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	495375	A. BUILDING ______ B. WING ______	C 03/13/2018

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 3/9/18 and 3/12/18 through 3/13/18. One complaint was investigated during the survey. Corrections are required for compliance with the following 42 CRC Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 90 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Residents #2 through #4) and 1 closed record reviews (Resident #1).	F 000		
F 600	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 staff interview, facility documentation review and clinical record review, the facility staff failed for one (Resident #1) of 4 residents in the survey sample, to prevent unexplained genital	F 600	F 600 483.12(a) Freedom from Abuse and Neglect	4/2/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/29/2018

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

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F 600 Continued From page 1
bruising.

Resident #1 had bruising of unknown origin on her labia.

The findings included:

Resident #1 was originally admitted to the facility on 1/8/2004, readmitted on 2/18/11 and discharged to the hospital on 3/7/18 due to labial bruising of unknown origin. Her diagnoses included, but were not limited to, cerebral palsy, epilepsy, and contractures of right and left lower extremities, right upper arm, and left hand.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 3/2/18. The MDS coded Resident #1 with severe cognitive impairment; makes self understood and ability to understand others; was dependent on staff for all activities of daily living; was always incontinent of bowel and bladder; no falls coded since prior assessment; no pressure ulcers coded; was not coded for restraint usage.

On 3/9/18 at 3:10 p.m. an interview was conducted with the Director of Nursing (Admin-B) and the Administrator (Admin-A). The facility reported incident dated 3/7/18 with an incident date of 3/7/18 for a "Bruise of unknown origin in groin area Resident sent to Emergency Room" was discussed. The Director of Nursing explained:
The CNA (Certified Nursing Assistant) found bruising and swelling on outer labia. She notified the nurse who called the family and MD (Medical Doctor). Another nurse told Admin-B who went to look at the area. Admin-B called the family who

F 600

With regard to the alleged deficient practice, the facility has taken the following action:

1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice.

Resident #1 was transferred to Southern Virginia Regional Medical Center for examination of the bruise.

An investigation into the cause of the bruise was completed.

Resident #1 was subsequently discharged from Emporia Manor.

2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken.

The facility has identified all residents as having the potential to be affected by this deficient practice.

DON/Designee will review all bruises or allegation of abuse and the facility will immediately report an allegation of abuse and unexplained bruising.

Social Services Director will audit the facility grievance logs from the past 90 days to determine if there were any concerns which would constitute abuse or neglect

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F 600	Continued From page 2 stated there was a history of sexual abuse. The RP (responsible party) was upset about the findings but after Admin-B talked with the RP the resident was sent to the local hospital. Dr. (Name of resident's doctor) was aware and did not evaluate her prior to sending her out since he couldn't get to the facility at the time. The Director of Nursing named the CNA's who worked with the resident at the time of the report and were identified as CNA-C, an agency CNA and CNA-B, a facility staff member. When asked about the care and transfer assistance Resident #1 required, Admin-B stated she "Is dependent on all ADL care; was a 2 person transfer, and 1 person for hygiene and bathing." She stated when Resident was out of bed she was "Normally in a Broda chair" which was described as a wide tilting chair with a high back and arm rests. When asked about the resident assessment she completed at the time the bruise was reported, Admin-B explained that Resident #1 had a brief on which sat kind of high because of the resident's position of right leg stayed out to the side by her hip and her left leg remained straight on the bed. She stated there were books and doll babies in the resident's bed. Admin-B stated she "Moved dolls out of the way and when I took brief off, didn't see anything." She stated the Resident had "Excess labia (larger than average) under her and had to lift the area." "On left outer side of labia minor there was a dark purple bruise that was dime size." Admin-B stated there were no bruises on the right side and the back part of the labia closest to the rectum was swollen. Admin-B stated CNA-B told her her she noticed Resident #1's labia swells prior to menstruation. Further discussion revealed Resident #1 resided in a 2 bedded room closer to the window with a female roommate. The Administrator stated "When we	F 600	3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Staff has been in-serviced by the DON/Designee on the facilities abuse policy to include reporting of suspected abuse and neglect. The Social Services Director will interview residents of the facility identified as interviewable twice weekly x4 weeks then monthly to determine if there are any concerns which would constitute abuse or neglect DON/Designee will audit incident reports and 24 hour reports daily M-F to ensure there are no concerns which constitute abuse or neglect. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur: Reports of the findings from the audits will be reported by the Director of Nursing to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	

