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	345166	A. BUILDING _____ B. WING _____	C 03/19/2020

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F 000	INITIAL COMMENTS A complaint investigation was conducted from 3/13/20 to 3/14/20. Additional information was obtained on 3/19/20. Therefore, the exit date was changed to 3/19/20. The one allegation that was investigated was substantiated.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to protect a resident's right to be free from physical abuse when a nurse aide hit residents during the provision of care for 2 (Resident #1 and Resident #3) of 5 sampled residents reviewed for abuse. As a result of Nurse Aide #2's physical abuse Resident #1 experienced a deep purple bruise on her hand with additional bruises on her hands and arms and Resident #3 experienced a deep purple bruise on her left ring finger with multiple bruises on her arms. Findings included:	F 600	Past noncompliance: no plan of correction required.	3/20/20

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

Electronically Signed | 03/27/2020

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1. Resident #1 had cumulative diagnoses, some of which included dementia, adult failure to thrive, and cerebral vascular accident.

A quarterly minimum data set assessment dated 9/18/19 coded Resident #1 as having severely impaired cognition with no behaviors or rejection of care. The assessment coded the resident as dependent on two people for bed mobility, dressing, hygiene, bathing, toilet use, in addition to being incontinent of both bowel and bladder.

An interview was conducted with the former Director of Nursing (DON) on 3/13/20 at 12:17 PM. The DON explained that on the morning of 9/30/19 she was contacted by an employee of the facility at approximately 8:30 AM revealing nurse aide (NA #1), who had worked 11:00 PM to 7:00 AM on 9/29/19 to 9/30/19, had witnessed abusive behavior by a nurse aide (NA #2). The former DON stated she instructed the employee to have NA #1 write down what happened and to return to the facility to give a statement. The former DON indicated she informed the Administrator of the abuse allegations that were made. The former DON indicated NA #1 returned to the facility with her statement on 9/30/19 at approximately noon and was subsequently interviewed in the presence of the DON, Administrator, and the minimum data set assessment (MDS) coordinator.

The statement written by NA #1, was signed and dated 9/30/19, stated in part, "While I was changing [Resident #6], [NA #2] was changing [Resident #1]. [NA #2] pulled the curtain between the two residents, but I could still see her in the mirror. Although [Resident #1] was combative per

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usual, I noticed when [Resident #1] would swing and hit [NA #2] that she would swing and hit back. I saw her mostly towards her arms and hands which seemed as if she was trying to get [Resident #1] to stop, but in a hateful way. When I finished with [Resident #6], I went to dump the dirty linen/brief into the cart. I came back into the room to her (NA #2) saying, "I just realized I didn't put these pillows back under her feet, but honestly I don't give a [expletive] right now" and she walked out."

Documentation of the 9/30/19 interview by the former DON, Administrator, and the MDS coordinator conducted at 12:50 PM with NA #1 revealed, "When we went into [Resident #1's] room, [NA #2] told me to change [Resident # 6]. I could see in the mirror that [Resident #1] was trying to fight her and [Resident #1] don't like to be touched. I heard [Resident #1] say get off me and stop hitting me. I could see her hitting back at [Resident #1]. The pillows are usually under [Resident #1's] feet and she had not put them there. [NA #2] commented, "I don't give a [expletive] now" and walked away. [NA # 1] thought [Resident #1] looked scared."

NA #1 was interviewed on 3/13/20 at 2:18 PM. NA #1 indicated that she was in initial facility training on 9/29/19 to 9/30/19 and the 11:00 PM to 7:00 AM shift which was the first time she had trained on that shift. NA #1 confirmed the accuracy of her written statements and that she saw NA #2 hit Resident #1 on the arms and hands on 9/30/19.

Documentation of an interview on 9/30/19 at 7:10 PM revealed NA #2 was questioned as to the etiology of unknown bruises on Resident #1 and if anything, out of the ordinary occurred on her shift

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on 9/29/19 to 9/30/19. The documentation of the response by NA #2 stated in part, "[Resident #1 name] is not really hitting me, nothing out of the ordinary" and "The residents who had bruising are [Resident #1] and [Resident #3]. [Resident #1] has a large bruise on her right hand. [NA #2] responded that [Resident #1] and [Resident #3] always have bruises. "I can't think of a time when they don't have a bruise." For [Resident #1] "If I had bruised her it would be red. I don't grab her by the hands, I use her shoulders and waist to turn her." "I don't think she would keep [geriatric] sleeves on to help her bruising." The documentation in the interview with NA #2 on 9/30/19 indicated NA #2 was suspended after the interview pending a full investigation.

