STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING _____ B. WING _____	C 11/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 483.25 (F323) at J Immediate Jeopardy began on 10/11/17 when Resident #216 eloped from the facility without staff's knowledge that he was outside without supervision. Resident #216 had exited the building from the 400 Hall exit door and into the parking lot in front of a storm drain when he was found by Nurse #1 who assisted him back to the building. The storm drain was observed to measure 80 feet from the outside door of 400 Hall to the storm drain and it was 188 feet and 2 inches from the storm drain to the road. Nurse #1 indicated Resident #216 had no injuries and returned to the facility without resistance. Immediate Jeopardy was removed on 11/17/17 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put in place and completion of employee training. An extended survey was conducted as part of the facility's survey from 11/13/17 through 11/17/17. Event ID# 8V2Q11. On 12/11/17 an amended Statement of Deficiencies was provided to the facility because the State Survey Agency changed the scope and severity of tag F-223 from a "G" level to a "D" level. Revisions were also made by the State Survey Agency to the language in tags F-0000 and F-323. Event ID# 8V2Q11.	F 000		
F 223 SS=D	FREE FROM ABUSE/INVOLUNTARY SECLUSION	F 223		12/15/17

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

Electronically Signed | 12/05/2017

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F 223	Continued From page 1 CFR(s): 483.12(a)(1) 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. 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, records review and Medical Director, Family Nurse Practitioner and staff interviews, the facility failed to protect a resident from being physically abused by another resident for 1 of 5 sampled residents reviewed for abuse. The facility failed to keep Resident #216 and Resident #46 separated which resulted in Resident #216 becoming agitated and slapping Resident #46 in the face. Findings included: Resident #46 was readmitted to the facility on 06/06/17 with diagnoses that included Alzheimer's disease, dementia, anxiety disorder and depression. Review of the most recent quarterly Minimum Data Set (MDS) dated 09/27/17 coded Resident #46 with severe impairment in cognition and required extensive to total staff assistance with activities of daily living. Further review of the	F 223	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; On 11/3/17, resident #216 slapped resident #46 at 6:55 p.m. without provocation. At 7:55 p.m. on 11/3/17 the Sheriff□s Department was notified of the	

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F 223	Continued From page 2 MDS revealed Resident #46 displayed verbal behavior 4 to 6 days during the 7 day assessment period. Review of the care plans for Resident #46 revealed the following: "Impaired cognitive function/dementia or impaired thought processes related to Alzheimer's, initiated on 02/17/17 and revised on 05/24/17", included the goals she "would be able to communicate basic needs on a daily basis and would develop skills to cope with cognitive decline through the review date." Interventions included to "administer medications as ordered, provide the resident with necessary cues - stop and return if agitated, reduce any distractions, and cue, reorient and supervise as needed." "Behavioral symptoms such irritation and repeating statements, initiated on 02/27/17 and revised on 10/24/17", included a goal she "would have fewer episodes of behavior symptoms by review date." Interventions included to "administer medications as ordered, praise any indication of progress/improvement in behavior, if reasonable discuss behavior and explain why behavior is inappropriate, and caregivers to provide opportunity for positive interaction attention - stop and talk with her as passing by." On 11/14/17 at 5:30 PM Resident #46 was observed well-groomed and sitting with other residents by the nurses' station with no behaviors being exhibited. On 11/15/17 at 12:30 PM Resident #46 was observed well-groomed and sitting in the dining room with other residents receiving assistance	F 223	incident and report filed by the facility. The system failure was identified at the time the surveyors reported to the facility that during their interview an agency staff member who had previously witnessed resident #216 have a verbal altercation with another resident the same day. If this information had been reported to the facility Administration then appropriate steps could have been taken to possibly prevent the later altercation that was physical in nature. Resident #46 and Resident #216 were separated and no outward injuries noted. The Activity Director on 11/4, 11/5, 11/6 checked resident daily to ensure there were no latent injuries noted that were not present at the time of the slap. Resident #216 had no further incidents during his stay. Alternative placement was found for Resident #216 and the discharged to that facility on 11/13/17. Upon notification of the verbal altercation, on 11/16/17 additional training was initiated to staff on abuse and neglect with a focus on Resident to Resident Abuse which focused on the following areas for immediate strategies during an episode of a resident to resident altercation to de-escalate: " 1) Engage in a swift, focused, decisive, firm, and coordinated intervention. " 2) Immediately defuse chain reactions (Anxiety is contagious!). " 3) Redirect resident(s) from the area (and pay attention to un-intended victims & residents with poor judgment re. safety).	

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F 223	Continued From page 3 with her meal with no behaviors being exhibited. A telephone interview on 11/16/17 at 11:16 AM with Nurse #5 revealed it was normal behavior for Resident #46 to "yell out non-stop when awake." Nurse #5 added Resident #46 would stop yelling temporarily whenever she received attention from staff. Resident #216 was admitted to facility on 09/21/17 with diagnoses that included nontraumatic subarachnoid hemorrhage (bleeding in the area between the brain and surrounding membrane), Alzheimer's disease and dementia with behavioral disturbance. Review of the facility's Admission Assessment/Screening - Nursing form dated 09/21/17 for Resident #216 read in part, "admitted from hospital. Short and long term memory impairment. Resident wanders aimlessly in and out of other resident rooms." Behaviors checked were "resistive and aggressive." Review of the care plans for Resident #216 revealed the following: "Resistance to Care related to dementia, initiated on 09/22/17 and revised on 09/25/17", included a goal he "would cooperate with care through the next review date." Interventions included to "allow him to make decisions about treatment, give clear explanation of all care activities prior to and as they occur each contact and praise when behavior is appropriate." "Impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease and impaired decision making, initiated on	F 223	" 4) Offer the person to take a walk together. " 5) Distract/divert to a different activity / change the activity. " 6) Refocus/switch topic to his/her favorite conversation topic. " 7) Position, reposition, or change seating arrangement. " 8) Stay, calm! The resident will mirror your emotional state and respond to your body language and tone of Voice. " 9) Be sincere. Many are able to detect insincerity& Avoid smiling which could be interpreted as In-sincerity on your part, worsening the residents□ behavior. " 10) Be firm and direct (rather than angry or irritated). " 11) Identify & address underlying needs behind the aggression. " 12) Use short, simple, familiar words/sentences & one-step directions. " 13) Never ignore the emotions of a resident. Encourage expression of feelings (fear; anger; and frustration) but in a safe location. " 14) Seek assistance from co-workers (esp. those resident trusts). " 15) Be consistent in approach (across staff, shifts, & weekends). " 16) Meet with staff and let them know about the outburst and provide additional monitoring up too and including one on one to make sure emotional state is stabilized. " 17) Notify Administration and the	

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F 223	Continued From page 4 09/22/17 and revised on 11/9/17, included a goal he "would develop skills to cope with cognitive decline and maintain safety by the next review date." Interventions included for staff to "administer medications as ordered, ask yes/no questions in order to determine his needs, reduce any distractions, provide him with necessary cues - stop and return later if he becomes agitated, 1:1 sitters as indicated, and monitor/document/report as needed any changes in cognitive function." "Physical aggression potential related to dementia, poor impulse control and sexually inappropriate behavior, initiated on 09/27/17 and revised on 11/7/17, included a goal that he would not harm self or others through the next review date. Interventions included for staff to administer medications as ordered, assess and anticipate resident's needs, provide physical and verbal cues to alleviate anxiety, assist to set goals for more pleasant behavior, monitor/document/report as needed any signs or symptoms of resident posing danger to self and others, proceed with discharge if behavior cannot be managed within facility, Psychiatric consult as indicated, and intervene when the resident becomes agitated." Review of the MDS dated 09/28/17 revealed Resident #216's cognition was severely impaired. The MDS indicated he had displayed physical and verbal behavior directed toward others and other behavioral symptoms not directed toward others 1 to 3 days during the assessment period which interfered with his care, participation in social activities and put others at risk of injury. Review of the initial Psychiatric Evaluation dated 10/02/17 for Resident #216 revealed in part, seen	F 223	physician regarding the episodes for further direction or physician or administrative orders. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Current employees were re-educated on Abuse and Neglect with a focus placed on Resident-to-Resident abuse and how such altercations to include verbal altercations are to be reported to Administration so that appropriate action can be taken to protect the resident initiating the altercation and other residents, staff or family members. New employees during orientation are trained on Preventing, Recognizing and Reporting Patient Abuse as well as annually through assigned training, in addition to Care of the Cognitively Impaired. Current employees will be trained or removed from the schedule until the training is completed. Future agency staff will be required to obtain Abuse Education prior to being allowed to work on the floor. The system change in addition to current abuse prevention training, we had Care of the Cognitively Impaired has been added to our Electronic Education System to be provided annually. To ensure current staff are educated a course outline with content was printed and given to the Staff Development Coordinator to ensure staff were made aware of the upcoming system change.	