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found out she was transferred to (2nd Hospital Name) we called the (Town facility is located in) Police.

On 3/9/18 at 3:45 p.m. the full Facility Reported Incident (FRI) and investigation to date was requested and presented by the Administrator. The FRI had documented the report to the State Agency date as 3/7/18 at 3:35 p.m. and the incident date as 3/7/18. Incident type was listed as "Bruise of unknown origin in groin area Resident sent to Emergency Room." It was documented on the FRI that the Responsible party, Physician, and APS were notified on 3/7/18. Fax confirmation printouts were reviewed which confirmed the State Agency, APS, and the Ombudsman fax numbers received the notifications on 3/7/18. Admin-A stated "The police, APS and Social Worker were at the facility this morning."

On 3/9/18 at 4:55 p.m. when asked, the Director of Nursing stated except for Resident #1, there were "No FRI's since last survey."

On 3/12/18 at 10:00 a.m. the Complaint Unit was called to request additional information from the 1st hospital (local hospital) and 2nd hospital (where a forensic's evaluation was done).

On 3/12/18 at 10:05 a.m. an interview was conducted with Licensed Practical Nurse-A (LPN-A) who worked 3/7/18 on the 7 a.m.-3 p.m. shift. LPN-A was asked to describe her interactions with Resident #1 on 3/7/18. LPN-A stated she gave the resident her medications that morning and she took them with no problems. She gave her her books that the resident had dropped on the floor. When asked about

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F 600	Continued From page 4 Resident #1's personality or behaviors that morning, LPN-A stated "She smiled, no yelling out." When asked what position the resident was in, LPN-A stated she was laying in bed with head of bed up and her hands were visible. She did not not witness the resident's hands in her private area or scratching self. LPN-A stated she evaluated the resident for pain and Resident #1 stated she wasn't in pain. When asked if she noticed any odors in the room, LPN-A stated "No." When asked if the resident had her menstrual cycle that morning, LPN-A stated she was not made aware if she did. When asked if she saw the resident out of bed on 3/7/18, LPN-A stated she "Did not see her out of bed" and "Only saw her during the morning and when CNA's called me into her room." When asked to explain what she observed, LPN-A stated "(Name of CNA-B) came to the desk and asked if I could come to (Name of Resident #1) room" and stated "Upon exam left side of labia toward top of vaginal area was a dime size blackish purplish bruise." LPN-A stated she "Came back out, called the doctor to see what else he wanted us to do." "The doctor's nurse stated send to emergency room since he didn't have time to come and see her." LPN-A stated she "Made (Director of Nursing Name) aware and called family, Aunt named (Name)." She stated the resident was sent to (Name of local Hospital). LPN-A stated "She had a brief under her and open, there was no blood, odor or discharge." She stated "During the exam she did not yell out, say stop or showed signs of pain." LPN-A added "Side of labia where bruise was was larger; did not look red or irritated." On 3/12/18 10:20 a.m. Received call from OLC-State Agency complaint department; there	F 600		

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were no further records from either hospital at this time and was informed the resident went to another nursing facility.