NA #2 was interviewed on 3/14/20 at 2:06 PM. NA #2 revealed that on the 11:00 PM to 7:00 AM shift on 9/29/19 to 9/30/19, she was training a new nurse aide (NA #1). NA #2 explained that it took two to three hours to do incontinent care rounds and she was very tired on that day. NA #2 further explained that she did see the bruises on Resident #1 on her shift, but she was sure someone else had seen them and reported them. NA #2 recalled that she had "bothered" the nurse (Nurse #3) on the unit about many other concerns on that shift and she did not want to bother him again. NA #2 indicated she did her first incontinent rounds when she arrived at 11:30 PM. NA #2 indicated she did not initially notice the bruising on Resident #1 on the first incontinent care rounds but did notice the bruising on the second incontinent care rounds she made in the early morning hours. NA #2 confirmed the bruising was two to three black purple tinted bruises on the right hand of Resident #1. NA #2 confirmed she did not report the bruising on

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Resident #1 to Nurse #2 on 9/30/19. NA #2 stated that Resident #1 would hit at her sometimes but that she took the time to try to explain to Resident #1 what she was doing while providing care.

Nurse #3, who was working on the 11:00 PM to 7:00 AM shift on 9/29/19 to 9/30/19, was interviewed on 3/14/20 at 6:25 AM. Nurse #3 stated that he had seen NA #2 be a little rough with the residents in the past, but he had never seen NA #2 hit any of the residents. Nurse #3 revealed he did not see the bruising on Resident #1 on the morning of 9/30/19 but saw them after the fact. Nurse #3 revealed he thought NA #2 was more verbally abusive than physically abusive to the residents. When asked why he did not say anything to a supervisor, Nurse #3 replied that he thought they already knew.

An interview was conducted with the interim DON/MDS coordinator on 3/13/20 at 12:45 PM. The interim DON/MDS coordinator revealed that after the administrative interview with NA #1 on 9/30/19 at 12:50 PM, a skin assessment was completed for Resident #1. The interim DON/MDS coordinator indicated the skin assessment revealed bruising on the right upper arm, right hand, and the left forearm of Resident #1. The interim DON/MDS coordinator further stated that the nursing staff members who worked on the 7:00 AM to 3:00 PM shift and the 3:00 PM to 11:00 PM shift on 9/29/19 were interviewed regarding any bruising on Resident #1 on those shifts. The interim DON/MDS Coordinator stated no one who worked on these shifts stated they observed any bruising on Resident #1.

A "problem focused charting - altered skin

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integrity" report by Nurse #4 dated 9/30/19 at 3:30 PM documented Resident #1 had bruising 6 centimeters in length by 4 centimeters in width on the right hand. There were no other further details on the report.

Nurse #4 was interviewed on 3/19/20 at 11:35 AM regarding her observations on 9/30/19 of the skin assessment for Resident #1. Nurse #4 revealed she was asked by the DON to complete documentation on the bruising the DON had observed on Resident #1. Nurse #4 stated she was a little overwhelmed because the local authorities were taking pictures of Resident #1 and she knew an investigation was being initiated. Nurse #4 admitted she did not fill out the paperwork on the problem focused charting - altered skin integrity sheet for Resident #1 dated 9/30/19 as completely as she could have. Nurse #4 elaborated and described scattered bruises on the hand, right upper arm, and left forearm of Resident #1. Nurse #4 stated that her major focus was on a large deep purple bruise on the resident's right hand.

Nurse #1, who worked on the 7:00 AM to 7:00 PM shift on 9/29/19 on the unit which Resident #1 resided, was interviewed on 3/13/20 at 2:34 PM. Nurse #1 stated there was no new bruising on Resident #1 on 9/29/19. Nurse #1 revealed that Resident #1 sometimes had small bruises on her hands and forearms, but she did not have any new or any major bruising to her arms on her shift on 9/29/19.

