was visiting or his reason for being in the facility. She stated that the instances occurred over a two week period and described that both times the unknown male was with someone else that she was unable to identify. The Nurse reported that one instance she saw the unknown male during the 7 am to 3 pm shift and the other time was on the 3 pm to 11 pm shift. She could not recall what he was doing and she did not ask him his identity.</p> <p>On 09/07/17 at 11:15 AM Nurse #2 was interviewed and described on 08/31/17 "around 9:45 PM" she observed the door to Resident #2's room closed. The nurse stated this was concerning because the resident required close monitoring because she was a fall risk and had a tracheostomy and unable to call for help. The Nurse described that she attempted to open the door but it was barricaded and she called inside the room and there was no answer. The Nurse</p>	{F 223}	<p>A staff member will then allow access and give them a visitor name badge. All staff have received education on this.</p> <p>" Root cause analysis determinations:</p> <ul style="list-style-type: none"> o Unknown male was not initially removed from room due to escalating situation and the unknown male's potential aggressive response. This later escalated to his noncompliance to keeping door open, and he was permanently removed from room. o Nurse #1, 2 and House Coordinator were all involved in calls with key persons in resolving the above situation; therefore, all believed someone else had called 911. When it became apparent that no one had called 911, the nurses waited until the family confirmed that the unknown male was not a family member and then immediately called 911. Education/Coaching about 911 emergency procedures provided to nurses 1, 2 and House Coordinator on 9/8/17 by Administrator. o Because the nurses did not want to alarm the unknown male and wanted to keep him in the Center until the police arrived, the unknown male was not removed from all patient care areas. Communication occurred to other patient care areas, but communication did not reach everyone. Walkie-talkies were provided to nurses for unit to unit communication. o Nurse #1, upon initially noticing unknown male in center, did not inquire as to his identity and whom he was visiting. <p>Systemic Correction:</p>		

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{F 223}	<p>Continued From page 8</p> <p>stated she forced the door open and witnessed an unknown male in Resident #2's room and the unknown male had removed the resident's brief leaving her exposed. The Nurse stated at first she thought the unknown male had "killed her (Resident #2) and feared he was going to rape her (Resident #2)." Nurse #2 described that the unknown male had lowered Resident #2's bed to the floor, removed the sheets and placed them in the floor, removed the pillows from the bed and, extended the resident's legs out straight and had them separated and the unknown male had taken his shoes off.</p> <p>On 09/07/17 at 12:03 PM the House Coordinator was interviewed on the telephone and explained that the night of 08/31/17 she was on the telephone with another resident's family for a non-emergency situation when she heard Nurse #2 ask her to call 911. The House Coordinator stated she did not know what was going on for the Nurse #2 to yell for help and to call 911 but that she remained on the phone and did not call 911. The House Coordinator offered no explanation why she did not respond to Nurse #2's yell to call 911. The House Coordinator explained that when she finished with the phone call she went to Nurse #2 to find out what was going on. The House Coordinator was unaware of how long she was on the phone. She explained that she spoke with the unknown male and asked him to sign the guest registry located at the front entrance. She added she walked him to the front and watched as he signed the guest registry. The House Coordinator stated that when the police arrived to the facility, the unknown male had left the facility. The House Coordinator explained that in an attempt to keep</p>	{F 223}	<p>" 9/6/17 Vice President of Operations educated Administrator on reasonable suspicion of a crime/serious bodily reporting requirements and on 9/6/17 Administrator educated DON of serious bodily injury reporting requirements.</p> <p>" All visitors will be required to sign in to the visitor log, denoting name, name of individual they are visiting and entry/exit time. All visitors will receive a dated guest badge before entry into patient care areas. Any visitor noted in the center without a guest badge will be stopped and taken to the lobby by a staff member, to sign in/obtain a badge. All vendors or contractors must display a visible name badge. If not, one will be provided. Receptionist will be responsible for putting out dated guest badges every day. Facility now provides a receptionist 7 days per week from 9AM to 8PM, to follow above protocol. Receptionist will provide guest badges during these hours. After these hours, a nurse will answer front door bell, and provide guest badge using same protocol above.</p> <p>o All staff were educated on this new process beginning on 9/11, to completion on 9/14/17 by the Administrator and designees. Any staff member that has not been educated will not be allowed to return to work prior the receiving the education.</p> <p>" The center has initiated the use of walkie-talkies to be kept on the nurse's person on 9/14/17, to communicate immediate needs from unit to unit, including a situation where there is a patient protection emergency or</p>		

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{F 223}	<p>Continued From page 9</p> <p>the unknown male from leaving she told Nurse #4 (the 100 Hall nurse) not to let anyone out of the facility. The House Coordinator stated that assumed Nurse #4 relayed the message to all staff on the 100 Hall.</p> <p>Nurse #4 no longer works in the facility and was unable to be reached for an interview.</p> <p>On 09/07/17 at 1:34 PM Law Enforcement Officer #1 was interviewed The Law Enforcement Officer stated the unknown male had confessed to sexual crimes against Resident #2. The Law Enforcement Officer added that he was aware the hospital concluded Resident #2 had no visible injury from the assault and that sexual assault exam showed a 4 millimeter excoriated area on Resident #2's vagina. He explained that samples obtained from Resident #2 had been sent to the crime lab and could take weeks to get results. He stated the results could show fingerprints and saliva from the unknown male on Resident #2 that would not be evident in the sexual assault exam. He added the unknown male was currently in custody for the crime committed on 08/31/17. The Officer reported the unknown male stated he walked in the front entrance to the facility and entered Resident #2's room with intention to steal items of value, sifted along her body looking for items to steal and penetrated her vagina with his fingers more than once.</p> <p>An attempt was made to contact the hospital nurse that performed the sexual assault exam for Resident #2.</p>	{F 223}	<p>lock-down situation. Walkie-talkies are stored on the medication cart. Walkie-talkies are charged via nurse computer. Nurses will pass walkie-talkies on when giving report.</p> <p>" All residents who are interviewable (as evidenced by a BIMS of 12+) received verbal education by Administrator and other designees on:</p> <ul style="list-style-type: none"> ¿ Residents to be free from abuse and expected reporting of residents/staff ¿ Visitation procedures <ul style="list-style-type: none"> o This education began on September 11th, to completion on September 14th, and was documented in the medical record. All new patients will receive this education via the admissions process with review of Residents Rights and Notice of Patient's Bill of Rights. " All Responsible Parties received written communication via letter, mailed on September 13th, with information including the following: <ul style="list-style-type: none"> o Door lock times, and gaining entry during these times o The Elder Justice Act o What a reasonable suspicion of a crime is o The use of one-time use Visitor identification, ie. Guest Badges o What methods we use to keep our patients, employees and visitors safe both during and after normal business hours. <p>Measures to be put in place or system changes made to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory</p>		

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{F 223}	<p>Continued From page 10</p> <p>On 09/07/17 at 2:16 PM floor technician #1 was interviewed and stated he had seen the unknown male in the facility several times and did not feel his behavior was suspicious. The floor technician explained that he did not know the reason for unknown male's visits. The floor technician added that on each witnessed account he noticed the unknown male brought a fast food bag with him but did not have then bag when he left. The floor technician stated he assumed the unknown male was bringing food to someone. The floor technician stated there was a lot of people in and out of the facility and unless they were wandering around or going in and out of rooms he would not question them or ask them what they were doing.</p> <p>On 09/07/17 at 2:27 PM the Administrator was interviewed and explained he would expect his staff to question the identity of a visitor that was acting suspicious. The Administrator did not believe the unknown male opening a closed door to a resident's room, then leaving was suspicious behavior.</p> <p>The facility's medical director was out of the country and unable to be reached for an interview.</p> <p>On 09/08/17 at 11:15 AM the Administrator was notified of Immediate Jeopardy.</p>	{F 223}	<p>requirements:</p> <p>" Administrator will daily M-F, for a period of four weeks, then twice weekly for four weeks, and weekly for four weeks will check to ensure visitors are adhering to guest badge protocols and walkie talkies are on the nurse person. Any deficient practice will be addressed immediately by the administrator.</p> <p>" Automatic front door lock system will lock door at 5PM and will remain locked until 9:00 AM</p> <p>" All new hires during orientation will receive education on abuse/neglect/ misappropriation/crime Nursing P/P 101, Elder Justice Act and Visitor Badge protocols.</p> <p>" All new licensed nurses will receive education on use of walkie talkies.</p> <p>" Administrator will audit that all new patients received education via the admissions process with review of Residents Rights, Visitation procedure and Notice of Patient's Bill of Rights for three months. Any deficient practice will be addressed immediately by the administrator.</p> <p>" Responsible parties for all new admission will receive a letter notifying them of:</p> <ul style="list-style-type: none"> o Door lock times, and gaining entry during these times o Elder Justice Act o What a reasonable suspicion of a crime is o The use of one-time use Visitor identification, ie. Guest Badges o What methods we use to keep our patients, employees and visitors safe both 		