On 3/12/18 at 10:35 a.m. an interview was conducted with the CNA (CNA-A) who worked with Resident #1 on the 11 p.m.-7 a.m. shift starting 3/6/18. When asked if she had previously worked with Resident #1, CNA-A stated she "Has worked with her before." When asked about her normal routine with the resident, CNA-A explained: She makes her first round of checks around 11 p.m. to be sure no one is on the floor and in bed. She stated Resident #1 "Mostly sleeps at night" and her "First changing time is around 12:45 a.m."
CNA-A stated "When I go in, I tell her I'm going to check you, I look at the brief if (it's) wet." When asked how Resident #1 is normally positions, CNA-A stated "She normally sleeps with her legs open to the side, she likes her book on her chest and pillow next to her arm." CNA-A stated she did not have to change her during first rounds, the brief was positioned right and it was not wet.
CNA-A stated "At approximately 6:30 a.m., her normal time for peeing is 6 or 6:30 a.m., went in, she asked whatcha doing." CNA-A stated she explained to the resident that she was going to change her. CNA-A said she noticed she had growths, like little pink bumps, on labia which she always had. She explained "When turned her towards the window on left side, noticed a pink piece of tissue which could be hidden by back of thigh." When asked if she saw any bruising CNA-A stated she did not see bruising; did see a slight brown stain on her brief, thought stool or her (menstrual) cycle was about to come on. She stated the resident "Still gets her cycle." When asked if Resident #1 showed any signs of pain

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she stated "She showed no signs of pain." CNA-A stated she's been a CNA for 20 years and has been employed at the facility for 2 years. CNA-A stated the door to room stays shut all the time, she did not see anyone from the outside cone into the building and had not seen any other residents go in and out of the room recently.

On 3/12/18 at 11:00 a.m. an interview was conducted with the local Department of Social Services worker (Other-A). When asked if and how she was notified of the injury of unknown origin she stated the FRI was received by the facility and she received a call from the ER from (Local Hospital Name). Other-A stated "We did go to the ER and it was very difficult to communicate with the resident." She stated "We took pictures of the bruise; the (hospital) nurse was in the exam room during the examination." She explained "The whole area (labia) had loose skin and the bruise area was long." Other-A stated "The facility stated it was dime size but looked long." She stated "When we went to the facility on Friday" and "Knowing she was no longer in the facility we would no longer be investigating." When asked while taking pictures if the resident had a brief or underwear on, Other-A stated "A brief." When asked if there were any stains or blood on the brief, she stated "Not that I remember."

On 3/12/18 at 11:20 a.m. an interview was conducted with CNA-B who worked 3/7/18 on the 7 a.m. to 3 p.m. shift. When asked about her interactions with Resident #1, CNA-B explained the "Other CNA (CNA-C) was assigned to (Resident Name), she asked me to come and assist with bath in her room." CNA-B stated the resident was in bed. When asked if she's worked

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F 600	Continued From page 7 with the resident before, CNA-B stated "I know the resident well. (Resident Name) talks, calls your name." "When she doesn't want something she'd say I don't want it." CNA-B was asked to describe how she observed the resident on 3/7/18; she stated when she walked in the room the resident was already being bathed and a brief was on. When the brief was removed she had urine in the brief. CNA-B stated her labia was normally swollen but she was "More swollen than she normally be." CNA-B stated from the front she could not see redness, only when the resident was turned on her side "Saw dark discoloration by crease of buttock on the labia." She stated she "Had not seen the discoloration before." When asked, CNA-B stated "There was no redness or creases where brief was positioned." When asked what she did after seeing the discolored area, CNA-B stated "I went and reported to nurse in charge (LPN-A) because that wasn't there yesterday" CNA-B stated "If notice anything not right would report." When asked if Resident #1 complained of pain or grimaced, she stated "She didn't show any type of pain we just noticed the area." She stated the resident normally lies on her back with legs opened. When asked if she'd noticed any other residents going in or out of the room recently she stated she hadn't. When asked about transferring in and out of bed, and if the resident gets out of bed, CNA-B explained Resident was a "2 person lift from bed to chair and back." She stated she was out of bed Tuesday (3/6/18) to her Broda chair and had not problem transferring her on 3/6. She stated the resident had a little pad on the chair. CNA-B stated "She got up around noon, 12:30, on Tuesday" and she "Did not put her back to bed on 7-3 shift." When asked if the resident was seen	F 600		