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F 223	Continued From page 5 for "reduction in assaultive and inappropriate behavior. Family member present and reports episodes of hallucinations. Staff and family member report that his mood 'changes quickly.' It is reported he grabs and swings at staff. Since he has been at this facility, he has been sent to the hospital twice due to his behaviors in which he was returned back to the facility. Due to his level of dementia, his answers to my questions are unreliable. Short term and long term memory poor." Medications were initiated with instructions to "monitor for changes in mood and behavior." Review of the nurses' notes related to Resident #216's behaviors revealed the following entries: A note written by Nurse #8 on 10/02/17 at 6:08 PM read in part, "Resident #216 is alert and oriented to self, has trouble verbalizing needs due to cognitive impairment, always close to staff and in high traffic areas to be in view of staff." A note written by Nurse #9 on 10/10/17 at 7:57 PM read in part, "Resident #216 was very agitated, in and out of other rooms and was given Ativan for comfort. Tried to redirect but was unsuccessful." A note written by Nurse #8 on 10/11/17 at 2:17 PM read in part, "Resident #216 was alert and oriented to self, able to verbalize needs majority of the time but due to cognitive impairment resident has a hard time making sense or keeping a straight though. Tolerated medications with no difficulty noted at this time." A note written by Nurse #6 on 10/17/17 at 6:45 PM read in part, Late Entry: "Resident #216 became combative after nurse tried to redirect	F 223	Measures to be put in place or systemic changes made to ensure practice will not re-occur: To help staff with dealing with cognitively impaired patients, requested that education be provided for all new staff on hire to receive education utilizing the Electronic Education System. In the meantime until this is uploaded for completion in the Electronic System, current staff will be in-serviced on dealing with the cognitively impaired cognitively. Any staff member not trained will be removed from the schedule until they have received the training. Daily Monday through Friday the DON and/or Unit Manager will continue to print and review progress notes to look for documentation of behaviors. On the Weekend the Manager on Duty will inquire of each nurse if they have any patients exhibiting behaviors such as being aggressive, entering other patients rooms, wandering around with no purpose. These audits will be turned in to the Administrator during morning stand-up and reviewed at that time for any suspicious responses for a period 3 months. Once Administrator or DON is notified of suspicious behaviors such as being aggressive, entering other patient□s rooms, wandering around with no purpose, an assessment will be made by DON or UM for need of a psych service referral or other interventions as appropriate and the plan of care will be updated with the exhibited behaviors noted. DDP will be notified to assess the need for alternate placement and assist with services as needed. DON or UM will	

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F 223	Continued From page 6 from going out the door, his fists clenched, he screamed 'get out of my way or I'll kill you.'" A note written by Nurse #3 on 10/26/17 at 9:29 AM read in part: Resident #216 went into another resident's room, was resistive to leave room, combative and clung onto door handle. Resident #216 "began to curse and swing his hands at all nurses and started to growl and yell." A note written by Nurse #2 on 10/28/17 at 2:00 AM read in part, "staff is one on one with resident and unable to redirect with snacks, coloring, or TV. Patient is resistant to diversions and becomes aggressive frequently. Patient with this nurse entire shift with multiple corrections made to not touch nurse or staff. Continues to attempt to pull meds from cart while on med pass." A note written by Nurse #4 on 11/4/17 at 4:21 AM read in part, "patient was verbally and physically abusive to a patient (Resident #46) by telling her to "shut up" and then proceeding to slap patient. The two patients were separated and Administrator, the cops and family members were notified. Separating the two was effective." A telephone interview on 11/14/17 at 5:23 PM with Nurse #4 revealed she was employed through an agency and on 11/03/17 she was assigned to work 3:00 PM to 11:00 PM on 200 Hall the night she witnessed Resident #216 slap another resident (Resident #46). Nurse #4 recalled it was her first day at the facility and Resident #216 had just recently been moved to 200 Hall. She explained Resident #216 was sitting out in the middle of the hall with another resident, who repeatedly yelled out, when they started "hollering back and forth, telling each other to shut up."	F 223	ensure behavior monitoring is placed on the MAR for monitoring q shift. The Administrator or DON will sit in on one abuse training session a month for a period of three months and evaluate the program and results of rounding and behavior audits. Audits will be presented to the Quality Assurance Performance Improvement Committee for the committees review. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The administrator will be responsible to ensure that the plan of correction is implemented. Audits of findings will be reviewed at the Quality Assurance Performance Improvement Committee meeting, monthly for 12 months, for review and revision as needed to ensure compliance is maintained.	

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F 223	Continued From page 7	F 223		

She stated he got up from his wheelchair, went over to the other resident and gave her a pat on the shoulder. She indicated Resident #216 sat back down as she instructed and both residents calmed down. She added it was not an aggressive incident and felt no other interventions were needed at the time. Nurse #4 stated later that evening when the other resident started hollering out again, Resident #216 became agitated and she turned in time to see him slap Resident #46 across the face. Nurse #4 stated she assisted Resident #216 back to his wheelchair and he sat back down. Nurse #4 added Resident #216 was taken to another hall, the police were contacted by the Administrator and they came to the facility to talk to him. She indicated Resident #216's family member came to the facility after the incident, he had calmed down and there were no further incidents.

An interview on 11/15/17 at 8:10 AM the Administrator confirmed she had been informed Resident #216 had slapped another resident (Resident #46) the evening of 11/03/17. She stated the incident occurred around 6:00 PM and was witnessed by an agency nurse assigned to his hall. The Administrator stated she personally contacted both resident's families to inform them of the incident and the agency nurse contacted the police. She indicated the police came to the facility to talk with Resident #216 but they did not fill out a police report since both residents had dementia and the other resident's family had not wanted to press charges. The Administrator stated Resident #46 had a red mark on her face after the incident but when assessed the next day there was no bruising or other negative outcome. She added that it was difficult for facility staff to provide constant supervision to Resident #216

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F 223	Continued From page 8 and after the incident on 11/03/17 agency staff were utilized to ensure Resident #216 had one on one supervision. A telephone interview on 11/15/17 at 5:48 PM with the Medical Director (MD) confirmed she was aware of Resident #216's behaviors and stated they looked for alternate placement for Resident #216 but this facility had been the only option for him at the time. She explained he had dementia with aggressive behaviors and had been hospitalized twice since his admission. The MD stated she felt the facility was following their protocols to keep him and other residents safe. An interview on 11/16/17 at 9:02 AM with the Family Nurse Practitioner (FNP) revealed she was unaware Resident #216 had slapped another resident (Resident #46) and confirmed he was severely impaired with cognition, decision making and safety awareness. The FNP stated Resident #216 was often aggressive and directed it toward "anyone who attempted to provide redirection." She added a "sitter" was the most effective intervention for his behaviors.	F 223		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based	F 315		12/11/17