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{F 223}	Continued From page 11	{F 223}	during and after normal business hours. How facility will monitor corrective action (s) to ensure deficient practice will not re-occur: Results of all audits will be reviewed by the QAPI (Quality Assurance Performance Improvement) committee monthly times three, for continued compliance or revisions to the plan as needed. Administrator responsible for implementing the acceptable plan of correction.		
{F 225} SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee,	{F 225}		9/22/17	

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

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{F 225}	<p>Continued From page 12 which would indicate unfitness for service as a nurse aide or other facility staff.</p> <p>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p>	{F 225}			

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{F 225}	<p>Continued From page 13</p> <p>Based on staff interviews, Law Enforcement Officer Interview, nurse practitioner interview and record review the facility failed to notify Health Care Personnel Investigations of a crime against a resident within the required 2 hour timeframe, failed to notify Adult Protective Services of the incident and failed to notify law enforcement immediately of suspicion of a crime for 1 of 1 resident (Resident #2).</p> <p>Immediate Jeopardy began on 08/31/17 when Nurse #2 had to use force to open Resident # 2's barricaded door and observed an unknown male in Resident #2's room, the sheets were off the bed and the resident's brief had been removed; and the facility did not notify local law enforcement immediately. The Immediate Jeopardy is present and ongoing.</p> <p>The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation for the removal of the Immediate Jeopardy on 09/14/17.</p> <p>A revisit survey was conducted on 09/21/17 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following:</p> <ul style="list-style-type: none"> - Systematic changes implemented to ensure visitors are identified before being allowed inside the facility. - Evidence of staff, resident and family education on abuse, emergency response and resident protection. - Documentation of audits for the in-servicing and procedures implemented related to abuse prohibition, protection of residents and 	{F 225}	<p>F225 Charlotte Health Care Center</p> <p>This allegation of compliance is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following credible allegations constitutes the center's allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated.</p> <p>How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • On the evening of August 31, 2017, at or around 9:30 pm, Nurse 2 observed Resident 2's door closed. Nurse 2 opened Resident 2's door and found an unknown male in the room with Resident 2. Resident 2 was found with her covers down and brief off. When questioned, the unknown male told Nurse 2 that he was the nephew of Resident 2 and he was changing his aunt's brief. Nurse 2 then approached House Coordinator, who was in an office and on the phone with a family member of a resident. House Coordinator heard Nurse 2 ask House Coordinator to call 911, but House Coordinator directed Nurse 2 to ask Nurse 1 to call 911 while House Coordinator finished her call. Nurse 1 overheard Nurse 2's request to call 911, but did not hear House 	

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{F 225}	<p>Continued From page 14 emergency response procedures.</p> <p>Observations of the facility's new security procedures for visitation were made and interviews with staff, residents and visitor were aware of the systemic changes implemented. The facility provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F 225 at a lower scope and severity (D) isolated, no actual harm that is not immediate jeopardy while the facility continues the process of monitoring and implementation of the corrective action.</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on 07/20/17 with diagnoses that included acute respiratory failure with hypoxia, seizures, tracheostomy, gastrostomy, dementia, and urinary tract infections. The admission Minimum Data Set (MDS) dated 07/27/17 specified the resident had short and long term memory impairment with severely impaired cognitive skills for daily decision making. The MDS also specified the resident was not comatose, but had no speech and the rare ability to make herself understood. The resident required two person physical assistance with activities of daily living.</p> <p>The facility provided a 24-Hour Initial Report dated 09/01/17 that specified an allegation of Resident Abuse with reasonable suspicion of crime had occurred on 08/31/17 for Resident #2. The facility documented there was a Reasonable Suspicion of a Crime but there was no Serious</p>	{F 225}	<p>Coordinator's response and therefore assumed House Coordinator called 911.</p> <ul style="list-style-type: none"> Nurse 1 then joined Nurse 2 in Resident 2's room, and continued to question the unknown male. The unknown male insisted he was Resident 2's nephew and provided a first name and a last name that matched Resident #2's last name. At this point, the unknown male began to show signs of aggression and Nurse 1 instructed Nurse 2 to leave the room. Nurse 2 stationed herself in the hallway just outside Resident 2's room while Nurse 1 explained to the unknown male that she was going to call Resident 2's daughter to confirm his identity. Nurse 1 left Resident 2's room for privacy while she called Daughter and Nurse 2 remained stationed in the hallway just outside the room. However, the unknown male closed Resident 2's door which prompted Nurse 1 to reopen the door and instruct the unknown male not to close the door. This occurred several more times until the unknown male was instructed to exit Resident 2's room and remain in the hallway. Nurse 1 called Daughter at 9:51 pm from Nurse 1's cell phone. However, Daughter did not pick up the call. Nurse 1 returned to the area outside of Resident 2's room where the unknown man and Nurse 2 were waiting. Daughter returned the phone call at 9:52 pm so Nurse 1 stepped away again and explained to Daughter what had transpired and that the unknown male claimed he was a family member and provided a first name. Daughter advised Nurse 1 that they did have a family member by that first name 	

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{F 225}	<p>Continued From page 15</p> <p>Bodily Injury. The facility notified the Police Department.</p> <p>A facsimile receipt documented Health Care Personnel Investigations was notified of the allegation on 09/01/17 at 4:39 PM. The facility did not provide documentation that Adult Protective Services (APS) was notified of the incident.</p> <p>On 09/07/17 at 11:15 AM Nurse #2 was interviewed and described on 08/31/17 "around 9:45 PM" she observed the door to Resident #2's room closed. The nurse stated this was concerning because the resident required close monitoring because she was a fall risk and had a tracheostomy and unable to call for help. The Nurse described that she attempted to open the door but it was blocked and she called inside the room and there was no answer. The Nurse stated she forced the door open and witnessed an unknown male in Resident #2's room and the unknown male had removed the resident's brief leaving her exposed. The Nurse stated at first she thought the unknown male had "killed her (Resident #2) and feared he was going to rape her (Resident #2)." Nurse #2 reported she left the room and yelled for the House Coordinator to call 911. Nurse #2 stated the House Coordinator replied that she was "on the phone." Nurse #2 explained that it was 15- 20 minutes before the police were called because she was trying to keep the Resident #2 safe. Nurse #2 stated that when the police arrived a staff member had allowed the unknown male to leave the facility.</p>	{F 225}	<p>and that she was going to drive to the Center to confirm whether the unknown male was a family member.</p> <ul style="list-style-type: none"> Around 9:52 pm, when Nurse 1 stepped away to speak to Daughter, House Coordinator went to find Nurse 2 to see if she could be of assistance. Not knowing yet what had transpired, House Coordinator found the unknown male and questioned whether he had signed in at the front desk. When the unknown male responded that he had not signed in, House Coordinator escorted him to the front desk and observed him sign in. The unknown male and House Coordinator returned to the hallway at which point House Coordinator asked Nurse 2 what was going on. Nurse 1 advised Nurse 2 and House Coordinator that Daughter was on her way to identify the unknown male. Nurse 2 called the DON at 9:59 pm to explain what had transpired. Nurse 1, Nurse 2, and House Coordinator then worked together to keep an eye on the unknown male, keep in contact with Daughter, care for and protect the residents, alert the DON, and try to alert other staff members of the situation while attempting to keep the unknown male calm and not alert him as to their actions. It was around this time that Nurse 1, Nurse 2, and House Coordinator realized that no one had called 911. Nurse 1 then called Daughter at 10:09 pm to obtain her status. Daughter advised that she was on her way and in close proximity to the center. The nurses would call 911 if the unknown male was not identified by Daughter as a 		

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{F 225}	<p>Continued From page 16</p> <p>On 09/07/17 at 12:03 PM the House Coordinator was interviewed on the telephone and explained that the night of 08/31/17 she was on the telephone with another resident's family for a non-emergency situation when she heard Nurse #2 ask her to call 911. The House Coordinator stated she did not know what was going on for the nurse to yell for help and to call 911 but that she remained on the phone and did not call 911. The House Coordinator offered no explanation why she did not respond to Nurse #2's yell to call 911. The House Coordinator explained that when she finished with the phone call she went to Nurse #2 to find out what was going on. The House Coordinator was unaware of how long she was on the phone. The House Coordinator stated that when the police arrived to the facility, the unknown male had left the facility.</p> <p>On 09/07/17 at 1:34 PM Law Enforcement Officer #1 was interviewed on the telephone and explained he was the reporting officer for the case against Resident #2. The Law Enforcement Officer reviewed police reports and stated police were contacted by the facility on 08/31/17 at 10:20 PM and were dispatched immediately. The Law Enforcement Officer explained that when the police arrived to the facility, the unknown male had been allowed to leave the facility. He added that witnesses in the parking lot were able to give a description of the unknown male and make and model of the vehicle he was driving. The Law Enforcement Officer added that once the resident was transported to the Emergency Department for a sexual assault examination, police were re-dispatched to the facility at 11:41 PM.</p>	{F 225}	<p>family member.</p> <ul style="list-style-type: none"> At 10:18 pm, Daughter called Nurse 1's cell phone and advised that she had arrived at the Center and had looked through the window to observe the unknown male. Daughter confirmed what the unknown male was wearing with Nurse 1 and then Daughter stated that the unknown male was not her family member. At this point, Nurse 1 hung up with Daughter and immediately called 911 at 10:20 pm. Per telephone interview with Detective assigned to case on 9/13/17 by Administrator, the 911 call was confirmed at 10:20pm, and dispatched at 10:22pm. Around the same time, CNA 1 unlocked (by swiping her badge) the front door to allow the unknown male out of the building at 10:19 pm. CNA 1 had no knowledge as to what had transpired related to the unknown male. Based on information provided by Detective, the police arrived at the Center at 10:23 pm. Nurse 1 and Daughter spoke with police outside the Center, at which time Nurse 1 provided a description of the unknown male and Daughter provided a description of the vehicle he fled in. Based on information and belief, per interview of Detective, the event was closed by the police at 10:42pm. Visual assessment of resident body done by Nurse #2 for any signs of bruising, redness, bleeding, agitation/anxiety-none found. The decision was made to not change or clean resident prior to sending for possible sexual assault examination. Daughter visited with Resident 2, 		