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F 600	Continued From page 8 scratching herself or had had in her brief, CNA-B stated "No, she can't get her hand down there." CNA-B stated she had seen her "spotting" at time of her period coming on. On 3/12/18 at 3:00 p.m. an interview was conducted with the Director of Nursing (Admin-B). When asked about the facility investigation she stated "They are still working on the investigation." When asked about the bruised area again, Admin-B stated "It was about the size of a dime but APS (Adult Protective Services) stated it was much larger." Admin-B stated because of where the bruise and labia swelling was she thought it was maybe caused by positioning or the brief bunched up. On 3/12/18 at 3:10 p.m. an interview was conducted with the facility Social Worker (Admin-D) to discuss a claim of "history of sexual assault" that was included in the local "ED Nurse Documentation" note. Admin-D explained Resident #1 was in her gerichair in the dining room and a male resident was seen with his hand down her shirt on her breast. She stated she called the police and they arrested him. The male resident did not return to the facility. Admin-D stated she assumed it happened in 2012. When asked if she's seen Resident #1's RP at the facility, Admin-D stated she "Hasn't seen the resident's aunt up here in years." On 3/12/18 at 3:30 p.m., the Administrator (Admin-A) presented the facility investigation to date which included the initial incident report from LPN-A, a statement from the agency CNA (CNA-C) who was assigned to Resident #1 at the time of the bruise observation, the LPN (LPN-C) who worked the 3 p.m.-11 p.m. shifts on 3/6/18	F 600		

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and 3/7/18-did not see any bruises and none reported. The facility had copies of criminal background checks done on the agency staff and there were no barrier crimes or sex registry findings. Admin-A stated the investigation was still in progress and the final report was due 3/14/18.

On 3/12/18 at 3:55 p.m. an interview was conducted with CNA-E who worked 3/6/17 on the 3 p.m.-11 p.m. shift. CNA-E was assigned to Resident #1. When asked to describe her normal work routine, CNA-E explained, when she gets in, she gets the linen cart and sets up resident rooms for night-time, she then checks if anyone is wet or needs changing. CNA-E stated she would talk with Resident #1, had to sweet talk her into eating, she read to her and laughed with her. When asked how she found Resident #1 on 3/6/17 CNA-E stated "Resident was in wheelchair from start of shift and at approximately 3:30 (p.m.) I put her in the bed, checked her and she was dry." She stated she "Took her pants down, took brief off, it was dry and reapplied brief, put her back in wheelchair and back to day room." When asked how she positioned the resident while checking her brief, CNA-E stated she "Had rolled resident to the side and did not notice anything out of the ordinary except for reddened lines where the brief sits" and "Due to her positioning the brief rises up, we loosen brief as best as we can." When asked how Resident #1 is normally positioned and if she's noticed any labia swelling, CNA-E stated when she is "Sitting or laying in bed legs sit like a butterfly, turned outward." She stated "Her labia is normally larger and when she's on her cycle her labia is larger and skin is redder." When asked to describe the rest of her interactions with Resident #1 that shift,

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she stated "Approximately 7:30 p.m. I put her in bed, brief was wet, I cleaned her with 3-in-1 soap, dry, barrier cream and applied brief." CNA-E stated she transferred the resident by lift pivot and had no problems transferring the resident by herself. She stated she had "No problem lifting her myself, she's light, someone else might need two people." CNA-E stated "If you are hurting her or she is hurt she will tell you or cry." CNA-E stated the resident told her she had body aches and wasn't feeling good.