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F 315	Continued From page 9 on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, physician and staff interviews the facility failed to properly care for a indwelling urinary catheter by allowing the tubing and drainage valve to touch/drag on the floor for 1 of 1 resident reviewed for a urinary catheter. (Resident #222) Findings included: Resident #222 was admitted to the facility on 10/31/17 with diagnoses that included acute	F 315	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; During the survey it was observed by a surveyor that resident #222 who had a foley, noted to have the drain spout touching the floor and on another occasion the bag was hanging on the wheelchair, but the tubing was rubbing the floor. This occurred due to a lack of	

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F 315	Continued From page 10 kidney failure, benign prostatic hyperplasia with lower urinary tract symptoms. A review of the most recent annual Minimum Data Set (MDS) indicated Resident #222 was cognitively intact. The MDS also indicated Resident #222 had an indwelling urinary catheter and needed extensive assistance with transfers, toileting, personal hygiene, and was frequently incontinent of bowel. The Care Area Assessment revealed a history of urinary tract infections and included urinary catheter care and monitoring and a catheter care plan was initiated. A review of the care plan revised on 11/10/17 included a focus for an indwelling urinary catheter. The goal was to remain free from catheter related trauma and show no signs or symptoms of a urinary tract infection. The interventions included positioning the catheter and tubing below the level of the bladder. The interventions also included to monitor, record, and report signs and symptoms of a urinary tract infection to Medical Doctor. During an observation at 11:18 AM on 11/14/17, Resident #222 was sitting in a wheelchair with a urinary catheter bag attached underneath the chair with the tubing and drainage valve touching the floor. During an observation at 11:24 AM on 11/14/17, Resident #222 was being propelled down the hallway in a wheelchair with the catheter tubing dragging on the floor. During an observation at 10:34 AM on 11/15/17, Resident #222 was assisted to a wheelchair by the Physical Therapist Assistant (PTA) who hung	F 315	attention by the nursing staff when setting the patient up at bedside and preparing them for mobility about the building and not following Guidance as below. 1) Proper perineal/foley catheter care of the person with indwelling Foley Catheter is important in the prevention of urinary tract infections. 2) When providing perineal care, always clean from clean to dirty (urethra to rectum) to prevent transmission of bacteria from the anus to the vagina/penis. 3) Always perform hand hygiene prior to perineal-care and after removing gloves after providing perineal care. 4) Provide foley care to patients every shift and as needed after bowel movements or if vaginal discharge is present. 5) Clean from urethral meatus down the foley catheter away from the body- 6) Keep the drainage bag below the bladder to prevent urine from flowing back into the bladder as this can cause a urinary tract infection. 7) Move the bag as needed when patient is in bed and is turned or repositioned on their side. 8) Do not let the bag rest on the floor to prevent contamination. 9) Do not let the drain on the drainage bag touch any surface. The procedure for implementing the	

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F 315	Continued From page 11 the catheter bag underneath the wheelchair with the bag and tubing touching the floor. The PTA then propelled Resident #222 from the therapy room, down the hallway to the residents room. During an interview at 12:50 PM on 11/15/17, the PTA revealed she had assisted Resident #222 and placed the catheter bag underneath the wheelchair and propelled the chair from the therapy room to the resident's room. The PTA also revealed she had been trained infection control by the facility that included to keep the catheter bag and tubing off the floor. During an interview at 2:21 PM on 11/16/17, the Family Nurse Practitioner (FNP) revealed the catheter bag and tubing should not be dragging or touching the floor and placed the resident at risk for a urinary infection. During an interview at 2:59 PM on 11/16/17, the Corporate Nurse Consultant (CNC) explained his expectations were for staff to be aware of the catheter bag and tubing placement and to ensure the catheter bag and tubing were off the floor to prevent contamination. The CNC also revealed the physical therapy staff received training during orientation and annually related to catheter care and infection control.	F 315	acceptable plan of correction for the specific deficiency cited; Nurses and Certified Nursing Assistants were in-serviced by the Staff Development Coordinator on: 1) Proper perineal and foley care of the person with indwelling Foley Catheter is important in the prevention of urinary tract infections. 2) When providing perineal care, always clean from clean to dirty (urethra to rectum) to prevent transmission of bacteria from the anus to the vagina/penis. 3) Always perform hand hygiene prior to peri-care and after removing gloves after providing peri care. 4) Provide foley care to patients every shift and as needed after bowel movements or if vaginal discharge is present. 5) Clean from urethral meatus down the foley catheter away from the body. 6) Keep the drainage bag below the bladder to prevent urine from flowing back into the bladder as this can cause a urinary tract infection. 7) Move the bag as needed when patient is in bed and is turned or repositioned on their side. 8) Do not let the bag rest on the floor to prevent contamination. 9) Do not let the drain on the drainage bag touch any surface.	

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F 315	Continued From page 12	F 315	Measures to be put in place or systemic changes made to ensure practice will not re-occur: Education was completed on the foley catheter care and perineal care, anyone that has not received the training will not be allowed to work until training has been accomplished. A weekly audit will be completed by the Unit Manager or Staff Development Coordinator during infection control rounds observing all patients with a foley catheter will be observed and any infractions corrected immediately. The audit will be completed weekly for a period of 3 months and reported to the Quality Assurance Performance Improvement Committee monthly and review POC and determine if additional changes are needed. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The administrator will be responsible to ensure that the plan of correction is implemented. Audits of findings will be reviewed at the Quality Assurance Performance Improvement Committee meeting, monthly for 12 months, for review and revision as needed.	
F 323 SS=J	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free	F 323		12/15/17

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F 323	Continued From page 13 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review and Medical Director, Family Nurse Practitioner and staff interviews, the facility failed to provide supervision necessary to prevent 1 of 1 resident who was at risk for elopement from exiting the facility (Resident #216). The facility also failed to implement action to keep two residents separated to prevent 1 of 1 resident (Resident #216) from becoming agitated and slapping another resident (Resident #46) in the face. Immediate Jeopardy began on 10/11/17 when Resident #216 eloped from the facility without staff's knowledge that he was outside without supervision. Resident #216 had exited the building from the 400 Hall exit door and into the	F 323	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; On October the 11th Resident #216 exited the facility by the 400 Hallway exit door, which was unlocked and unalarmed. Resident #216 made it to the storm drain, in his wheel chair, which is eighty feet from the exit door to the storm drain and became stuck on the decline of the pavement around the storm drain and was not able to proceed any further. The resident was at that point, one hundred and eighty-eight feet at the bottom of an incline from the highway. The resident	

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F 323	Continued From page 14 parking lot in front of a storm drain when he was found by Nurse #1 who assisted him back to the building. The storm drain was observed to measure 80 feet from the outside door of 400 Hall to the storm drain and it was 188 feet and 2 inches from the storm drain to the road. Nurse #1 indicated Resident #216 had no injuries and returned to the facility without resistance. Immediate Jeopardy was removed on 11/17/17 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put in place and completion of employee training. The facility was cited at F323 for example #2 at a scope and severity level of D. The findings included: 1. Resident #216 was admitted to the facility on 09/21/17 with diagnoses that included Alzheimer's disease and dementia with behavioral disturbance. Review of the facility's admission assessment/screening dated 09/21/17 revealed Resident #216 had "short and long term memory impairment and wandered aimlessly". Further review revealed a comment which read "wandering in and out of other resident's rooms." Review of the care plan, created on 09/27/17, revealed Resident #216 was an "elopement risk/wanderer related to being disoriented to place and impaired safety awareness." The goals	F 323	had the potential of reaching the highway if he had not become stuck on the storm drain incline. On 10/11/17 at 3:50 PM the Minimum Data Set Coordinator had clocked out and was leaving for the day when she noted the resident at the storm drain. She assisted the resident to the sidewalk where she pushed the resident to the porch area and assisted him from his wheelchair to the bench. The receptionist came out and assisted the resident back into his wheelchair and returned the resident back into the building. The door that the resident exited from was immediately secured and alarm reset. " During the investigation by the Administrator on October 12, 2017 it was discovered that the Maintenance Director had not been checking the magnetic lock since his hire date of 09/27/2017 to ensure that they were secure and alarmed as intended. On October 12, 2017 the Administrator educated the Maintenance Director that as a routine practice the doors will be checked daily Monday through Friday by him and the Weekend Manager on Duty would be tasked with checking the doors on the weekend. The Administrator educated the Department Heads who are the managers on duty and was completed on October 12, 2017. " In an effort to determine why the door was unsecure it was discovered that the previous Housekeeping Director had made arrangements with a vendor to unlock the side door on the 400 Hall side of the building near the parking lot for deliveries. The vendor had made a	