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{F 225}	<p>Continued From page 17</p> <p>On 09/07/17 at 2:27 PM the Administrator was interviewed and explained he was notified of the incident on 09/01/17 by the Corporate Consultant because he was on vacation. He stated that in his absence the Director of Nursing, Corporate Consultant and Director of Operations oversaw facility operations. The Administrator added that he returned to work on 09/05/17 and started the investigation into the incident and intended to have the 5 day report completed and submitted to the State Agency on 09/08/17. The Administrator did not state if other agencies had been notified of the allegation.</p> <p>On 09/07/17 at 3:55 PM the interim Director of Nursing (DON) was interviewed and reported she was contacted by Nurse #2 on 08/31/17 at 9:59 PM informing her an unknown male was found in Resident #2's room and had removed her brief. The DON stated she directed Nurse #2 to call the police. The DON explained that it did not matter that the unknown male was alleging to be family based on what Nurse #2 had witnessed in the room. The DON was unaware when the police were called. But the DON was aware the unknown male had been able to leave the facility when the police arrived. The DON added an abuse investigation was initiated that night when she contacted the Corporate Consultant.</p> <p>On 09/08/17 at 11:10 AM the Corporate Consultant was interviewed and reported that she was contacted by the Director of Nursing (DON) about the assault allegation on 08/31/17. The Consultant explained that the facility proceeded with an abuse investigation. The Consultant reported the Health Care Personnel</p>	{F 225}	<p>facility staffed consoled the family, and family was counseled by the nurses about sending Resident 2 to hospital to be evaluated. Decision was made to send resident to hospital to rule out sexual assault. While family was questioned by Nurse #1 whether they wanted the assessment done, the nurse stated she did this only to include them since it was a significant event, but intentioned to send her anyway to protect the resident, herself and the center.</p> <ul style="list-style-type: none"> As a result of this second call to 911, both EMS and law enforcement officers were dispatched to the center. EMS unit dispatched per 911 call at 11:38pm, and reached patient's room at 11:52pm. Arrived to Hospital at 12:24AM. Per hospital report no evidence of break in skin, abrasions except for excoriation to labia, redness, bruising, swelling, or bleeding to the body. No evidence of semen, DNA pending at this time, and detective assigned to case unable to tell us when we will get it back, and undetermined time at this point. Per verbal transfer report from ED nurse to Nurse 3 at the time of discharge from the Emergency Department, it appeared unidentified male was interrupted before he was able to do anything to resident. Family updated by hospital. A 24 hour initial report was filed with the Health Care Personnel Investigation on 9/1/17 A 5 day working report was filed with the Health Care Registry detailing the incident 9/8/17, within 5 working days. APS was notified on 9/11/17. 		

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{F 225}	<p>Continued From page 18</p> <p>Investigations was not notified of the crime within the 2 hour timeframe because there was no "serious bodily injury" sustained to Resident #2. The Consultant stated she did not consider an allegation of sexual assault to be serious bodily injury because the resident did not have signs of injury to her body such as vaginal trauma or bleeding.</p> <p>The Consultant referenced Resident #2's "Sexual Assault Nurse Examination" dated 09/01/17 that specified the Resident had no physical injuries from the assault.</p> <p>The facility's medical director was out of the country and unable to be reached for an interview.</p> <p>On 09/08/17 at 2:10 PM the Nurse Practitioner (NP) was interviewed and explained that she would expect staff to call police immediately if they suspected assault on a resident and send the resident to the Emergency Department immediately for evaluation. The NP also stated that it would be helpful if the facility had a communication system such as a "code" system to alert all staff of a dangerous situation to prevent a staff member from letting a perpetrator from leaving the building.</p> <p>On 09/08/17 at 11:15 AM the Administrator was notified of Immediate Jeopardy.</p>	{F 225}	<ul style="list-style-type: none"> • Root cause analysis determinations: <ul style="list-style-type: none"> o Nurse #1, 2 and House Coordinator were all involved in calls with key persons in resolving the above situation; therefore, all believed someone else had called 911. When it became apparent that no one had called 911, the nurses waited until the family confirmed that the unknown male was not a family member and then immediately called 911. o Education/Coaching regarding appropriate and timely reporting procedures provided to nurses 1, 2 and House Coordinator on 9/8/17 by Administrator. o Facility did not report within the required 2-hour period to State Agency, because it was determined based on hospital report that the patient did not suffer serious bodily injury, as a result of the abuse. Moving forward, we will report anyway, given the nature of the allegation within a 2 hour period. <p>Systemic Correction:</p> <ul style="list-style-type: none"> • 9/6/17 Vice President of Operations educated Administrator on reasonable suspicion of a crime/serious bodily reporting requirements and on 9/6/17 Administrator educated DON of all abuse/crime reporting requirements. • All staff re-inserviced on reporting requirements on 9/14/17. The center has initiated the use of walkie-talkies to be kept on the nurse's person on 9/14/17, to communicate immediate needs from unit to unit, including a situation where there is a patient protection emergency or lock-down situation. Walkie-talkies are 		

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{F 225}	Continued From page 19	{F 225}	<p>stored on the medication cart. Walkie-talkies are charged via nurse computer. Nurses will pass walkie-talkies on when giving report. Once information is communicated staff will follow abuse policies and procedures.</p> <ul style="list-style-type: none"> All residents who are interviewable (as evidenced by a BIMS of 12+) received verbal education by Administrator and other designees on: <ul style="list-style-type: none"> Residents to be free from abuse and expected reporting of residents/staff <ul style="list-style-type: none"> This education began on September 11th, to completion on September 14th, and was documented in the medical record. All new patients will receive this education via the admissions process with review of Residents Rights and Notice of Patient's Bill of Rights. All Responsible Parties received written communication via letter, mailed on September 13th, with information including the following: <ul style="list-style-type: none"> The Elder Justice Act What a reasonable suspicion of a crime is <p>Measures to be put in place or system changes made to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:</p> <ul style="list-style-type: none"> Administrator will daily M-F, for a period of four weeks, then twice weekly for four weeks, and weekly for four weeks will check to ensure visitors are adhering to guest badge protocols and walkie talkies are on the nurse person. Any deficient practice will be addressed 		

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{F 225}	Continued From page 20	{F 225}	<p>immediately by the administrator.</p> <ul style="list-style-type: none"> • Automatic front door lock system will lock door at 5PM and will remain locked until 9:00AM. • All new hires during orientation will receive education on abuse/neglect/ misappropriation/crime Nursing P/P 101, Elder Justice Act and Visitor Badge protocols. • All new licensed nurses will receive education on use of walkie talkies. • Administrator will audit that all new patients received education via the admissions process with review of Residents Rights, Visitation procedure and Notice of Patient's Bill of Rights for three months. Any deficient practice will be addressed immediately by the administrator. • Responsible parties for all new admission will receive a letter notifying them of: <ul style="list-style-type: none"> o Door lock times, and gaining entry during these times o Elder Justice Act o What a reasonable suspicion of a crime is o The use of one-time use Visitor identification, ie. Guest Badges o What methods we use to keep our patients, employees and visitors safe both during and after normal business hours. <p>How facility will monitor corrective action (s) to ensure deficient practice will not re-occur: Results of all audits will be reviewed by the QAPI (Quality Assurance Performance Improvement) committee monthly times three, for continued compliance or</p>	

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{F 225}	Continued From page 21	{F 225}			
{F 226} SS=D	<p>483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>483.12 (b) The facility must develop and implement written policies and procedures that:</p> <p>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>(2) Establish policies and procedures to investigate any such allegations, and</p> <p>(3) Include training as required at paragraph §483.95,</p> <p>483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-</p> <p>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>(c)(3) Dementia management and resident abuse</p>	{F 226}	<p>revisions to the plan as needed. Administrator responsible for implementing the acceptable plan of correction.</p>	9/22/17	