On 3/12/18 at 4:20 p.m. the Administrator was asked about and provided evidence that Resident #1 was inappropriately touched by a male resident on 1/21/12 (as described during the interview with Social Worker-Admin-D). He stated the other resident was arrested. Resident #1's clinical record was reviewed and revealed there were no signs or symptoms of pain documented for the from March 1, 2018 through discharge. The "Nursing Weekly Summary" dated 3/5/18 read: "Wkly skin assessmebt done: Resident is aler (sic) but disoriented. Some confusion noted. She depends on the direct care staff for all her Adl's She uses a depend and is incont. of bowel and bladder. Incont care provided q2 (every 2 hours) & PRN (as needed). She is non ambulatory and is up in the geri chair as tolerated. She like books and antention (sic) from staff. Monitor for changes & refer as needed." There were no "skin conditions/wounds, etc." noted on the body illustration areas on the summary.

On 3/12/18 at 4:56 p.m. a telephone interview was conducted with the Police Detective (Other-B) who was investigating the alleged sexual assault. He stated the facility did not

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F 600	Continued From page 11	F 600		

contact him, the hospital did. When asked if he was in the room at the time Social Services took photos, he stated he was not since it was his protocol not to be when a female is involved. He stated "The nursing home RN said the bruise was the size of a dime but was much larger at the hospital." He explained he didn't feel it was a sexual assault but will call (the 2nd hospital name) to find out more information from the forensic doctor. He stated he was going to be at the facility tomorrow (3/13/18) to question staff.

On 3/13/18 at 10:20 a.m. an attempt was made to contact the agency CNA-C for an interview. A message was left to return the inspector's phone call however a return call from the agency nor CNA was received

On 3/13/18 at 10:25 a.m. a voice message was left on LPN-B's (nurse who worked on 3/6/18 on the 11 p.m.-7 a.m. shift) to return the inspector's phone call however a return call was not received. The Director of Nursing was notified that the inspector was waiting for return calls from both the agency and LPN.

As of 10:40 a.m. on 3/13/18 there was no further information received from the OLC complaint unit after the 2nd hospital was contacted for a forensic report.

On 3/13/18 at 12:05 p.m. at an end of day meeting with the Administer and Director of Nursing, Admin-B stated she left messages for the agency CNA and facility LPN and had not received return calls yet. Admin-B stated she "Did not think the area was due to sexual assault." Admin-A stated the final investigation report will be completed by tomorrow (3/14/18).

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	495375	A. BUILDING ______ B. WING ______	C 03/13/2018

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F 600	Continued From page 12 Complaint Deficiency. Severity/Scope = 2/1	F 600		
F 656	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		4/2/18

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F 656	Continued From page 13 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to implement the comprehensive care plan for one (Resident #1) of 4 residents in the survey sample. During the course of a complaint investigation, which involved Resident #1's injury of unknown origin, staff interviews revealed a mechanical lift was not used as directed by the care plan. The findings included: Resident #1 was originally admitted to the facility on 1/8/2004, readmitted on 2/18/11 and discharged to the hospital on 3/7/18 due to labial bruising of unknown origin. Her diagnoses included, but were not limited to, cerebral palsy, epilepsy, and contractures of right and left lower extremities, right upper arm, and left hand. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 3/2/18. The MDS coded Resident #1 with severe cognitive impairment; makes self understood and ability to understand others; was dependent on staff for all activities of daily living; was always incontinent of bowel and bladder; no falls coded since prior assessment; no pressure ulcers coded; was not	F 656	F 656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21 (b)(1) With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice. Resident #1 was discharged from Emporia Manor on 3/8/18. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. The facility has identified all residents as having the potential to be affected by this deficient practice. DON/Designee will review all resident□s records who require the use of a mechanical lift for transfers to ensure interventions are care planned, and in the CNA Kardex	

F 656 Continued From page 14
coded for restraint usage.