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F 323	Continued From page 15 were for his "safety to be maintained and he would not leave the facility unattended through the next review date." The interventions included: "identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Wander Alert: ensure in place and functioning." Review of the Admission Minimum Data Set (MDS) dated 09/28/17 revealed Resident #216's cognition was severely impaired. The MDS indicated he had displayed continuous and non-fluctuating behaviors of inattention, disorganized thinking and altered level of consciousness. The MDS further indicated Resident #216 had displayed wandering behavior 1 to 3 days during the 7 day assessment period. Review of Resident #216's electronic medical record revealed the following nurses' notes: A note written by Nurse #10 on 09/28/17 at 3:38 PM read in part, "Resident #216 was alert but confused. Attempted to enter another patient's room, difficult to redirect but staff was able to redirect him away from patient's door." A note written by Nurse #8 on 10/02/17 at 6:08 PM read in part, "Resident #216 is alert and oriented to self, has trouble verbalizing needs due to cognitive impairment, always close to staff and in high traffic areas to be in view of staff. Resident has a wander guard on his wheelchair because he will not let staff apply wander guard so when resident gets close to the doors, the alarm goes off and notify staff." A note written by Nurse #9 on 10/10/17 at 7:57	F 323	delivery and the door was not relocked and alarm reset upon completion of the delivery. When this was discovered the Maintenance Director, called the vendor and spoke to the dispatcher and the delivery driver and informed them that deliveries would not be allowed through any doors other than the service hall door at the rear of the building where deliveries are intended to be delivered. On 11/3/17 resident #216 slapped resident #46 at 6:55 p.m. without provocation. At 7:55 p.m. on 11/3/17 the Sheriff□s Department was notified of the incident and report filed by the facility. The system failure was identified at the time the surveyors reported to the facility that during their interview an agency staff member who had previously witnessed resident #216 have a verbal altercation with another resident the same day. If this information had been reported to the facility Administration then appropriate steps could have been taken to possibly prevent the later altercation that was physical in nature. Resident #46 and Resident #216 were separated and no outward injuries noted. The Activity Director on 11/4, 11/5, 11/6 checked resident daily to ensure there were no latent injuries noted that were not present at the time of the slap. Resident #216 had no further incidents during his stay. Alternative placement was found for Resident #216 and the discharged to that facility on 11/13/17. Upon notification of the verbal altercation, on 11/16/17 additional training was initiated to staff on	

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F 323	Continued From page 16 PM read in part, "Resident #216 was very agitated, in and out of other rooms and given Ativan for discomfort. Tried to redirect resident but was unsuccessful." A note written by Nurse #8 on 10/11/17 at 2:17 PM read in part, "Resident #216 was alert and oriented to self but due to cognitive impairment has a hard time making sense or keeping a straight thought. Tolerated medications with no difficulty noted at this time. Wander guard is in place on wheelchair due to resident refusing to left staff place it on wrist. Wander guard is activated and will go off when resident is close to an exit door." A note written by Nurse #8 on 10/12/17 at 12:19 PM read in part, "wander guard is in place on wheelchair due to resident refusing to let staff place it on wrist. Wander guard is activated and will go off when resident is close to an exit door." A review of the facility's elopement investigation and plan of correction dated 10/11/17 revealed Resident #216 was found outside in the parking lot by the therapist with no injuries. Administration was notified and an investigation initiated which included a root cause analysis to determine how Resident #216 had gotten outside the facility and interviews with facility staff. The facility's investigation concluded the alarm on the exit door at the end of 400 Hall had been unarmed on 10/10/17 for deliveries and the alarm was not reactivated after the deliveries were made which had allowed Resident #216 to exit the building on 10/11/17. Once identified by the facility, the exit door at the end of 400 Hall had been immediately secured. The facility initiated a plan of correction that included education of	F 323	abuse and neglect with a focus on Resident to Resident Abuse which focused on the following areas for immediate strategies during an episode of a resident to resident altercation to de-escalate: " Engage in a swift, focused, decisive, firm, and coordinated intervention. " Immediately defuse chain reactions (Anxiety is contagious!). " Redirect resident(s) from the area (and pay attention to un-intended victims & residents with poor judgment re. safety). " Offer the person to take a walk together. " Distract/divert to a different activity / change the activity. " Refocus/switch topic to his/her favorite conversation topic. " Position, reposition, or change seating arrangement. " Stay, calm! The resident will mirror your emotional state and respond to your body language and tone of Voice. " Be sincere. Many are able to detect insincerity& Avoid smiling which could be interpreted as In-sincerity on your part, worsening the residents behavior. " Be firm and direct (rather than angry or irritated). " Identify & address underlying needs behind the aggression. " Use short, simple, familiar words/sentences & one-step directions. " Never ignore the emotions of a resident. Encourage expression of	

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F 323	Continued From page 17 nursing staff, maintenance staff, non-direct care staff and vendors. The monitoring procedure included daily and indefinite audits of all facility doors by the Maintenance Director to be reviewed by the Administrator. Review of the elopement statement (undated) for Resident #216 written by Nurse #1 read in part, "on Wednesday, October 11, 2017 at approximately 3:45 PM I was leaving work. I was pulling out of the parking lot on the facing left hand side of the building and I saw Resident #216, sitting in his wheelchair to move. I pushed Resident #216 to the cement sidewalk and there we met the Discharge Planning Assistant (DPA). I told her I found Resident #216 in the parking area. I then pushed Resident #216 to the porch area who wanted to stay outside. Resident #216 wanted to sit on the wooden bench on the porch area in the shade with other residents. The DPA went into the building to get help. I assisted Resident #216 transferring from wheelchair to bench. At this point, the Receptionist came out and told Resident #216 to get back in the wheelchair, it was too hot outside and assisted him back inside." Review of the elopement statement dated 10/12/17 for Resident #216 written by the DPA read, "As I was leaving work I found Nurse #1 pushing Resident #216 back onto the sidewalk. Nurse #1 claimed he had been found in the parking lot by self and his wheelchair was stuck in a drain. I helped talk Resident #216 into returning to the building. Then I told the Receptionist and they went out to Resident #216 and relieved Nurse #1. I then proceeded to warn admission staff. Resident #216 did not appear to be harmed. I also do not see how he got out of	F 323	feelings (fear; anger; and frustration) but in a safe location. " Seek assistance from co-workers (esp. those resident trusts). " Be consistent in approach (across staff, shifts, & weekends). " Meet with staff and let them know about the outburst and provide additional monitoring up too and including one on one to make sure emotional state is stabilized. " Notify Administration and the physician regarding the episodes for further direction or physician or administrative orders. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " On 10/11/17 the door on 400 Hall door was secured and all other doors in the facility providing access to the outside of the building were checked to ensure that they were secured and the alarm armed. " On October 12, 2017 the Maintenance Director was educated on checking doors every day Monday □ Friday and Manager on Duty for the weekend would check them on the weekends. " Between October 12 and October 18, 2017 Nurses (were the only staff that had access to the keys) on staff were educated that the exit doors are not to be opened for any reason other than an emergency and no deliveries are to be received through the exit doors. All	