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{F 226}	<p>Continued From page 22 prevention.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff, nurse practitioner and Law Enforcement interviews and record review, the facility failed to follow policy and procedures for Abuse Prohibition for protecting a resident after an assault for 1 of 3 sampled residents (Resident #2). After the assault, the facility allowed the unknown male to remain in the room with the resident, waited to contact police and allowed the unknown male to flee the facility. The unknown male was arrested on 09/05/17 and confessed to two 2nd degree sex offenses.</p> <p>Immediate Jeopardy began on 08/31/17 when Nurse #2 had to use force to open Resident # 2's barricaded door and observed an unknown male in Resident #2's room, the sheets were off the bed and the resident's brief had been removed. The Nurse allowed the unknown male to stay in the room, the nursing staff waited before calling police and allowed the unknown male to flee the facility before the police arrived. The Immediate Jeopardy is present and ongoing.</p> <p>The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation for the removal of the Immediate Jeopardy on 09/14/17.</p> <p>A revisit survey was conducted on 09/21/17 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following:</p> <ul style="list-style-type: none"> - Systematic changes implemented to ensure visitors are identified before being allowed inside 	{F 226}	<p>F226 Charlotte Health Care Center</p> <p>This allegation of compliance is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following credible allegations constitutes the center's allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated.</p> <p>How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • On the evening of August 31, 2017, at or around 9:30 pm, Nurse 2 observed Resident 2's door closed. Nurse 2 opened Resident 2's door and found an unknown male in the room with Resident 2. Resident 2 was found with her covers down and brief off. When questioned, the unknown male told Nurse 2 that he was the nephew of Resident 2 and he was changing his aunt's brief. Nurse 2 then approached House Coordinator, who was in an office and on the phone with a family member of a resident. House Coordinator heard Nurse 2 ask House Coordinator to call 911, but House Coordinator directed Nurse 2 to ask Nurse 1 to call 911 while House Coordinator finished her call. 		

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{F 226}	<p>Continued From page 23</p> <p>the facility.</p> <ul style="list-style-type: none"> - Evidence of staff, resident and family education on abuse, emergency response and resident protection. - Documentation of audits for the in-servicing and procedures implemented related to abuse prohibition, protection of residents and emergency response procedures. <p>Observations of the facility's new security procedures for visitation were made and interviews with staff, residents and visitor were aware of the systemic changes implemented. The facility provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F 226 at a lower scope and severity (D) isolated, no actual harm that is not immediate jeopardy while the facility continues the process of monitoring and implementation of the corrective action.</p> <p>The findings included:</p> <p>A policy titled "Abuse/Neglect/Misappropriation/Crime" dated 11/04/16 read in part, "There is a zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center." Procedures include:</p> <ul style="list-style-type: none"> - Any staff member observing or suspecting abuse, neglect, misappropriation of property, mistreatment or a reasonable suspicion of a crime will remove the patient from any observed danger or harm and immediately report the 	{F 226}	<p>Nurse 1 overheard Nurse 2's request to call 911, but did not hear House Coordinator's response and therefore assumed House Coordinator called 911.</p> <ul style="list-style-type: none"> • Nurse 1 then joined Nurse 2 in Resident 2's room, and continued to question the unknown male. The unknown male insisted he was Resident 2's nephew and provided a first name and a last name that matched Resident #2's last name. At this point, the unknown male began to show signs of aggression and Nurse 1 instructed Nurse 2 to leave the room. Nurse 2 stationed herself in the hallway just outside Resident 2's room while Nurse 1 explained to the unknown male that she was going to call Resident 2's daughter to confirm his identity. Nurse 1 left Resident 2's room for privacy while she called Daughter and Nurse 2 remained stationed in the hallway just outside the room. However, the unknown male closed Resident 2's door which prompted Nurse 1 to reopen the door and instruct the unknown male not to close the door. This occurred several more times until the unknown male was instructed to exit Resident 2's room and remain in the hallway. Nurse 1 called Daughter at 9:51 pm from Nurse 1's cell phone. However, Daughter did not pick up the call. Nurse 1 returned to the area outside of Resident 2's room where the unknown man and Nurse 2 were waiting. Daughter returned the phone call at 9:52 pm so Nurse 1 stepped away again and explained to Daughter what had transpired and that the unknown male claimed he was a family member and provided a first name. 		

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{F 226}	<p>Continued From page 24</p> <p>incident to the immediate supervisor.</p> <ul style="list-style-type: none"> - The Administrator will immediately file an initial report to the State Agency. <ul style="list-style-type: none"> o Serious bodily injury must be reported no later than two hours after forming the suspicion. - The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include but not limited to, collecting evidence, interviewing alleged victims and witnesses and involving other appropriate individuals, agents or authorities to assist in the process and determinations. - The Administrator will immediately (within 2 or 24 hours of knowledge of the allegation) notify the Adult Protective Services Agency, the local Ombudsman and the appropriate law enforcement authorities. <p>Resident #2 was admitted to the facility on 07/20/17 with diagnoses that included acute respiratory failure with hypoxia, seizures, tracheostomy, gastrostomy, dementia, and urinary tract infections. The admission Minimum Data Set (MDS) dated 07/27/17 specified the resident had short and long term memory impairment with severely impaired cognitive skills for daily decision making. The MDS also specified the resident was not comatose, but had no speech and the rare ability to make herself understood. The resident required two person physical assistance with activities of daily living.</p> <p>A nurse's entry made by Nurse #1 dated 08/31/17 at 11:38 PM specified 911 was called and police arrived at the facility in relation to an unknown</p>	{F 226}	<p>Daughter advised Nurse 1 that they did have a family member by that first name and that she was going to drive to the Center to confirm whether the unknown male was a family member.</p> <ul style="list-style-type: none"> • Around 9:52 pm, when Nurse 1 stepped away to speak to Daughter, House Coordinator went to find Nurse 2 to see if she could be of assistance. Not knowing yet what had transpired, House Coordinator found the unknown male and questioned whether he had signed in at the front desk. When the unknown male responded that he had not signed in, House Coordinator escorted him to the front desk and observed him sign in. The unknown male and House Coordinator returned to the hallway at which point House Coordinator asked Nurse 2 what was going on. Nurse 1 advised Nurse 2 and House Coordinator that Daughter was on her way to identify the unknown male. Nurse 2 called the DON at 9:59 pm to explain what had transpired. • Nurse 1, Nurse 2, and House Coordinator then worked together to keep an eye on the unknown male, keep in contact with Daughter, care for and protect the residents, alert the DON, and try to alert other staff members of the situation while attempting to keep the unknown male calm and not alert him as to their actions. It was around this time that Nurse 1, Nurse 2, and House Coordinator realized that no one had called 911. Nurse 1 then called Daughter at 10:09 pm to obtain her status. Daughter advised that she was on her way and in close proximity to the center. 		

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{F 226}	<p>Continued From page 25 male observed in Resident #2's room.</p> <p>Review of Resident #2's medical record revealed a medical transportation report dated 08/31/17. The report specified the medical transport was dispatched at 11:38 PM and arrived to Resident #2 at 11:52 PM. The report specified the chief complaint was assault and that they arrived on scene to find an 85 year old "semi-flower" in bed. The report also revealed family reported the resident may have been sexually assaulted by an unknown male that barricaded himself in the room and had removed the resident's brief. The unknown male had been allowed to leave the facility. Staff reported to the medical transport unit that the resident had not been changed or cleaned since the assault.</p> <p>Further review of the medical record revealed a document titled "Sexual Assault Nurse Examination" dated 09/01/17 at 1:42 AM performed in the Emergency Department. The exam revealed that Resident #2 had no physical injuries from the assault. The exam report revealed the resident had a 4 millimeter excoriation on her labia. Evidence was collected and provided to Law Enforcement.</p> <p>A nurse's entry made by Nurse #3 dated 09/01/17 at 5:15 AM revealed Resident #2 was returning to the facility from the Emergency Department after having had a sexual assault exam. The nurse documented, "Report was received from the hospital that according to the assessment and testing it appeared the unidentified male was interrupted before he could do anything to the resident." The facility provided a 24-Hour Initial Report</p>	{F 226}	<p>The nurses would call 911 if the unknown male was not identified by Daughter as a family member.</p> <ul style="list-style-type: none"> At 10:18 pm, Daughter called Nurse 1's cell phone and advised that she had arrived at the Center and had looked through the window to observe the unknown male. Daughter confirmed what the unknown male was wearing with Nurse 1 and then Daughter stated that the unknown male was not her family member. At this point, Nurse 1 hung up with Daughter and immediately called 911 at 10:20 pm. Per telephone interview with Detective assigned to case on 9/13/17 by Administrator, the 911 call was confirmed at 10:20pm, and dispatched at 10:22pm. Around the same time, CNA 1 unlocked (by swiping her badge) the front door to allow the unknown male out of the building at 10:19 pm. CNA 1 had no knowledge as to what had transpired related to the unknown male. Based on information provided by Detective, the police arrived at the Center at 10:23 pm. Nurse 1 and Daughter spoke with police outside the Center, at which time Nurse 1 provided a description of the unknown male and Daughter provided a description of the vehicle he fled in. Based on information and belief, per interview of Detective, the event was closed by the police at 10:42pm. Visual assessment of resident body done by Nurse #2 for any signs of bruising, redness, bleeding, agitation/anxiety-none found. The decision was made to not change or clean resident prior to sending for possible 		