Nurse #2, who worked 3:00 PM to 11:00 PM on 9/29/19, was interviewed on 3/13/20 at 2:00 PM. Nurse #2 indicated she was not notified of any bruising nor did she notice any bruising on

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Resident #3 during her shift on 9/29/19.

Nurse aide (NA #3), who worked on the 3:00 PM to 11:00 PM shift on 9/29/19 on the hall which Resident #1 resided, was interviewed on 3/13/20 at 2:08 PM. NA #3 was adamant that there was no bruising on Resident #1 during his shift on 9/29/19.

Nurse aide (NA #4), who worked on the 3:00 PM to 11:00 PM shift on 9/29/19 on the hall which Resident #1 resided, was interviewed on 3/13/20 at 3:29 PM. NA #4 indicated she worked with NA #3 on the hall for which Resident #1 resided on 9/29/19. NA #4 confirmed that she did not notice any bruising to Resident #1 on her shift on 9/29/19.

The Administrator was interviewed on 3/13/20 at 11:39 AM. The Administrator indicated that after the allegations were made, the bruising on Resident #1 observed, and staff interviews were made, the evidence pointed to abuse that could not be discounted. The Administrator stated that the resident was prone to bruising but the extensive bruising discovered on 9/30/19 on her right upper arm, left forearm, and the bruising on the right hand could not be explained away as accidental or self-inflicted. The Administrator revealed that NA #2 was suspended during the initial investigation but was terminated on 10/7/20 after providing a statement regarding the events on 9/30/19.

The Administrator was interviewed again on 3/14/20 at 12:47 PM. The Administrator revealed and reviewed the steps taken after the allegation of abuse of Resident #1 was made at the facility. The Administrator revealed local law enforcement

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was contacted along with the state division of health service regulation on 9/30/19. The residents in the long-term care unit were interviewed by the facility social worker by 10/1/19. The social worker questioned all the residents regarding their perceived safety, disrespect from staff, and if staff had hurt them. Any concerns expressed by the residents were followed up by the Director of Nursing. A retrospective analysis of the 2019 reported bruises and injuries of unknown origin was completed on 10/3/19 by the risk manager to determine if any patterns of potential abuse could be identified. Skin assessments of the residents were completed by 10/4/19. The facility immediately interviewed and took statements from all the nursing staff members who had worked on 9/29/19 and 9/30/19 in the long-term care unit. The facility additionally interviewed and took statements from additional nursing co-workers of NA #2. All the interviewed staff members were received immediate retraining on the abuse policies and procedures for the facility focusing on the reporting aspect of the training. The Administrator revealed all the nursing staff working in the long-term care unit were retrained in the abuse policies and procedures as of 10/4/19. The entire staff, to include volunteers, was retrained on the abuse policies and procedures in November and December 2019. The Administrator explained that prior to the retraining of the entire staff, the abuse policies and procedure training was redone and updated to emphasize the importance of the information. The Administrator explained and provided documentation of discussion in the patient safety organization committee held on 10/17/19 regarding bruising of unknown origin. Quality assurance performance improvement committee

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meetings were held on 10/14/19 and 11/19/19 during which discussion and review of continued abuse training for the staff as well as the details of extra elements of safety for the long-term care residents. The Administrator confirmed the investigation and the retraining of the staff on abuse policies and procedures was completed as of 10/4/19.

2. Resident #3, admitted on 3/16/16, had cumulative diagnoses one of which included dementia with behavioral disturbance.

Documentation on the quarterly minimum data set assessment dated 12/19/19 coded the resident as severely cognitively impaired with physical behavioral symptoms one to three days of the assessment period. Documentation on the same assessment specified the resident required total care assistance of two staff members with bed mobility, transfers, dressing, toilet use, personal hygiene, bathing in addition to being incontinent of both bowel and bladder.

The care plan for Resident #3, reviewed on 9/26/19, revealed a problem area for behavioral symptoms of combativeness toward staff at times with yelling, cursing, throwing food, and pinching staff. Documentation of the interventions revealed multiple interventions some of which included: "Always approach resident calmly and unhurriedly and speak in a calm voice" and "If appropriate, stop giving care when resident is hostile and try again later."