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F 323	Continued From page 18 the building." Review of the elopement statement dated 10/12/17 for Resident #216 written by the Receptionist read in part, "on the date of 10/11/17, after hearing from down the hall that the resident was outside, I went over to the main outside door and saw the resident sitting on one of the benches. There was another resident with family sitting on the bench located next to Resident #216. I walked out and sat next to Resident #216 who was unaware how he had gotten outside. After a short talk, we decided it was too hot and we needed to get inside. There were no issues with getting him back into the building and from the front lobby he went back to his hall." Review of the elopement statement dated 10/11/17 for Resident #216 written by Nurse Aide (NA) #8 read in part, "At approximately 3:50 PM on 10/11/17 I witnessed Resident #216 sitting in his wheelchair at the nurses' station, he was acting his normal self. I walked past him sitting there on my way to answer a call light. When I finished with my resident and exited the room I was informed at around 4:00 PM that Resident #216 had gotten out of the facility and the Admissions person had brought him back in. He was not injured and didn't seem any different for the rest of the shift." An interview on 11/14/17 at 2:52 PM with the Receptionist revealed Resident #216 exited the building through an unlocked door off of one of the units and out into the parking lot. She was unable to recall the exact date this occurred but stated it happened around 5:00 PM, possibly on a weekday, within a couple of weeks after his	F 323	deliveries are to be received in the rear of the building at the delivery entrance. A cover was installed over the alarm box that has a lock which can only be opened by the nurse manning the Jasmine and Dogwood medication cart. This would allow for only the Maintenance Director and the one nurse on each hall would be able to alarm and unarm the mag lock door. " The Maintenance Director on 11/17/17 installed magnetic alarm switches to each exit door to allow an audible sound if the door is opened. Current employees were re-educated on Abuse and Neglect with a focus placed on Resident to Resident abuse and how such altercations to include verbal altercations are to be reported to Administration so that appropriate action can be taken to protect the resident initiating the altercation and other residents, staff or family members. New employees during orientation are trained on Preventing, Recognizing and Reporting Patient Abuse as well as annually through assigned training, in addition to Care of the Cognitively Impaired. Current employees will be trained or removed from the schedule until the training is completed. Future agency staff will be required to obtain Abuse Education prior to being allowed to work on the floor. The system change in addition to current abuse prevention training, we had Care of the Cognitively Impaired has been added to our Electronic Education System to be provided annually. To ensure current staff	

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F 323	Continued From page 19 admission to the facility. The Receptionist was not sure who found Resident #216 in the parking lot but thought it might have been the DPA. The Receptionist recalled that after staff assisted Resident #216 to the front of the building, he requested to sit on one of the benches and the Receptionist went outside to sit with him until he could be coaxed back inside. She stated he was agreeable to returning back inside the building and had done so without resistance. The Receptionist added she wrote a statement of the incident and gave to the Administrator. An interview on 11/14/17 at 3:50 PM with the DPA revealed she could not recall the exact day Resident #216 eloped but stated it occurred on a weekday at approximately 4:45 PM. She explained she had clocked out and walked out the front of the building toward the parking lot when she noticed Nurse #1 assisting Resident #216 back toward the building. The DPA indicated she walked back toward the front of the building with Resident #216 and Nurse #1 when he requested to sit outside on one of the benches. She stated Nurse #1 stayed with him while she went inside to get assistance from the Receptionist and to inform Administration. She added she wrote a statement of the incident and gave it to the Administrator. An interview was conducted on 11/15/17 at 8:10 AM with the Administrator who confirmed an investigation was immediately initiated when she was informed Resident #216 had been located outside the facility without supervision on 10/11/17. The Administrator stated they had determined the alarm on the exit door at the end of 400 Hall had been unarmed for a delivery and not rearmed after the delivery was made. She	F 323	are educated a course outline with content was printed and given to the Staff Development Coordinator to ensure staff were made aware of the upcoming system change. Measures to be put in place or systemic changes made to ensure practice will not re-occur: The Maintenance Director enters his checks on the doors (checking to ensure alarms are engaged and no doors were found to be unsecure) into the Preventative Maintenance Work-order System and prints the report and gives to the administrator weekly. Any checks that indicate a failure, the Maintenance Director or Weekend Manager on Duty will notify the Administrator immediately to inform, but the Maintenance Director will contact the alarm company for immediate check. Until the check occurs a staff member will posted at the door until the issue is resolved. The weekend Manager on Duty completes the checks during their assigned day and notifies Administrator and Maintenance, so that results can be entered into the Preventative Maintenance Work-order system. This will be accomplished by the Maintenance Director and Managers on Duty indefinitely. To prevent the potential for further elopements Daily Monday through Friday the DON and/or Unit Manager will continue to print and review progress notes to look for documentation of behaviors. Additionally staff were educated during Abuse and Neglect	

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F 323	Continued From page 20 added the exit door at the end of 400 Hall was not wander guard protected. The Administrator confirmed the door was secured as soon as it was discovered and a plan of correction was implemented which included a facility-wide audit of all exit doors and in-service education on door alarms was provided to staff. An interview on 11/15/17 at 8:33 AM with Nurse #1 revealed she was leaving for the day when she noticed Resident #216 sitting in his wheelchair out in the parking lot unattended on 10/11/17. Nurse #1 indicated he did not appear injured and she immediately assisted him back toward the front of the building where they met the DPA who was also leaving at the time. Nurse #1 recalled it was a nice day and she assisted Resident #216 out of his wheelchair to sit on the bench at his request when they got to the front of the building. Nurse #1 was unsure how long Resident #216 had been sitting out in the parking lot prior to her intervention. She added she wrote a statement of the incident and gave it to the Administrator. An observation of the parking lot where Resident #216 had been located was conducted on 11/15/17 at 8:56 AM with Nurse #1. She walked to left side of the building to an area in the middle of the parking lot where a water drain grate was located. She explained he was faced toward the road and the back wheels of his wheelchair had been situated right in front of the water drain grate. A follow-up interview on 11/15/17 at 10:00 AM with Nurse #1 revealed she "clocked out of work about 3:45 PM on 10/11/17, went straight to her car and started to drive out of the parking lot"	F 323	Training and Dealing with Cognitively Impaired about redirecting residents and notifying nurse and administration of this need to redirect from the doors. On the Weekend the Manager on Duty will inquire of each nurse if they have any patients exhibiting behaviors such as being aggressive, entering other patients rooms, wandering around with no purpose. These audits will be turned in to the Administrator during morning stand-up and reviewed at that time for any suspicious responses for a period of three months. Once Administrator or DON is notified of suspicious behaviors such as being aggressive, entering other patient□s rooms, wandering around with no purpose, an assessment will be made by DON or UM for need of a psych service referral or other interventions as appropriate and the plan of care will be updated with the exhibited behaviors noted. DDP will be notified to assess the need for alternate placement and assist with services as needed. DON or UM will ensure behavior monitoring is placed on the MAR for monitoring q shift. The Administrator or DON will sit in on one abuse training session a month for a period of three months and evaluate the program and results of rounding and behavior audits. Audits will be presented to the Quality Assurance Performance Improvement Committee for the committees review. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:	