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{F 226}	<p>Continued From page 26</p> <p>dated 09/01/17 that specified an allegation of Resident Abuse with reasonable suspicion of crime had occurred on 08/31/17 for Resident #2. The facility documented there was a Reasonable Suspicion of a Crime but there was no Serious Bodily Injury. The facility notified the Police Department.</p> <p>The police report titled "Criminal Investigations Case Synopsis" created on 09/01/17 and updated on 09/05/17 specified the unknown male became a person of interest on 09/01/17 for possible sexual assault when he was found in Resident #2's room. The Resident's gown was opened and brief pulled down. The report revealed the unknown male had been allowed to flee. The unknown male was located and interviewed on 09/05/17. The unknown male was arrested and charged with two 2nd degree sex offenses against Resident #2 on 09/05/17.</p> <p>On 09/07/17 at 9:50 AM Resident #2 was observed in bed and her eyes were closed.</p> <p>On 09/07/17 at 10:35 AM Nurse #1 was interviewed and reported the facility had one entrance for visitors that automatically locked at 9:30 PM. She stated that after 9:30 PM visitors were dependent on a staff member to let them in and out of the facility. Nurse #1 described that on 08/31/17 she was working 3 PM to 11 PM and was preparing to start her 9 PM medication pass on the 200 A Hall. The Nurse explained that at 9:15 or 9:20 PM she was at the top of the 200 A Hall standing at her medication cart when she noticed an unknown male walk past her to the</p>	{F 226}	<p>sexual assault examination.</p> <ul style="list-style-type: none"> Daughter visited with Resident 2, facility staffed consoled the family, and was counseled by the nurses about sending Resident 2 to hospital to be evaluated. Decision was made to send resident to hospital to rule out sexual assault. While family was questioned by Nurse #1 whether they wanted the assessment done, the nurse stated she did this only to include them since it was a significant event, but intentioned to send her anyway to protect the resident, herself and the center. As a result of this second call to 911, both EMS and law enforcement officers were dispatched to the center. EMS unit dispatched per 911 call at 11:38pm, and reached patient's room at 11:52pm. Arrived to Hospital at 12:24AM. Per hospital report no evidence of break in skin, abrasions except for excoriation to labia, redness, bruising, swelling, or bleeding to the body. No evidence of semen, DNA pending at this time, and detective assigned to case unable to tell us when we will get it back, and undetermined time at this point. Per verbal transfer report from ED nurse to Nurse 3 at the time of discharge from the Emergency Department, it appeared unidentified male was interrupted before he was able to do anything to resident. Family updated by hospital. Excoriation to labia noted in ER record, but undetermined as to source. Beginning 9/1, automatic front door lock system was moved from auto lock of 9:30pm to auto lock at 8PM and will 		

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{F 226}	<p>Continued From page 27</p> <p>end of the 200 A Hall, opened a door, looked in the room, shut the door and walked back up the hall. She stated she felt this was "odd" because she didn't know who the male was and why he would have been visiting that Resident. The Nurse added that when the unknown male walked back up the hall she said, "Hi" and the unknown male waved and stated, "Good night."</p> <p>During the same interview the Nurse continued with her story that she remained in the same location at the top of the 200 A Hall and assumed the unknown male exited the building. Nurse #1 explained that she proceeded with her medication pass and approximately "5 minutes later" she heard a "boom" and Nurse #2 yelling for the House Coordinator to, "Call 911! He's trying to rape her (Resident #2)." Nurse #1 described that she stopped her medication pass, grabbed an umbrella and went to Nurse #2 on the 200 B Hall. Nurse #1 asked what was going on and Nurse #2 reported that she found Resident #2's door closed and when she opened it she saw an unknown male in the room and he had taken the Resident's bed sheets off and removed her brief. Nurse #1 stated that it was the same unknown male she saw 5 minutes earlier that she assumed had left the building. The unknown male told the nurses he was visiting his "aunt" and needed to provide incontinence care because the nursing staff were not doing their jobs of providing care to Resident #2.</p> <p>Continuing the interview, Nurse #1 stated she asked the unknown male his identity and after stating the question several times, he provided his name. She stated she wanted to try to diffuse</p>	{F 226}	<p>remain locked until 9:00 AM; the receptionist hours are 9:00 AM -8:00 PM. The system does not allow any other doors to be used for entry by visitors, and never has. All other doors are and have always been locked continuously and require badge access for entry and exit.</p> <ul style="list-style-type: none"> Between the hours of 5pm and 9pm beginning 9/1/17, the patient received a sitter to ensure her safety. The perpetrator/unknown male was apprehended/caught by law enforcement on 9/5/17. Sitter services were discontinued on 9/6/17. Staff began to receive education immediately following the event on 8/31/17 by the DON, and designees on: <ul style="list-style-type: none"> Expectations for visitor identification after door lock times. All visitor's will call facility or ring bell to identify who they are and who they want to see. A nurse or person in change will then allow access and give them a visitor name badge. All staff have received education on this. A 24 hour initial report was filed with the Health Care Personnel Investigation on 9/1/17 A 5 day working report was filed with the Health Care Registry detailing the incident 9/8/17, within 5 working days. APS was notified on 9/11/17. <p>Systemic Correction:</p> <ul style="list-style-type: none"> 9/6/17 Vice President of Operations educated Administrator on reasonable suspicion of a crime/serious bodily reporting requirements and on 9/6/17 Administrator educated DON of serious bodily injury reporting requirements. 		

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{F 226}	<p>Continued From page 28</p> <p>the situation because she could tell the unknown male was angry with Nurse #2, so she asked the unknown male to have a seat in Resident #2's room while she called the family to verify his identify. Nurse #1 stated she realized when she walked away from the room, the unknown male had shut the door to the room. Nurse #1 opened the door and explained to the unknown male that he would need to sit in the room with the door open. Nurse #2 stood outside the room continuing her medication pass to watch the unknown male while Nurse #1 used the telephone. Nurse #1 reported that the unknown male attempted to shut the door 4 times until she finally told him he had to get out of the room. Nurse #1 stated the unknown male was shutting the door because he was "fixing Resident #2" back.</p> <p>Nurse #1 explained the unknown male had reattached the resident's brief and put the covers back on her body. Nurse #1 described that she went to the nurses' station area and observed the House Coordinator on the telephone and assumed she was on the phone with 911 as Nurse #2 had called for her to do. The Nurse stated her goal became to keep Resident #2 safe and contact the family. The nurse stated she saw the House Coordinator and asked her if she had called 911 and she hadn't. The Nurse stated she was so confused and upset that 911 had not been called but she knew she had to protect Resident #2. Nurse #1 decided to contact the family because she knew the unknown male was locked inside the facility since it was after 9:30 PM. The nurse used her cell phone to track call times and revealed she spoke with Resident #2's daughter at 9:52 PM to ask if she had a family member</p>	{F 226}	<ul style="list-style-type: none"> • All staff began to receive education on 9/6/17 by the DON/designee on: <ul style="list-style-type: none"> o Abuse policy/procedures; Nursing P/101, titled "Abuse, Neglect/Misappropriation/Crime" including: <ul style="list-style-type: none"> ¿ reasonable suspicion of a crime and examples of things that fall into this category ¿ protecting the resident first ¿ calling 911 immediately after and/or simultaneously if possible ¿ reporting timeframes of a 2-hour period vs. the 24 hour period of the Federal Elder Justice Act to the appropriate persons (police, State Agency, APS) o Education began on 9/6/17 and completed on 9/14/17; Any staff that has not received the education will not be allowed to work until education completed. • Root cause analysis determinations: <ul style="list-style-type: none"> o Unknown male was not initially removed from room due to escalating situation and the unknown male's potential aggressive response. This later escalated to his noncompliance to keeping door open, and he was permanently removed from room. o Nurse #1, 2 and house coordinator were all involved in calls with key persons in resolving the above situation; therefore, all believed someone else had called 911. When it became apparent that no one had called 911, the nurses waited until the family confirmed that the unknown male was not a family member and then immediately called 911. Education/Coaching provided to nurses 1, 		