An interview was conducted with the former Director of Nursing (DON) on 3/13/20 at 12:17 PM. The DON explained that on the morning of

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9/30/19 she was contacted by an employee of the facility at approximately 8:30 AM revealing nurse aide (NA #1), who had worked 11:00 PM to 7:00 AM on 9/29/19 to 9/30/19, had witnessed abusive behavior by a nurse aide (NA #2). The former DON stated she instructed the employee to have NA #1 write down what happened and to return to the facility to give a statement. The former DON indicated she informed the Administrator of the abuse allegations that were made. The former DON indicated NA #1 returned to the facility with her statement on 9/30/19 at approximately noon and was subsequently interviewed in the presence of the DON, Administrator, and the minimum data set assessment (MDS) coordinator.

The statement written by NA #1, signed and dated 9/30/19, stated in part, "When I finished with [Resident #7] and [Resident #8], I go into help finish and put [Resident #3] on the Hoyer (lift), so she (Resident #3) would be up for the day. Once we got her (Resident #3) into the chair, she (NA #2) asked me if she had a comb which I went out and combed her hair. While she (NA #2) changed [Resident #3] in the hall, I was making up [Resident #3's] bed and I could see from the corner of my eye that [Resident #3] was trying to hit [NA #2], but it seemed as if [NA #2] was hitting [Resident #3] back stating, "You better not start with me today, quit hitting me, I'm not in the mood."

Documentation of the 9/30/19 interview by the former DON, Administrator, and the MDS coordinator conducted at 12:50 PM with NA #1 revealed, "The other hall is when she (NA #2) started "hitting them." [Resident #3] - Put shirt on and [NA #2] said bring the comb to do her hair.

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[Resident #3] was angry and swings arms to swat away at staff and [NA #2] swung back at her and commented, "You better not start with me today."

NA #1 was interviewed on 3/13/20 at 2:18 PM. NA #1 indicated that she was in initial training on 9/29/19 to 9/30/19 and the 11:00 PM to 7:00 AM shift was the first time she had trained on that shift. NA #1 confirmed the accuracy of her written statements and that she saw NA #2 swing at Resident #3 hitting her arms and hands on 9/30/19.

Documentation of an interview on 9/30/19 at 7:10 PM revealed NA #2 was questioned as to the etiology of unknown bruises on Resident #2 and if anything, out of the ordinary occurred on her shift on 9/29/19 to 9/30/19. The documentation of the response by NA #2 stated in part: "[Resident #3] swats but I don't hit back or anything"; "The residents who had bruising are [Resident #1] and [Resident #3]. [Resident #1] has a large bruise on her right hand. [NA #2] responded that [Resident #1] and [Resident #3] always have bruises. "I can't think of a time when they don't have a bruise"; and "[Resident #3] always swats at us when we are getting her ready in the morning." The documentation in the interview with NA #2 on 9/30/19 indicated NA #2 was suspended after the interview pending a full investigation.

NA #2 was interviewed on 3/14/20 at 2:06 PM. NA #2 revealed that on the 11:00 PM to 7:00 AM shift on 9/29/19 to 9/30/19, she was training a new nurse aide (NA #1). NA #2 explained that it took two to three hours to do incontinent care rounds and she was very tired on that day. NA #2 insisted Resident #3 always had bruises on her hands because the resident "fights" with the staff every

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day. NA #2 stated Resident #3 was well documented in the nursing notes as hitting the nurse aides. NA #2 insinuated that she was being unfairly judged for bruising on Resident #3 that was always there. NA #2 insisted that she did report the bruising when she saw it.

Nurse #3, who was working on the 11:00 PM to 7:00 AM shift on 9/29/19 to 9/30/19, was interviewed on 3/14/20 at 6:25 AM. Nurse #3 stated that he had seen NA #2 be a little rough with the residents in the past, but he had never seen NA #2 hit any of the residents. Nurse #3 revealed he thought NA #2 was more verbally abusive than physically abusive to the residents. When asked why he did not say anything to a supervisor, Nurse #3 replied that he thought they already knew. Nurse #3 confirmed Resident #3 was combative at times and needed to be left alone to calm down. Nurse #3 stated he was not aware of the bruising on Resident #3 on 9/30/19.