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F 323	Continued From page 21 when she noticed Resident #216. Nurse #1 estimated she noticed Resident #216 at "3:50 PM" and it took her "approximately 5 minutes" to assist him back toward the front of the building. A follow-up interview on 11/15/17 at 5:30 PM with the Administrator revealed the plan of correction put into place on 10/11/17 when Resident #216 eloped from the building stated "the therapist had been the one to find him in the parking lot but it was actually Nurse #1." The Administrator confirmed they did not provide inservice education to the NA staff because nursing staff were the only ones that were authorized to unlock exit doors. An interview and tour was conducted on 11/15/17 at 5:37 PM with the Maintenance Director. The Maintenance Director used a multi-foot tape measure to determine the distance measurements for the area of the parking lot where Resident #216 had been located. The area was observed to measure 188 feet and 2 inches from the road to the front of the water drain grate and was 80 feet from the outside door of 400 Hall to the front of the water drain grate. The Maintenance Director confirmed the exit door had been unarmed to allow a delivery sometime "between 2:00 PM and 3:00 PM on 10/10/17" and he was unaware it was still unarmed until 10/11/17 when Resident #216 had exited the building. An interview on 11/15/17 at 7:06 PM with NA #8 revealed she was assigned to care for Resident #216 on 10/11/17 when she was informed he had exited the building. NA #8 stated it shocked her "how quickly he got out" of the facility and verified she saw Resident #216 "sitting by the nurses	F 323	The administrator will be responsible to ensure that the plan of correction is implemented. Audits of findings will be reviewed at the Quality Assurance Performance Improvement Committee meeting, monthly for 12 months, for review and revision as needed and to ensure compliance is maintained.	

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station at approximately 3:45 PM" prior to him exiting the building.

The Administrator and Corporate Nurse Consultant were informed of Immediate Jeopardy on 11/16/17 at 6:13 PM.

On 11/17/17 at 6:45 PM, the facility provided the following Credible Allegation of Compliance:

1. On 10/11/17 Resident #216 exited the facility by the 400 Hallway exit door, which was unlocked and unalarmed. Resident #216 made it to the storm drain, in his wheel chair, which is eighty feet from the exit door to the storm drain and became stuck on the decline of the pavement around the storm drain and was not able to proceed any further. The resident was at that point, one hundred and eighty-eight feet at the bottom of an incline from the highway. The resident had the potential of reaching the highway if he had not become stuck on the storm drain incline. On 10/11/17 at 3:50 PM the Minimum Data Set Coordinator had clocked out and was leaving for the day when she noted the resident at the storm drain. She assisted the resident to the sidewalk where she pushed the resident to the porch area and assisted him from his wheelchair to the bench. The receptionist came out and assisted the resident back into his wheelchair and returned the resident back into the building. The door that the resident exited from was immediately secured and alarm reset.

During the investigation by the Administrator on October 12, 2017 it was discovered that the Maintenance Director had not been checking the magnetic lock since his hire date of 09/27/2017 to ensure that they were secure and alarmed as

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intended. On October 12, 2017 the Administrator educated the Maintenance Director that as a routine practice the doors will be checked daily Monday through Friday by him and the Weekend Manager on Duty would be tasked with checking the doors on the weekend. The Administrator educated the Department Heads who are the managers on duty and was completed on October 12, 2017.

In an effort to determine why the door was unsecured it was discovered that the previous Housekeeping Director had made arrangements with a vendor to unlock the side door on the 400 Hall side of the building near the parking lot for deliveries. The vendor had made a delivery and the door was not relock and alarm reset upon completion of the delivery. When this was discovered the Maintenance Director, called the vendor and spoke to the dispatcher and the delivery driver and informed them that deliveries would not be allowed through any doors other than the service hall door at the rear of the building where deliveries are intended to be delivered.

2. On 10/11/17 the door on 400 Hall door was secured and all other doors in the facility providing access to the outside of the building were checked to ensure that they were secured and the alarm armed. On October 12, 2017 the Maintenance Director was educated on checking doors every day Monday - Friday and Manager on Duty for the weekend would check them on the weekends.

Between October 12 and October 18, 2017 Nurses (were the only staff that had access to the keys) on staff were educated that the exit doors

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are not to be opened for any reason other than an emergency and no deliveries are to be received through the exit doors. All deliveries are to be received in the rear of the building at the delivery entrance. A cover was installed over the alarm box that has a lock which can only be opened by the nurse manning the Jasmine and Dogwood medication cart. This would allow for only the Maintenance Director and the one nurse on each hall would be able to alarm and unarm the magnetic lock door.

The Maintenance Director on 11/17/17 installed magnetic alarm switches to each exit door to allow an audible sound if the door is opened.

3. The Maintenance Director enters his checks in to the Preventative Maintenance Work-order System and prints their assigned day and notifies Administrator and Maintenance, so that results can be entered into the Preventative Maintenance Work-order system. This will be accomplished by the Maintenance Director and Managers on Duty indefinitely.

4. The administrator will be responsible to ensure that the plan of correction is implemented, audit findings will be reviewed at the Quality Assurance Performance Improvement Committee Monthly, indefinitely for review and revision as needed.

Immediate Jeopardy was removed on 11/17/17 at 6:45 PM when observations revealed the alarms/chimes were functioning at each exit door, observations of residents identified with wandering behaviors revealed their wander guards to be in place and interviews with the Maintenance Director, Housekeeping Director and nursing staff confirmed they had received

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in-service training on codes and door alarms.

2. Resident #216 was admitted to facility on 09/21/17 with diagnoses that included nontraumatic subarachnoid hemorrhage (bleeding in the area between the brain and surrounding membrane), Alzheimer's disease and dementia with behavioral disturbance.

Review of the facility's Admission Assessment/Screening - Nursing form dated 09/21/17 for Resident #216 read in part, "admitted from hospital. Short and long term memory impairment. Resident wanders aimlessly in and out of other resident rooms." Behaviors checked were "resistive and aggressive."

Review of the care plans for Resident #216 revealed the following:

"Resistance to Care related to dementia, initiated on 09/22/17 and revised on 09/25/17", included a goal he "would cooperate with care through the next review date." Interventions included to "allow him to make decisions about treatment, give clear explanation of all care activities prior to and as they occur each contact and praise when behavior is appropriate."

"Impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease and impaired decision making, initiated on 09/22/17 and revised on 11/9/17, included a goal he "would develop skills to cope with cognitive decline and maintain safety by the next review date." Interventions included for staff to "administer medications as ordered, ask yes/no questions in order to determine his needs, reduce

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any distractions, provide him with necessary cues - stop and return later if he becomes agitated, 1:1 sitters as indicated, and monitor/document/report as needed any changes in cognitive function."

"Physical aggression potential related to dementia, poor impulse control and sexually inappropriate behavior, initiated on 09/27/17 and revised on 11/7/17, included a goal that he would not harm self or others through the next review date. Interventions included for staff to administer medications as ordered, assess and anticipate resident's needs, provide physical and verbal cues to alleviate anxiety, assist to set goals for more pleasant behavior, monitor/document/report as needed any signs or symptoms of resident posing danger to self and others, proceed with discharge if behavior cannot be managed within facility, Psychiatric consult as indicated, and intervene when the resident becomes agitated."

Review of the Admission Minimum Data Set (MDS) dated 09/28/17 revealed Resident #216's cognition was severely impaired. The MDS indicated he had displayed physical and verbal behavior directed toward others and other behavioral symptoms not directed toward others 1 to 3 days during the assessment period which interfered with his care, participation in social activities and put others at risk of injury.

Review of the initial Psychiatric Evaluation dated 10/02/17 for Resident #216 revealed in part, seen for "reduction in assaultive and inappropriate behavior. Family member present and reports episodes of hallucinations. Staff and family member report that his mood 'changes quickly.' It is reported he grabs and swings at staff. Since

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he has been at this facility, he has been sent to the hospital twice due to his behaviors in which he was returned back to the facility. Due to his level of dementia, his answers to my questions are unreliable. Short term and long term memory poor." Medications were initiated with instructions to "monitor for changes in mood and behavior."