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{F 226}	<p>Continued From page 29</p> <p>with the name provided and the daughter said, "Yes." Nurse #1 provided a description of the unknown male and the descriptions did not match but the family stated she was on her way to the facility. Nurse #1 placed a second call to the daughter at 10:18 PM asking her where she was and she was pulling into the parking lot. During the phone call the daughter sat in her vehicle and was able to see the unknown male through the window and front door of the facility. The daughter told Nurse #1 the unknown male was not family and to call the police. Nurse #1 ended the call with the daughter and called 911 at 10:20 PM. At the same time, Nurse #1 explained nurse aide #1 unlocked the front door for the unknown male and he left. Nurse #1 added the police arrive to the facility "less than 5 minutes" after she called.</p> <p>In the same interview with Nurse #1 she reported that she had received training on abuse and knew to report immediately any suspected allegation and to protect the resident.</p> <p>On 09/07/17 at 11:15 AM Nurse #2 was interviewed and described on 08/31/17 "around 9:45 PM" she observed the door to Resident #2's room closed. The nurse stated this was concerning because the resident required close monitoring because she was a fall risk and had a tracheostomy and unable to call for help. The Nurse described that she attempted to open the door but it was barricaded and she called inside the room and there was no answer. The Nurse stated she forced the door open and witnessed an unknown male in Resident #2's room and the unknown male had removed the resident's brief</p>	{F 226}	<p>2 and house coordinator on 9/8/17 by Administrator.</p> <ul style="list-style-type: none"> o Because the nurses did not want to alarm the unknown male and wanted to keep him in the Center until the police arrived, the unknown male was not removed from all patient care areas. Communication occurred to other patient care areas, but communication did not reach everyone. o Nurse #1, upon initially noticing unknown male in center, did not inquire as to his identity and whom he was visiting. o Facility did not report within the required 2-hour period to State Agency, because it was determined based on hospital report that the patient did not suffer serious bodily injury, as a result of the abuse. Moving forward, we will report anyway, given the nature of the allegation. <ul style="list-style-type: none"> • All visitors will be required to sign in to the visitor log, denoting name, name of individual they are visiting and entry/exit time. All visitors will receive a dated guest badge before entry into patient care areas. Any visitor noted in the center without a guest badge will be stopped and taken to the lobby by a staff member, to sign in/obtain a badge. All vendors or contractors must display a visible name badge. If not, one will be provided. Receptionist will be responsible for putting out dated guest badges every day. Facility now provides a receptionist 7 days per week from 9AM to 8PM, to follow above protocol. Receptionist will provide guest badges during these hours. After these hours, a nurse will answer front door bell, and provide guest badge using 		

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{F 226}	<p>Continued From page 30</p> <p>leaving her exposed. The Nurse stated at first she thought the unknown male had "killed her (Resident #2) and feared he was going to rape her (Resident #2)." Nurse #2 reported she left the room and yelled for the House Coordinator to call 911. Nurse #2 stated the House Coordinator replied that she was "on the phone." Nurse #2 explained that it was 15- 20 minutes before the police were called because she was trying to keep the Resident #2 safe. Nurse #2 stated that when the police arrived a staff member had allowed the unknown male to leave the facility. Nurse #2 described that the unknown male had lowered Resident #2's bed to the floor, removed the sheets and placed them in the floor, removed the pillows from the bed and, extended the resident's legs out straight and had them separated and the unknown male had taken his shoes off.</p> <p>On 09/07/17 at 12:03 PM the House Coordinator was interviewed on the telephone and explained that the night of 08/31/17 she was on the telephone with another resident's family for a non-emergency situation when she heard Nurse #2 ask her to call 911. The House Coordinator stated she did not know what was going on for the Nurse #2 to yell for help and to call 911 but that she remained on the phone and did not call 911. The House Coordinator offered no explanation why she did not respond to Nurse #2's yell to call 911. The House Coordinator explained that when she finished with the phone call she went to Nurse #2 to find out what was going on. The House Coordinator was unaware of how long she was on the phone. She explained that she spoke with the unknown male and asked him to sign the guest registry located</p>	{F 226}	<p>same protocol above.</p> <ul style="list-style-type: none"> o All staff were educated on this new process beginning on 9/11, to completion on 9/14/17 by the Administrator and designees. Any staff member that has not been educated will not be allowed to return to work prior the receiving the education. <ul style="list-style-type: none"> • The center has initiated the use of walkie-talkies to be kept on the nurse's person on 9/14/17, to communicate immediate needs from unit to unit, including a situation where there is a patient protection emergency or lock-down situation. Walkie-talkies are stored on the medication cart. Walkie-talkies are charged via nurse computer. Nurses will pass walkie-talkies on when giving report. • All residents who are interviewable (as evidenced by a BIMS of 12+) received verbal education by Administrator and other designees on: <ul style="list-style-type: none"> ¿ Residents to be free from abuse and expected reporting of residents/staff ¿ Visitation procedures <ul style="list-style-type: none"> o This education began on September 11th, to completion on September 14th, and was documented in the medical record. All new patients will receive this education via the admissions process with review of Residents Rights and Notice of Patient's Bill of Rights. • All Responsible Parties received written communication via letter, mailed on September 13th, with information including the following: <ul style="list-style-type: none"> o Door lock times, and gaining entry during these times 		

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{F 226}	<p>Continued From page 31</p> <p>at the front entrance. She added she walked him to the front and watched as he signed the guest registry. The House Coordinator stated that when the police arrived to the facility, the unknown male had left the facility. The House Coordinator explained that in an attempt to keep the unknown male from leaving she told Nurse #4 (the 100 Hall nurse) not to let anyone out of the facility. The House Coordinator stated that she assumed Nurse #4 relayed the message to all staff on the 100 Hall.</p> <p>Nurse #4 no longer works in the facility and was unable to be reached for an interview.</p> <p>On 09/07/17 at 11:56 AM nurse aide (NA) #1 was interviewed and explained that on 08/31/17 around 10:30 PM she met an unknown male in the hall who asked her to let him out and she did. The aide reported the unknown male looked "scary" and was upset because he stated he had been trying to get out of the building "for an hour." NA #1 stated she asked him who he was and he told the aide he was visiting his aunt but did not provide a name.</p> <p>On 09/07/17 at 1:34 PM Law Enforcement Officer #1 was interviewed on the telephone and explained he was the reporting officer for the case against Resident #2. The Law Enforcement Officer reviewed police reports and stated police were contacted by the facility on 08/31/17 at 10:20 PM and were dispatched immediately. The Law Enforcement Officer explained that when the police arrived to the facility, the unknown male had been allowed to leave the facility. He added</p>	{F 226}	<ul style="list-style-type: none"> o The Elder Justice Act o What a reasonable suspicion of a crime is o The use of one-time use Visitor identification, ie. Guest Badges o What methods we use to keep our patients, employees and visitors safe both during and after normal business hours. <ul style="list-style-type: none"> • All new patients will receive education via the admission process with review of visitation guidelines. • Policies and procedures # 101 titled Abuse/Neglect/Misappropriation/Crime and Policy #516 Patient Visitation were reviewed on 9/14/17 by Administrator to determine whether revisions or updating was required, or whether additional staff training was required for adherence to policies and procedures. No revisions or updates to policies were made, but all staff have been retrained on the policies. • All abuse allegations will be investigated by the Administrator at the time it is reported to him to ensure resident was immediately taken out of harms way and that abuse policy #101 was followed. All staff will be re-educated on abuse policies, and future non-compliance with policy and procedure will result in corrective action up to and including termination from employment. Measures to be put in place or system changes made to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: <ul style="list-style-type: none"> • Administrator will daily M-F, for a period of four weeks, then twice weekly 		

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{F 226}	<p>Continued From page 32</p> <p>that witnesses in the parking lot were able to give a description of the unknown male and make and model of the vehicle he was driving. The Law Enforcement Officer added that once the resident was transported to the Emergency Department for a sexual assault examination, police were re-dispatched to the facility at 11:41 PM. The Law Enforcement Officer stated the unknown male had confessed to crimes against Resident #2. He also explained that samples taken from Resident #2 had been sent to the crime lab and could take weeks to get results. He stated the results could show fingerprints and saliva from the unknown male on Resident #2 that would not be evident in the sexual assault exam. He added the unknown male was currently in custody for the crime committed on 08/31/17. The Officer reported the unknown male stated he walked in the front entrance to the facility and entered Resident #2's room with intention to steal items of value, sifted along her body looking for items to steal and penetrated her vagina with his fingers more than once.</p> <p>On 09/07/17 at 2:27 PM the Administrator was interviewed and explained he was notified of the incident on 09/01/17 by the Corporate Consultant because he was on vacation. He stated that in his absence the Director of Nursing, Corporate Consultant and Director of Operations oversaw facility operations. The Administrator added that he returned to work on 09/05/17 and started the investigation into the incident. The Administrator reported the police should have been called sooner on 08/31/17 and would expect staff to call the police immediately if there was suspicion of a crime.</p>	{F 226}	<p>for four weeks, and weekly for four weeks will check to ensure visitors are adhering to guest badge protocols and walkie talkies are on the nurse person. Any deficient practice will be addressed immediately by the administrator.</p> <ul style="list-style-type: none"> • Automatic front door lock system will lock door at 5PM and will remain locked until 9:00AM. • All new hires during orientation will receive education on abuse/neglect/ misappropriation/crime Nursing P/P 101, Elder Justice Act and Visitor Badge protocols. • All new licensed nurses will receive education on use of walkie talkies. • Administrator will audit that all new patients received education via the admissions process with review of Residents Rights. Visitation procedure and Notice of Patient's Bill of Rights for three months. Any deficient practice will be addressed immediately by the administrator. • Responsible parties for all new admission will receive a letter notifying them of: <ul style="list-style-type: none"> o Door lock times, and gaining entry during these times o Elder Justice Act o What a reasonable suspicion of a crime is o The use of one-time use Visitor identification, ie. Guest Badges o What methods we use to keep our patients, employees and visitors safe both during and after normal business hours. <p>How facility will monitor corrective action (s) to ensure deficient practice will not</p>		

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{F 226}	Continued From page 33 On 09/07/17 at 3:55 PM the interim Director of Nursing (DON) was interviewed and reported she was contacted by Nurse #2 on 08/31/17 at 9:59 PM informing her an unknown male was found in Resident #2's room and had removed her brief. The DON stated she directed Nurse #2 to call the police. The DON explained that it did not matter that the unknown male was alleging to be family based on what Nurse #2 had witnessed in the room. The DON was unaware when the police were called. But the DON was aware the unknown male had been able to leave the locked facility prior to the police arriving at the facility on 08/31/17 the first time they were dispatched to the facility. The DON added an abuse investigation was initiated that night when she contacted the Corporate Consultant. The DON stated she expected staff to call police immediately of suspicion of a crime and that she would want staff to question the identity of anyone in the facility after 9:30 PM they did not recognize. The facility's medical director was out of the country and unable to be reached for an interview. On 09/08/17 at 2:10 PM the Nurse Practitioner (NP) was interviewed and explained that she would expect staff to call police immediately if they suspected assault on a resident and send the resident to the Emergency Department immediately for evaluation. The NP also stated that it would be helpful if the facility had a communication system such as a "code" system to alert all staff of a dangerous situation to prevent a staff member from letting a perpetrator from leaving the building. On 09/08/17 at 11:15 AM the Administrator was	{F 226}	re-occur: Results of all audits will be reviewed by the QAPI (Quality Assurance Performance Improvement) committee monthly times three, for continued compliance or revisions to the plan as needed. Administrator responsible for implementing the acceptable plan of correction.		