An interview was conducted with the interim DON/MDS coordinator on 3/13/20 at 12:45 PM. The interim DON/MDS coordinator revealed that after the administrative interview with NA #1 on 9/30/19 at 12:50 PM, a skin assessment was completed for Resident #3, revealing bruising on the arms and hands of Resident #3. The DON/MDS coordinator further stated that the nursing staff members who worked on the 7:00 AM to 3:00 PM shift and the 3:00 to 11:00 PM shift on 9/29/19 were interviewed regarding any bruising on Resident #3 on those shifts. The former DON lamented that it was determined it was the cognitively impaired residents, the most vulnerable, who were injured by NA #2.

Documentation on a "problem focused charting -

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altered skin integrity" report dated 9/30/19 at 3:30 PM revealed, "scattered bruising on bilateral arms and hands" on Resident #3. There were no other further details on the skin assessment.

Nurse #4 was interviewed on 3/19/20 at 11:35 AM regarding her observations on 9/30/19 of the skin assessment for Resident #3. Nurse #4 revealed she was asked by the DON to complete documentation on the bruising the DON had observed on Resident #3. Nurse #4 stated she was a little overwhelmed because the local authorities were taking pictures of Resident #3 and she knew an investigation was being initiated. Nurse #4 revealed she did not know why she did not chart further documentation on the bruising. Nurse #4 described scattered bruising on the upper forearms of Resident #3 that she saw on 9/30/19. Nurse #4 stated she saw three bruises on the right arm and three bruises on the left arm. Nurse #4 stated she saw a deep purple bruise on the ring finger of left hand of Resident #3.

Nurse #1, who worked on the 7:00 AM to 7:00 PM shift on 9/29/19 on the unit which Resident #1 resided, was interviewed on 3/13/20 at 2:34 PM. Nurse #1 stated Resident #3 did not have the bruising on her arms and hands on her shift on 9/29/19 and she did not see the bruising on Resident #3 until she returned to work on 10/2/19. Nurse #1 did confirm that Resident #3 would hit at the nurse aides who were attempting to provide care.

Nurse #2, who worked 3:00 PM to 11:00 PM on 9/29/19, was interviewed on 3/13/20 at 2:00 PM. Nurse #2 indicated she was not notified of any bruising nor did she notice any bruising on

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Resident #3 during her shift on 9/29/19.

Nurse aide (NA #3), who worked on the 3:00 PM to 11:00 PM shift on 9/29/19 on the hall which Resident #3 resided, was interviewed on 3/13/20 at 2:08 PM. NA #3 confirmed there was no bruising on Resident #3 during his shift on 9/29/19. NA #3 revealed Resident #3 was calm on his shift on 9/29/19.

Nurse aide (NA #4), who worked on the 3:00 PM to 11:00 PM shift on 9/29/19 on the hall which Resident #3 resided, was interviewed on 3/13/20 at 3:29 PM. NA #4 indicated she worked with NA #3 on the hall for which Resident #3 resided on 9/29/19. NA #4 confirmed that she did not notice any bruising to Resident #3 on her shift on 9/29/19.

The Administrator was interviewed on 3/13/20 at 11:39 AM. The Administrator indicated that after the allegations were made, the bruising on Resident #3 observed, and staff interviews were made, the evidence pointed to abuse that could not be discounted. The Administrator indicated that the bruising between the fingers of Resident #3 could not be explained away as accidental. The Administrator revealed that NA #2 was suspended during the initial investigation but was terminated on 10/7/20 after providing a statement regarding the events on 9/30/19.