On 3/9/18 at 3:10 p.m. an interview was conducted with the Director of Nursing (Admin-B) and the Administrator (Admin-A). The facility reported incident dated 3/7/18 with an incident date of 3/7/18 of a bruise of unknown origin in the groin area was discussed. When asked about the care and transfer assistance Resident #1 required, Admin-B stated she "Is dependent on all ADL (Activities of Daily Living) care; was a 2 person transfer, and 1 person for hygiene and bathing." She stated when Resident #1 was out of bed she was "Normally in a Broda chair" which was described as a wide tilting chair with a high back and arm rests. When asked about the resident assessment she completed at the time the bruise was reported, Admin-B explained that Resident #1 had a brief on which sat kind of high because of the resident's position of right leg stayed out to the side by her hip and her left leg remained straight on the bed. She stated there were books and doll babies in the resident's bed. Admin-B stated she "Moved dolls out of the way and when I took brief off, didn't see anything." She stated the Resident had "Excess labia (larger than average) under her and had to lift the area." "On left outer side of labia minor there was a dark purple bruise that was dime size." Admin-B stated there were no bruises on the right side and the back part of the labia closest to the rectum was swollen.

On 3/12/18 at 11:20 a.m. an interview was conducted with CNA-B (Certified Nursing Assistant-B) who worked 3/7/18 on the 7 a.m. to 3 p.m. shift. When asked if she's worked with the resident before, CNA-B stated "I know the resident well. (Resident Name) talks, calls your

F 656

3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur:

Staff has been in-serviced by the DON/Designee on review of the resident care plan and Kardex to ensure person centered care is provided consistent with the residents needs.

DON/Designee completed an 100% audit of residents Kardex to ensure they reflected the current plan of care.

DON/Designee will bring Kardex and care plans to the daily meeting M-F to update following any changes in resident condition.

DON/Designee will audit care plans and Kardex of residents with changes in condition weekly during risk meeting to ensure they are accurate and reflect the current plan of care.

DON/Designee will place all changes to the resident care plan and Kardex on the 24-hour report for 72 hours.

4. Monitoring of corrective action to ensure the deficient practice does not reoccur:

Reports of the findings from the audits will

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F 656 Continued From page 15

F 656

name." When asked about transferring in and out of bed, and if the resident gets out of bed, CNA-B explained Resident was a "2 person lift from bed to chair and back." She stated she was out of bed Tuesday (3/6/18) to her Broda chair and had no problem transferring her on 3/6. She stated the resident had a little pad on the chair. CNA-B stated "She got up around noon, 12:30, on Tuesday" and she "Did not put her back to bed on 7-3 shift."

On 3/12/18 at 3:55 p.m. an interview was conducted with CNA-E who worked 3/6/17 on the 3 p.m.-11 p.m. shift. CNA-E was assigned to Resident #1. When asked to describe her normal work routine, CNA-E explained, when she gets in, she gets the linen cart and sets up resident rooms for night-time, she then checks if anyone is wet or needs changing. CNA-E stated she would talk with Resident #1, had to sweet talk her into eating, she read to her and laughed with her. When asked how she found Resident #1 on 3/6/17 CNA-E stated "Resident was in wheelchair from start of shift and at approximately 3:30 (p.m.) I put her in the bed, checked her and she was dry." When asked to describe the rest of her interactions with Resident #1 that shift, she stated "Approximately
7:30 p.m. I put her in bed, brief was wet, I cleaned her with 3-in-1 soap, dry, barrier cream and applied brief." CNA-E stated she transferred the resident by lift pivot and had no problems transferring the resident by herself. She stated she had "No problem lifting her myself, she's light, someone else might need two people."

On 3/12/18 at 4:20 p.m. Resident #1's clinical record was reviewed and revealed a Care Plan originally dated 3/8/17 with a "Problem/Need

be reported by the Director of Nursing to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.