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{F 490} SS=D	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff, nurse practitioner and Law Enforcement interviews and record review, the administration failed to impose expectations related to immediately intervening when sexual abuse was suspected; failed to impose expectations related to immediately removing a perpetrator from resident care areas; failed to impose expectations related to immediately calling law enforcement when a crime was suspected; failed to empower the staff to respond to suspected sexual abuse and not sending the resident out for professional evaluation, failure to have systems in place whereby staff in the building are notified of an immediate threat to residents safety and failed to empower staff to know how to respond to an emergency situation immediately that would be in the best interest of all the residents for 1 of 3 sampled residents (Resident #2). Immediate Jeopardy began on 08/31/17 when Nurse #2 had to use force to open Resident # 2's barricaded door and observed an unknown male in Resident #2's room, the sheets were off the bed and the resident's brief had been removed.	{F 490}	F490 Charlotte Health Care Center This allegation of compliance is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following credible allegations constitutes the center's allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: • On the evening of August 31, 2017, at or around 9:30 pm, Nurse 2 observed Resident 2's door closed. Nurse 2 opened Resident 2's door and found an unknown male in the room with Resident 2. Resident 2 was found with her covers down and brief off. When questioned, the	9/22/17	

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{F 490}	<p>Continued From page 35</p> <p>And the staff did not immediately respond in a protective manner. The Immediate Jeopardy is present and ongoing.</p> <p>The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation for the removal of the Immediate Jeopardy on 09/14/17.</p> <p>A revisit survey was conducted on 09/21/17 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following:</p> <ul style="list-style-type: none"> - Systematic changes implemented to ensure visitors are identified before being allowed inside the facility. - Evidence of staff, resident and family education on abuse, emergency response and resident protection. - Documentation of audits for the in-servicing and procedures implemented related to abuse prohibition, protection of residents and emergency response procedures. <p>Observations of the facility's new security procedures for visitation were made and interviews with staff, residents and visitor were aware of the systemic changes implemented. The facility provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F 490 at a lower scope and severity (D) isolated, no actual harm that is not immediate jeopardy while the facility continues the process of monitoring and implementation of the corrective action.</p>	{F 490}	<p>unknown male told Nurse 2 that he was the nephew of Resident 2 and he was changing his aunt's brief. Nurse 2 then approached House Coordinator, who was in an office and on the phone with a family member of a resident. House Coordinator heard Nurse 2 ask House Coordinator to call 911, but House Coordinator directed Nurse 2 to ask Nurse 1 to call 911 while House Coordinator finished her call. Nurse 1 overheard Nurse 2's request to call 911, but did not hear House Coordinator's response and therefore assumed House Coordinator called 911.</p> <ul style="list-style-type: none"> • Nurse 1 then joined Nurse 2 in Resident 2's room, and continued to question the unknown male. The unknown male insisted he was Resident 2's nephew and provided a first name and a last name that matched Resident #2's last name. At this point, the unknown male began to show signs of aggression and Nurse 1 instructed Nurse 2 to leave the room. Nurse 2 stationed herself in the hallway just outside Resident 2's room while Nurse 1 explained to the unknown male that she was going to call Resident 2's daughter to confirm his identity. Nurse 1 left Resident 2's room for privacy while she called Daughter and Nurse 2 remained stationed in the hallway just outside the room. However, the unknown male closed Resident 2's door which prompted Nurse 1 to reopen the door and instruct the unknown male not to close the door. This occurred several more times until the unknown male was instructed to exit Resident 2's room and remain in the hallway. Nurse 1 called Daughter at 9:51 		

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{F 490}	Continued From page 36 The findings included: 1. Cross refer to F 223: Based on observations, staff, nurse practitioner and Law Enforcement interviews and record review, the facility failed to protect a resident from being assaulted by an unknown male for 1 of 3 sampled residents (Resident #2). The unknown male was arrested and charged on 09/05/17 with two 2nd degree sex offenses against Resident #2. 2. Cross refer to F 225: Based on staff interviews, Law Enforcement Officer Interview, nurse practitioner interview and record review the facility failed to notify Health Care Personnel Investigations of a crime against a resident within the required 2 hour timeframe, failed to notify Adult Protective Services of the incident and failed to notify law enforcement immediately of suspicion of a crime for 1 of 1 sampled resident (Resident #2). An unknown male was arrested and charged on 09/05/17 with two second degree sex offenses against Resident #2. 3. Cross refer to F 226: Based on observations, staff, nurse practitioner and Law Enforcement interviews and record review, the facility failed to follow policy and procedures for Abuse Prohibition for protecting a resident after an assault for 1 of 3 sampled residents (Resident #2). After the assault, the facility allowed the unknown male to remain in the room with the resident, waited to contact police and allowed the unknown male to flee the facility. The unknown male was arrested on 09/05/17 and charged with two 2nd degree	{F 490}	pm from Nurse 1's cell phone. However, Daughter did not pick up the call. Nurse 1 returned to the area outside of Resident 2's room where the unknown man and Nurse 2 were waiting. Daughter returned the phone call at 9:52 pm so Nurse 1 stepped away again and explained to Daughter what had transpired and that the unknown male claimed he was a family member and provided a first name. Daughter advised Nurse 1 that they did have a family member by that first name and that she was going to drive to the Center to confirm whether the unknown male was a family member. • Around 9:52 pm, when Nurse 1 stepped away to speak to Daughter, House Coordinator went to find Nurse 2 to see if she could be of assistance. Not knowing yet what had transpired, House Coordinator found the unknown male and questioned whether he had signed in at the front desk. When the unknown male responded that he had not signed in, House Coordinator escorted him to the front desk and observed him sign in. The unknown male and House Coordinator returned to the hallway at which point House Coordinator asked Nurse 2 what was going on. Nurse 1 advised Nurse 2 and House Coordinator that Daughter was on her way to identify the unknown male. Nurse 2 called the DON at 9:59 pm to explain what had transpired. • Nurse 1, Nurse 2, and House Coordinator then worked together to keep an eye on the unknown male, keep in contact with Daughter, care for and protect the residents, alert the DON, and		

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{F 490}	Continued From page 37 sex offenses. On 09/07/17 at 3:00 PM the Administrator was interviewed and stated he felt that facility had no way of knowing a crime like this could occur to a resident and felt the facility had necessary resources and procedures in place for handling emergency situations.	{F 490}	try to alert other staff members of the situation while attempting to keep the unknown male calm and not alert him as to their actions. It was around this time that Nurse 1, Nurse 2, and House Coordinator realized that no one had called 911. Nurse 1 then called Daughter at 10:09 pm to obtain her status. Daughter advised that she was on her way and in close proximity to the center. The nurses would call 911 if the unknown male was not identified by Daughter as a family member. • At 10:18 pm, Daughter called Nurse 1's cell phone and advised that she had arrived at the Center and had looked through the window to observe the unknown male. Daughter confirmed what the unknown male was wearing with Nurse 1 and then Daughter stated that the unknown male was not her family member. At this point, Nurse 1 hung up with Daughter and immediately called 911 at 10:20 pm. Per telephone interview with Detective assigned to case on 9/13/17 by Administrator, the 911 call was confirmed at 10:20pm, and dispatched at 10:22pm. Around the same time, CNA 1 unlocked (by swiping her badge) the front door to allow the unknown male out of the building at 10:19 pm. CNA 1 had no knowledge as to what had transpired related to the unknown male. • Based on information provided by Detective, the police arrived at the Center at 10:23 pm. Nurse 1 and Daughter spoke with police outside the Center, at which time Nurse 1 provided a description of the unknown male and Daughter		