The Administrator was interviewed again on 3/14/20 at 12:47 PM. The Administrator revealed and reviewed the steps taken after the allegation of abuse of Resident #3 was made at the facility. The Administrator revealed local law enforcement was contacted along with the state division of health service regulation on 9/30/19. The

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residents in the long-term care unit were interviewed by the facility social worker by 10/1/19. The social worker questioned all the residents regarding their perceived safety, disrespect from staff, and if staff had hurt them. Any concerns expressed by the residents were followed up by the Director of Nursing. A retrospective analysis of the 2019 reported bruises and injuries of unknown origin was completed on 10/3/19 by the risk manager to determine if any patterns of potential abuse could be identified. Skin assessments of the residents were completed by 10/4/19. The facility immediately interviewed and took statements from all the nursing staff members who had worked on 9/29/19 and 9/30/19 in the long-term care unit. The facility additionally interviewed and took statements from additional nursing co-workers of NA #2. All the interviewed staff members were received immediate retraining on the abuse policies and procedures for the facility focusing on the reporting aspect of the training. The Administrator revealed all the nursing staff working in the long-term care unit were retrained in the abuse policies and procedures as of 10/4/19. The entire staff, to include volunteers, was retrained on the abuse policies and procedures in November and December 2019. The Administrator explained that prior to the retraining of the entire staff, the abuse policies and procedure training was redone and updated to emphasize the importance of the information. The Administrator explained and provided documentation of discussion in the patient safety meeting held on 10/17/19 regarding bruising of unknown origin. Quality assurance performance improvement committee meetings were held on 10/14/19 and 11/19/19 during which discussion and review of continued abuse training for the

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F 600	Continued From page 15 staff as well as the details of extra elements of safety for the long-term care residents. The Administrator confirmed the investigation and the retraining of the staff on abuse policies and procedures was completed as of 10/4/19.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(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. §483.12(c)(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:	F 609		3/27/20

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F 609	Continued From page 16 Based on staff interview and record review the facility failed to report to the state agency within the two-hour required time frame allegations of a staff member physically abusing two (Resident #1 and Resident #3) of five sampled residents reviewed for abuse. Findings included: 1. Resident #1 had cumulative diagnoses, some of which included dementia, adult failure to thrive, and cerebral vascular accident. Documentation on a quarterly minimum data set assessment dated 9/18/19 coded Resident #1 as having severely impaired cognition with no behaviors or rejection of care. Documentation on the same assessment coded the resident as dependent on two people for bed mobility, dressing, hygiene, bathing, toilet use, in addition to being incontinent of both bowel and bladder. An interview was conducted with the former Director of Nursing (DON) on 3/13/20 at 12:17 PM. The DON explained that on the morning of 9/30/19 she was contacted by an employee of the facility at approximately 8:30 AM revealing nurse aide (NA #1), who had worked 11:00 PM to 7:00 AM on 9/29/19 to 9/30/19, had witnessed abusive behavior by a nurse aide (NA #2). The former DON stated she instructed the employee to have NA #1 write down what happened and to return to the facility to give a statement. The former DON indicated she then went into a meeting with the Administrator during which she revealed the abuse allegations that were made. The former DON indicated NA #1 returned to the facility with her statement on 9/30/19 at approximately noon and was subsequently interviewed in the presence of the DON, Administrator, and the minimum data set assessment (MDS)	F 609	Corrective action to be accomplished for the residents found to be affected by the deficient practice: Residents #1 and Resident #3- It was determined that the facility failed to report alleged abuse immediately, but not later than 2 hours after the allegation was made, since the events that caused the allegation involved abuse. It was determined the facility policy and procedure was not followed for Resident # 1 and Resident #3. The Administrator, DON and MDS coordinator participated in the initial witness interview and proceeded to contact law enforcement and conduct additional interviews and assessments. The report was completed and attempted to fax within 8 hours and unable to get fax through after 2 attempts. The report went through the next am at 19 hours. The corrective action for these residents is that policy has been updated to state 1 person will pull apart from the continued investigation to complete the initial report. This will be completed 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 and faxed per guidelines. After the immediate, but not later than 2 hour report is complete and submitted, the team member can rejoin the ongoing investigation. Address how the facility will identify other residents having the potential to be	

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coordinator. The former DON revealed that NA #2 was suspended pending the investigation on 9/30/19.