Review of the nurses' notes related to Resident #216's behaviors revealed the following entries:

A note written by Nurse #8 on 10/02/17 at 6:08 PM read in part, "Resident #216 is alert and oriented to self, has trouble verbalizing needs due to cognitive impairment, always close to staff and in high traffic areas to be in view of staff."

A note written by Nurse #9 on 10/10/17 at 7:57 PM read in part, "Resident #216 was very agitated, in and out of other rooms and was given Ativan for comfort. Tried to redirect but was unsuccessful."

A note written by Nurse #8 on 10/11/17 at 2:17 PM read in part, "Resident #216 was alert and oriented to self, able to verbalize needs majority of the time but due to cognitive impairment resident has a hard time making sense or keeping a straight though. Tolerated medications with no difficulty noted at this time."

A note written by Nurse #6 on 10/17/17 at 6:45 PM read in part, Late Entry: "Resident #216 became combative after nurse tried to redirect from going out the door, his fists clenched, he screamed 'get out of my way or I'll kill you.'"

A note written by Nurse #3 on 10/26/17 at 9:29 AM read in part: Resident #216 went into another

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resident's room, was resistive to leave room, combative and clung onto door handle. Resident #216 "began to curse and swing his hands at all nurses and started to growl and yell."

A note written by Nurse #2 on 10/28/17 at 2:00 AM read in part, "staff is one on one with resident and unable to redirect with snacks, coloring, or TV. Patient is resistant to diversions and becomes aggressive frequently. Patient with this nurse entire shift with multiple corrections made to not touch nurse or staff. Continues to attempt to pull meds from cart while on med pass."

A note written by Nurse #4 on 11/4/17 at 4:21 AM read in part, "patient was verbally and physically abusive to a patient (Resident #46) by telling her to "shut up" and then proceeding to slap patient. The two patients were separated and Administrator, the cops and family members were notified. Separating the two was effective."

A telephone interview on 11/14/17 at 5:23 PM with Nurse #4 revealed she was employed through an agency and was assigned to work 3:00 PM to 11:00 PM on 200 Hall the night she witnessed Resident #216 slap another resident (Resident #46). Nurse #4 recalled it was her first day at the facility and Resident #216 had just recently been moved to 200 Hall. She explained Resident #216 was sitting out in the middle of the hall with another resident, who repeatedly yelled out, when they started "hollering back and forth, telling each other to shut up." She stated he got up from his wheelchair, went over to the other resident and gave her a pat on the shoulder. She indicated Resident #216 sat back down as she instructed and both residents calmed down. She added it was not an aggressive incident and felt no other

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interventions were needed at the time. Nurse #4 stated later that evening when the other resident (Resident #46) started hollering out again, Resident #216 became agitated and she turned in time to see him slap Resident #46 across the face. Nurse #4 stated she assisted Resident #216 back to his wheelchair and he sat back down. Nurse #4 added Resident #216 was taken to another hall, the police were contacted by the Administrator and they came to the facility to talk to him. She indicated Resident #216's family member came to the facility after the incident, he had calmed down and there were no further incidents.

An interview on 11/15/17 at 8:10 AM the Administrator confirmed she had been informed Resident #216 had slapped another resident (Resident #46) the evening of 11/03/17. She stated the incident occurred around 6:00 PM and was witnessed by an agency nurse assigned to his hall. The Administrator stated she personally contacted both resident's families to inform them of the incident and the agency nurse contacted the police. She indicated the police came to the facility to talk with Resident #216 but they did not fill out a police report since both residents had dementia and the other resident's family had not wanted to press charges. The Administrator stated the other resident (Resident #46) had a red mark on her face after the incident but when assessed the next day there was no bruising or other negative outcome. She added that it was difficult for facility staff to provide constant supervision to Resident #216 and after the incident on 11/03/17 agency staff were utilized to ensure Resident #216 had one on one supervision.

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F 323	Continued From page 30 A telephone interview on 11/15/17 at 5:48 PM with the Medical Director (MD) confirmed she was aware of Resident #216's behaviors and stated they looked for alternate placement for Resident #216 but this facility had been the only option for him at the time. She explained he had dementia with aggressive behaviors and had been hospitalized twice since his admission. The MD stated she felt the facility was following their protocols to keep him and other residents safe. An interview on 11/16/17 at 9:02 AM with the Family Nurse Practitioner (FNP) revealed she was unaware Resident #216 had slapped another (Resident #46) resident and confirmed he was severely impaired with cognition, decision making and safety awareness. The FNP stated Resident #216 was often aggressive and directed it toward "anyone who attempted to provide redirection." She added a "sitter" was the most effective intervention for his behaviors.	F 323		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 371		12/11/17

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F 371	Continued From page 31 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store food under sanitary conditions by leaving produce on the floor and failed to properly label and discard expired foods for 1 of 1 reach-in refrigerators. Findings included: During an observation at 9:51 AM on 11/13/17, a large box of potatoes were placed directly on the kitchen floor. In the area where non-refrigerated foods were stored 4 loaves of white bread with an expiration date of 11/09/17 and 1 loaf of raisin bread with an expiration date of 11/10/17 were stored with unexpired bread. In the kitchen reach-in refrigerator was a salad topped with sliced turkey wrapped in plastic with no date. In the same refrigerator was a container of tuna salad with the use by date of 11/11/17. During an interview at 9:51 AM on 11/13/17, the Dietary Manager (DM) revealed the potatoes on the floor were used the day before and should not have been left on the kitchen floor and food should be stored off the floor. The DM also revealed the loaves of bread should have been	F 371	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; " During the survey process it was noted by the surveyor on 11/13/17 that a box of potato□s were being stored on the floor of the kitchen, there were three loaves of bread dated 11/9/17 and 11/10/17 being stored on the bread rack in dry storage and there was one container of expired tuna salad dated 11/11/17 being stored in the reach in refrigerator. The dining services staff failed to discard all expired products left in the reach in refrigerator at the end of their shift and properly store food at least 12 off of the floor. The contract bread service failed to remove expired bread upon bread delivery the morning of 11/13/17. Upon observation the box of potatoes stored improperly were immediately discarded, the expired loaves of bread were immediately discarded and the expired tuna salad was immediately discarded. All food items in dry and cold storage were evaluated and	

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F 371	Continued From page 32 thrown away on the evening of the expiration date. The DM revealed she did not know when the salad was made, but it should have been dated the day it was made and used within 2 days. The DM revealed the tuna salad should have been thrown away on 11/11/17. The DM revealed all foods should have a label to indicate the date the food was made or opened and the date it should be used and thrown away the date indicated to be discarded. During an interview at 12:30 PM on 11/15/17, the Administrator revealed it was her expectation for food to be stored off the floor and for opened food to be labeled correctly and expired food to be thrown away and not be stored with unexpired foods.	F 371	ensured to be properly labeled/dated and stored. On November 13, 2017, the dining services manager conducted a in-service regarding proper procedure for discarding expired food items, labeling and dating items and properly storing food items including storing food at least 12 off the floor. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; " November 13, 2017 all expired and improperly items were immediately discarded by the dining services manager. All dining services employees were in-serviced regarding proper procedure for discarding expired food items, labeling and dating items and properly storing food items including storing food at least 12 off the floor. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Corporate Dietitian will complete a sanitation inspection weekly x 4 weeks, twice-monthly x 4 weeks, and at least monthly thereafter to ensure compliance with corrective actions and sanitation standards. All new hires will receive in-service education on the proper procedure for discarding expired food items, labeling and dating items and properly storing food items including storing food at least 12 off the floor. Any	

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	345526	A. BUILDING _____ B. WING _____	C 11/17/2017