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{F 490}	Continued From page 38	{F 490}	<p>provided a description of the vehicle he fled in. Based on information and belief, per interview of Detective, the event was closed by the police at 10:42pm.</p> <ul style="list-style-type: none"> Visual assessment of resident body done by Nurse #2 for any signs of bruising, redness, bleeding, agitation/anxiety-none found. The decision was made to not change or clean resident prior to sending for possible sexual assault examination. Daughter visited with Resident 2, facility staffed consoled the family, and was counseled by the nurses about sending Resident 2 to hospital to be evaluated. Decision was made to send resident to hospital to rule out sexual assault. While family was questioned by Nurse #1 whether they wanted the assessment done, the nurse stated she did this only to include them since it was a significant event, but intentioned to send her anyway to protect the resident, herself and the center. As a result of this second call to 911, both EMS and law enforcement officers were dispatched to the center. EMS unit dispatched per 911 call at 11:38pm, and reached patient's room at 11:52pm. Arrived to Hospital at 12:24AM. Per hospital report no evidence of break in skin, abrasions except for excoriation to labia, redness, bruising, swelling, or bleeding to the body. No evidence of semen, DNA pending at this time, and detective assigned to case unable to tell us when we will get it back, and undetermined time at this point. Per verbal transfer report from ED nurse to 	

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{F 490}	Continued From page 39	{F 490}	<p>Nurse 3 at the time of discharge from the Emergency Department, it appeared unidentified male was interrupted before he was able to do anything to resident. Family updated by hospital. Excoriation to labia noted in ER record, but undetermined as to source</p> <ul style="list-style-type: none"> • Beginning 9/1, automatic front door lock system was moved from auto lock of 9:30pm to auto lock at 8PM and will remain locked until 9:00 am; the receptionist hours are 9:00 AM – 8:00 PM. The system does not allow any other doors to be used for entry by visitors, and never has. All other doors are and have always been locked continuously and require badge access for entry and exit. • Between the hours of 5pm and 9pm beginning 9/1/17, the patient received a sitter to ensure her safety. • The perpetrator/unknown male was apprehended/caught by law enforcement on 9/5/17. Sitter services were discontinued on 9/6/17. • Staff began to receive education immediately following the event on 8/31/17 by the DON, and designees on: <ul style="list-style-type: none"> o Expectations for visitor identification after door lock times. All visitor's will call facility or ring bell to identify who they are and who they want to see. A staff member will then allow access and give them a visitor name badge. All staff have received education on this on 9/14/17. • A 24 hour initial report was filed with the Health Care Personnel Investigation on 9/1/17 it is health care personnel investigation, not registry • A 5 day working report was filed with 	

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{F 490}	Continued From page 40	{F 490}	<p>the Health Care Registry detailing the incident 9/8/17, within 5 working days.</p> <ul style="list-style-type: none"> • APS was notified on 9/11/17. • Root cause analysis determinations: <ul style="list-style-type: none"> o Unknown male was not initially removed from room due to escalating situation and the unknown male's potential aggressive response. This later escalated to his noncompliance to keeping door open, and he was permanently removed from room. o Nurse #1, 2 and House Coordinator were all involved in calls with key persons in resolving the above situation; therefore, all believed someone else had called 911. When it became apparent that no one had called 911, the nurses waited until the family confirmed that the unknown male was not a family member and then immediately called 911. Education/Coaching provided to nurses 1, 2 and House Coordinator on 9/8/17 by Administrator. Because the nurses did not want to alarm the unknown male and wanted to keep him in the Center until the police arrived, the unknown male was not removed from all patient care areas. Communication occurred to other patient care areas, but communication did not reach everyone. o Nurse #1, upon initially noticing unknown male in center, did not inquire as to his identity and whom he was visiting. Facility did not report within the required 2-hour period to State Agency, because it was determined based on hospital report that the patient did not suffer serious bodily injury, as a result of the abuse. Moving forward, we will report anyway, 	

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{F 490}	Continued From page 41	{F 490}	<p>given the nature of the allegation within two hours.</p> <p>Systemic Correction: 9/6/17 Vice President of Operations educated Administrator on reasonable suspicion of a crime/serious bodily reporting requirements and on 9/6/17 Administrator educated DON of serious bodily injury reporting requirements.</p> <ul style="list-style-type: none"> • All staff began to receive education on 9/6/17 by the DON/designee on: <ul style="list-style-type: none"> o Abuse policy/procedures; Nursing P/ 101, titled "Abuse, Neglect/Misappropriation/Crime" including: <ul style="list-style-type: none"> ι reasonable suspicion of a crime and examples of things that fall into this category ι protecting the resident first ι calling 911 immediately after and/or simultaneously if possible ι reporting timeframes of a 2-hour period vs. the 24 hour period of the Federal Elder Justice Act to the appropriate persons (police, State Agency, APS) o Education began on 9/6/17 and completed on 9/14/17; any staff that has not received the education will not be allowed to work until education completed. • All visitors will be required to sign in to the visitor log, denoting name, name of individual they are visiting and entry/exit time. All visitors will receive a dated guest badge before entry into patient care areas. Any visitor noted in the center without a guest badge will be stopped and taken to the lobby by a staff member, to 	

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{F 490}	Continued From page 42	{F 490}	<p>sign in/obtain a badge. All vendors or contractors must display a visible name badge. If not, one will be provided. Receptionist will be responsible for putting out dated guest badges every day. Facility now provides a receptionist 7 days per week from 9AM to 8PM, to follow above protocol. Receptionist will provide guest badges during these hours. After these hours, a nurse will answer front door bell, and provide guest badge using same protocol above.</p> <ul style="list-style-type: none"> o All staff were educated on this new process beginning on 9/11, to completion on 9/14/17 by the Administrator and designees. Any staff member that has not been educated will not be allowed to return to work prior the receiving the education. <ul style="list-style-type: none"> • The center has initiated the use of walkie-talkies to be kept on the nurse's person on 9/14/17, to communicate immediate needs from unit to unit, including a situation where there is a patient protection emergency or lock-down situation. Walkie-talkies are stored on the medication cart. Walkie-talkies are charged via nurse computer. Nurses will pass walkie-talkies on when giving report. • All residents who are interviewable (as evidenced by a BIMS of 12+) received verbal education by Administrator and other designees on: <ul style="list-style-type: none"> ¿ Residents to be free from abuse and expected reporting of residents/staff ¿ Visitation procedures o This education began on September 11th, to completion on September 14th, 	

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{F 490}	Continued From page 43	{F 490}	<p>and was documented in the medical record. All new patients will receive this education via the admissions process with review of Residents Rights and Notice of Patient's Bill of Rights.</p> <ul style="list-style-type: none"> • All Responsible Parties received written communication via letter, mailed on September 13th, with information including the following: <ul style="list-style-type: none"> o Door lock times, and gaining entry during these times o The Elder Justice Act o What a reasonable suspicion of a crime is o The use of one-time use Visitor identification, i.e. Guest Badges o What methods we use to keep our patients, employees and visitors safe both during and after normal business hours. • Staff will be re-educated and future non-compliance with policy and procedure will result in corrective action up to and including termination from employment. • All abuse allegations will be investigated by the Administrator at the time it is reported to him, to ensure resident was immediately taken out of harms way and that abuse policy #101 was followed. All staff will be re-educated on abuse policies, and future non-compliance with policy and procedure will result in corrective action up to and including termination from employment. Measures to be put in place or system changes made to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: 	

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{F 490}	Continued From page 44	{F 490}	<ul style="list-style-type: none"> • Administrator will daily M-F, for a period of four weeks, then twice weekly for four weeks, and weekly for four weeks will check to ensure visitors are adhering to guest badge protocols and walkie talkies are on the nurse person. Any deficient practice will be addressed immediately by the administrator. • Automatic front door lock system will lock door at 5PM and will remain locked until 9:00AM. • All new hires during orientation will receive education on abuse/neglect/ misappropriation/crime Nursing P/P 101, Elder Justice Act and Visitor Badge protocols. • All new licensed nurses will receive education on use of walkie talkies. • Administrator will audit that all new patients received education via the admissions process with review of Residents Rights, Visitation procedure and Notice of Patient's Bill of Rights for three months. Any deficient practice will be addressed immediately by the administrator. • Regional Vice President of Operations and Regional Nurse Consultant will visit twice monthly for three months. The corporate personnel will round for adherence to the guest badge protocol and randomly audit portions of the Plan of Correction. Any deficient practice noted will be corrected immediately, with coaching/discipline as needed. Regional Vice President of Operations and Regional Nurse Consultant will attend quarterly QAPI meeting X's 2 and more frequently as needed. 	

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{F 490}	Continued From page 45	{F 490}	<ul style="list-style-type: none"> • Responsible parties for all new admission will receive a letter notifying them of: <ul style="list-style-type: none"> o Door lock times, and gaining entry during these times o Elder Justice Act o What a reasonable suspicion of a crime is o The use of one-time use Visitor identification, ie. Guest Badges o What methods we use to keep our patients, employees and visitors safe both during and after normal business hours. How facility will monitor corrective action (s) to ensure deficient practice will not re-occur: Results of all audits will be reviewed by the QAPI (Quality Assurance Performance Improvement) committee monthly times three, for continued compliance or revisions to the plan as needed. Administrator responsible for implementing the acceptable plan of correction. 		