Documentation on the statement written by NA #1, signed and dated 9/30/19, stated in part, "While I was changing [Resident #6], [NA #2] was changing [Resident #1]. [NA #2] pulled the curtain between the two residents, but I could still see her in the mirror. Although [Resident #1] was combative per usual, I noticed when [Resident #1] would swing and hit [NA #2] that she would swing and hit back. I saw her mostly towards her arms and hands which seemed as if she was trying to get [Resident #1] to stop, but in a hateful way. When I finished with [Resident #6], I went to dump the dirty linen/brief into the cart. I came back into the room to her (NA #2) saying, "I just realized I didn't put these pillows back under her feet, but honestly I don't give a [expletive] right now" and she walked out."

Documentation of the 9/30/19 interview by the former DON, Administrator, and the MDS coordinator conducted at 12:50 PM with NA #1 revealed, "When we went into [Resident #1's] room, [NA #2] told me to change [Resident #6]. I could see in the mirror that [Resident #1] was trying to fight her and [Resident #1] don't like to be touched. I heard [Resident #1] say get off me and stop hitting me. I could see her hitting back at [Resident #1]. The pillows are usually under [Resident #1's feet and she had not put them there. [NA #2] commented, "I don't give a [expletive] now and walked away. [NA # 1] thought [Resident #1] looked scared."

Documentation on a fax receipt for the initial report sent the Division of Health Service

affected by the same deficient practice:

For all other residents, it was determined that the facility failed to report alleged abuse immediately, but not later than 2 hours after the allegation was made, since the events that caused the allegation involved abuse.

It was determined the facility policy and procedure was not followed for reporting abuse. The Administrator, DON and MDS coordinator participated in the initial witness interview and proceeded to contact law enforcement and conduct additional interviews and assessments. All members of this group are trained to report abuse per the state guidelines and facility policy and procedure. The team investigating realized the 2 hour timeframe had been missed and immediately worked to complete and submit. The team also discussed that 1 team member should have pulled away to complete and submit the report while the other members of the team continued forward with the investigation.

The report was completed and attempted to fax within 8 hours and unable to get fax through after 2 attempts. The report went through the next am at 19 hours. The corrective action for these residents is that policy has been updated to state 1 person will pull apart from the continued investigation to complete the initial report. This will be completed immediately, but not later than 2 hours after the allegation is made, if the events that cause the

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F 609	Continued From page 18 Regulation revealed the report regarding the physical abuse allegation for Resident #1 was sent on 9/30/19 at 8:24 PM with a busy signal as a result, resent on 9/30/19 at 8:50 PM with a busy signal result, and 10/01/19 at 8:04 AM with the result being "okay." An interview was conducted with the Administrator on 3/14/20 at 12:47 PM. The Administrator explained that after the meeting with NA #1 she was in "shock." The Administrator explained that her administrative nursing staff started contacting staff members to conduct interviews and skin assessments of the residents were conducted. The Administrator revealed that after the bruises were discovered on Resident #1, the local law enforcement was contacted. The Administrator stated, "It didn't seem like we could come up for air until we uncovered everything." The Administrator said in retrospective it would have been a good idea to have someone from the administrative staff separate from the group and prepare an initial report for the state. The Administrator explained she had never called law enforcement for the long-term care portion of her facility and she had never had anything like this happen in her facility before causing her to forget the necessity of sending a 2-hour initial report to the state. 2. Resident #3 was admitted on 6/18/18 and had cumulative diagnoses one of which included dementia with behavioral disturbance. Documentation on the quarterly minimum data set assessment dated 12/19/19 coded the resident as severely cognitively impaired with behavioral symptoms one to three days of the assessment period. Documentation on the same	F 609	allegation involve abuse or result in serious bodily injury and faxed per guidelines. After the immediate, but not later than 2 hour report is complete and submitted, the team member can rejoin the ongoing investigation. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The facility policy and procedure was updated to state 1 person will pull apart from the investigation to complete the initial report. This will be completed 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 and faxed per guidelines. After the immediate, but not later than 2 hour report is complete and submitted, the team member can rejoin the ongoing investigation. All staff and investigating team members have been educated regarding the policy and procedure revision, specifically regarding the need to report alleged abuse immediately, but not later than 2 hours after the allegation is made, when the events that cause the allegation involve abuse or result in serious bodily injury. The investigating team will designate the one person who will complete and submit the report immediately, but not later than 2 hours after the allegation is made while	