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F 371	Continued From page 33	F 371	deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The administrator will be responsible to ensure that the plan of correction is implemented. Audits of findings will be reviewed at the Quality Assurance Performance Improvement Committee meeting, monthly for 12 months, for review and revision as needed.	
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		12/11/17

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F 441	Continued From page 34 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the	F 441		

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F 441	Continued From page 35 spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to disinfect a glucometer (blood glucose meter used for blood sugar monitoring) according to manufacturer's recommendations for 2 of 2 finger stick blood sugar (FSBS) observed (Resident #80 and #109). Findings included: 1. a. A review of a facility policy for blood glucose maintenance dated 02/01/15 indicated in part the glucometer needed to be cleansed according to manufacturer's recommendation. A review of the manufacturer's document entitled Cleaning & Disinfecting Blood Glucose Meters indicated cleaning and disinfecting could be completed by using a commercially available EPA (Environmental Protection Agency) germicidal wipe. The directions for use of the EPA Germicidal Disposable Wipe indicated to unfold the wipe and thoroughly wet the surface of the glucometer. Use additional wipe (s) if needed to assure continuous 4 minutes of wet contact time and allow to air dry. During a continuous observation on 11/14/17 at 4:15 PM Nurse #14 was observed placing the glucometer on top of the medication cart and then removed an individual packet of a germicidal disposable wipe and opened the package and wiped the front, sides and back of the glucometer	F 441	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Upon notification by the surveyor, nurses were immediately in-serviced on the cleaning of glucometers using the following steps. This failure in the system is direct result of the lack of understanding of the cleaning procedures for the glucometers. " Using PDI Sani-Cloth Germicidal Disposable Wipes to disinfect the Blood Glucose Meters. Steps for disinfecting Blood Glucose Meters: 1. Use one wipe to clean meter- discard 2. Use a second wipe and wrap the meter in it. 3. Place wrapped meter in cup, let stand for 4 minutes 4. Remove wrapped meter from cup, discard wipe, place meter On wash cloth to air dry. While this meter is being disinfected utilize your second Blood Glucose Meter. All new nurses will be trained during orientation on cleaning the glucometers according to manufacturer□s recommendation. The procedure for implementing the	

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F 441	Continued From page 36 for approximately 45 seconds and discarded the wipe in the trash on the medication cart. Nurse #14 laid the glucometer on top of the medication cart and indicated she was ready to obtain a FSBS on Resident #80. Nurse #14 gathered supplies and then carried the glucometer and supplies into Resident #80's room and placed them on the bed and stated she was ready to obtain the FSBS on Resident #80. Nurse #14 was stopped by the observer prior to obtaining a FSBS on Resident #80. An interview was conducted on 11/14/17 at 4:41 PM with Nurse #14 who stated she was an agency nurse who had worked at the facility for 4 days and had not received training on the facility policy and procedure for cleaning and disinfecting the glucometer. Nurse #14 stated she believed that the glucometer was cleaned appropriately after being wiped on the front, back, and sides with a germicidal wipe for 45 seconds and then allowed to air dry for one minute. Nurse #14 picked up the germicidal wipe container and read the manufacturer's instructions for use and verified the germicidal wipe was required to have continuous 4 minutes of wet contact time with the glucometer and allowed to air dry. On 11/14/2017 at 6:13 PM an interview was conducted with the Corporate Nurse Consultant (CNC) who stated his expectation was that staff and agency staff would have been trained on cleaning and disinfecting the glucometer during orientation. The CNC stated his expectation was that staff would have followed the manufacturer's recommendation on the germicidal disposal wipe for cleaning the glucometer as per facility policy. The CNC stated the staff development coordinator was a new employee and was in	F 441	acceptable plan of correction for the specific deficiency cited; Upon notification by the surveyor, nurses were immediately in-serviced on the cleaning of glucometers using the following steps. " Using PDI Sani-Cloth Germicidal Disposable Wipes to disinfect the Blood Glucose Meters. Steps for disinfecting Blood Glucose Meters: 1. Use one wipe to clean meter- discard 2. Use a second wipe and wrap the meter in it. 3. Place wrapped meter in cup, let stand for 4 minutes 4. Remove wrapped meter from cup, discard wipe, place meter On wash cloth to air dry. While this meter is being disinfected utilize your second Blood Glucose Meter. All new nurses will be trained during orientation on cleaning the glucometers according to manufacturer□s recommendation. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Staff development during orientation for staff nurses and agency nurses will educate nurses on cleaning of glucometers. The Staff Development Coordinator, Unit Manager or DON will monitor 5 Glucometer cleanings a week and document on the audit tool the results of the monitoring. The audit will be completed weekly for a period of 3 months and reported to the Quality	

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F 441	Continued From page 37 training and was not available to train new hires and agency staff on the facility policy for cleaning the glucometer. On 11/15/17 at 10:08 AM an interview was conducted with the Administrator who stated her expectation was that staff would have cleaned the glucometer per manufacturer's instructions and facility policy. The Administrator stated her expectation was that staff would have been trained on hire during the orientation period regarding the facility policy for cleaning and disinfecting the glucometer. 1. b. During a continuous observation on 11/14/17 at 5:02 PM Nurse #15 was observed taking a glucometer out of the top drawer of the medication cart and then laid the glucometer on top of the cart. Nurse #15 stated he was just beginning his FSBS for the shift and stated he was not sure if the glucometer had been cleaned. Nurse #15 put on gloves and took a 1 x 1 inch individual alcohol prep pad packet and opened the prep pad packet and wiped the front, back, and sides of the glucometer and tossed the alcohol prep pad in the trash on the medication cart and then removed his gloves and tossed them in the trash on the medication cart. Nurse #15 laid the glucometer down on the medication cart and indicated he was ready to obtain a FSBS on Resident #109. Nurse #15 gathered supplies and then carried the glucometer and supplies into Resident #109's room and placed them on the counter by the sink and stated he was ready to obtain the FSBS on Resident #109. Nurse #15 was stopped by the observer prior to obtaining a FSBS on Resident #109. An interview was conducted with Nurse #15 on	F 441	Assurance Performance Improvement Committee monthly and review POC and determine if additional changes are needed. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The administrator will be responsible to ensure that the plan of correction is implemented. Audits of findings will be reviewed at the Quality Assurance Performance Improvement Committee meeting, monthly for 12 months, for review and revision as needed.	

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F 441	Continued From page 38	F 441		

11/14/17 at 5:20 PM who stated he was not sure if the glucometer on the medication cart had been cleaned and disinfected by the person who had used the glucometer prior to him. Nurse #15 stated he thought that cleaning the back, front, and sides of the glucometer with an alcohol prep pad was appropriate to clean and disinfect the glucometer. Nurse #15 stated he was a new employee and had worked at the facility for about 3 weeks and had not received training on the facility policy and procedure for cleaning the glucometer. Nurse #15 verified the medication cart had germicidal wipes available and he read the manufacturer's instructions for use and verified the germicidal wipe was required to have continuous 4 minutes of wet contact time with the glucometer and allowed to air dry.

On 11/14/2017 at 6:13 PM an interview was conducted with the Corporate Nurse Consultant (CNC) who stated his expectation was that staff and agency staff would have been trained on cleaning and disinfecting the glucometer during orientation. The CNC stated his expectation was that staff would have followed the manufacturer's recommendation on the germicidal disposal wipe for cleaning the glucometer as per facility policy. The CNC stated the staff development coordinator was a new employee and was in training and was not available to train new hires and agency staff on the facility policy for cleaning the glucometer.

On 11/15/17 at 10:08 AM an interview was conducted with the Administrator who stated her expectation was that staff would have cleaned the glucometer per manufacturer's instructions and facility policy. The Administrator stated her expectation was that staff would have been

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F 441	Continued From page 39 trained on hire during the orientation period regarding the facility policy for cleaning and disinfecting the glucometer.	F 441		