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F 609	Continued From page 19 assessment revealed the resident required total care assistance of two staff members with bed mobility, transfers, dressing, toilet use, personal hygiene, bathing in addition to being incontinent of both bowel and bladder. An interview was conducted with the former Director of Nursing (DON) on 3/13/20 at 12:17 PM. The DON explained that on the morning of 9/30/19 she was contacted by an employee of the facility at approximately 8:30 AM revealing nurse aide (NA #1), who had worked 11:00 PM to 7:00 AM on 9/29/19 to 9/30/19, had witnessed abusive behavior by a nurse aide (NA #2). The former DON stated she instructed the employee to have NA #1 write down what happened and to return to the facility to give a statement. The former DON indicated she then went into a meeting with the Administrator during which she revealed the abuse allegation that was made. The former DON indicated NA #1 returned to the facility with her statement on 9/30/19 around lunch time and was subsequently interviewed in the presence of the DON, Administrator, and the minimum data set assessment (MDS) coordinator. The former DON revealed that NA #2 was suspended pending the investigation on 9/30/19. Documentation on the statement written by NA #1, signed and dated 9/30/19, stated in part, "When I finished with [Resident #7] and [Resident #8], I go into help finish and put [Resident #3] on the Hoyer (lift), so she (Resident #3) would be up for the day. Once we got her (Resident #3) into the chair, she (NA #2) asked me if she had a comb which I went out and combed her hair. While she (NA #2) changed [Resident #3] in the hall, I was making up [Resident #3's] bed and I could see from the corner of my eye that	F 609	the other team members continue the investigation. No other abuse investigations have occurred at the facility since this incident. The proper reporting time frames will be reviewed with all team members at the monthly QAPI meeting and with the housewide quality improvement committee. Indicate how the facility will monitor our performance to make sure that solutions are sustained: All reports of abuse will be reported immediately by the staff discovering or witnessing an event. This will be reported to the Administrator and CNO or SNF DON immediately for investigation and reporting per state regulations and facility policy and procedure. Performance will be monitored and reported monthly to the Nursing Home QAPI meeting as well as the Housewide Quality Improvement Committee. A report to the committee will be made even if no reports of abuse are made within the month in order to remind all members of the policy and reporting timeframes. This reporting will continue monthly for 1 year to make sure the solution is maintained. Dates when corrective action will be completed: March 27, 2020	

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[Resident #3] was trying to hit [NA #2], but it seemed as if [NA #2] was hitting [Resident #3] back stating, "You better not start with me today, quit hitting me, I'm not in the mood."

Documentation of the 9/30/19 interview by the former DON, Administrator, and the MDS coordinator conducted at 12:50 PM with NA #1 revealed, "The other hall is when she (NA #2) started "hitting them." [Resident #3] - Put shirt on and [NA #2] said bring the comb to do her hair. [Resident #3] was angry and swings arms to swat away at staff and [NA #2] swung back at her and commented, "You better not start with me today."

Documentation on a fax receipt for the initial report sent the Division of Health Service Regulation revealed the report regarding the physical abuse allegation for Resident #3 was sent on 9/30/19 at 8:24 PM with a busy signal as a result, resent on 9/30/19 at 8:50 PM with a busy signal result, and 10/01/19 at 8:04 AM with the result being "okay."

An interview was conducted with the Administrator on 3/14/20 at 12:47 PM. The Administrator explained that after the meeting with NA #1 on 9/30/19 she was in "shock." The Administrator explained that her administrative nursing staff started contacting staff members to conduct interviews and skin assessments of the residents were conducted. The Administrator revealed that after the bruises were discovered on Resident #3, the local law enforcement was contacted. The Administrator stated, "It didn't seem like we could come up for air until we uncovered everything." The Administrator said in retrospective it would have been a good idea to have someone from the administrative staff

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F 609	Continued From page 21 separate from the group and prepare an initial report for the state. The Administrator explained she had never called law enforcement for the long-term care portion of her facility and she had never had anything like this happen in her facility before causing her to forget the necessity of sending a 2-hour initial report to the state.	F 609		