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F 656	Continued From page 16 listed as: (Resident Name) is totally dependent in her ADL's..." and an updated "Approaches" dated 12/18/17 which included: "Staff education on transfers and lifting resident total care resident...use the lift (mechanical) for transfers..." The "RESIDENT STATUS SHEET" also known as the CNA Kardex with an "updated" date of "10/18/17" did not include the directive to use a mechanical lift. On 3/13/18 at 11:00 a.m. an interview was conducted with CNA-D. When asked how she'd know to care for a resident, she stated "In the ADL book (Kardex) at the (nursing) desk." CNA-D showed inspector a "RESIDENT STATUS SHEET" which included areas for grooming, speech, etc. When asked where lift use would be noted CNA-D stated "Locomotion area." When asked if the resident had a change of status who would make the changes on the status sheet, CNA-D explained if there was a change the nurses would update the kardex, On 3/13/18 at 12:05 p.m. at an end of day meeting with the Administer and Director of Nursing were informed that the nursing staff that were interviewed did not use a mechanical lift as directed by Resident #1's plan of care. No further information was provided by facility staff. Severity/Scope = 2/1	F 656		
F 689	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		4/2/18

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F 689	Continued From page 17 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed for one (Resident #1) of 4 residents in the survey sample, to implement the use of an assistive device as directed by the care plan. Resident #1 had bruising of unknown origin to her groin area; staff interviews revealed a mechanical lift was not used as directed by the care plan. The findings included: Resident #1 was originally admitted to the facility on 1/8/2004, readmitted on 2/18/11 and discharged to the hospital on 3/7/18 due to labial bruising of unknown origin. Her diagnoses included, but were not limited to, cerebral palsy, epilepsy, and contractures of right and left lower extremities, right upper arm, and left hand. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 3/2/18. The MDS coded Resident #1 with severe cognitive impairment; makes self understood and ability to understand others; was dependent on staff for all activities of daily living; was always incontinent of bowel and bladder; no falls coded since prior assessment; no pressure ulcers coded; was not coded for restraint usage. On 3/9/18 at 3:10 p.m. an interview was conducted with the Director of Nursing (Admin-B) and the Administrator (Admin-A). The facility	F 689	F 689 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25 (d)(1)(2) With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice. Resident #1 was discharged from Emporia Manor on 3/8/18. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. The facility has identified all residents as having the potential to be affected by this deficient practice. DON/Designee will review all resident□s records who require the use of a mechanical lift for transfers to ensure interventions are care planned, and in the CNA Kardex	

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F 689 Continued From page 18

reported incident dated 3/7/18 with an incident date of 3/7/18 of a bruise of unknown origin in the groin area was discussed. When asked about the care and transfer assistance Resident #1 required, Admin-B stated she "Is dependent on all ADL (Activities of Daily Living) care; was a 2 person transfer, and 1 person for hygiene and bathing." She stated when Resident #1 was out of bed she was "Normally in a Broda chair" which was described as a wide tilting chair with a high back and arm rests. When asked about the resident assessment she completed at the time the bruise was reported, Admin-B explained that Resident #1 had a brief on which sat kind of high because of the resident's position of right leg stayed out to the side by her hip and her left leg remained straight on the bed. She stated there were books and doll babies in the resident's bed. Admin-B stated she "Moved dolls out of the way and when I took brief off, didn't see anything." She stated the Resident had "Excess labia (larger than average) under her and had to lift the area." "On left outer side of labia minor there was a dark purple bruise that was dime size." Admin-B stated there were no bruises on the right side and the back part of the labia closest to the rectum was swollen.

On 3/12/18 at 11:20 a.m. an interview was conducted with CNA-B (Certified Nursing Assistant-B) who worked 3/7/18 on the 7 a.m. to 3 p.m. shift. When asked if she's worked with the resident before, CNA-B stated "I know the resident well. (Resident Name) talks, calls your name." When asked about transferring in and out of bed, and if the resident gets out of bed, CNA-B explained Resident was a "2 person lift from bed to chair and back." She stated she was out of bed Tuesday (3/6/18) to her Broda chair and had

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DON/Designee will bring Kardex and care plans to the daily meeting M-F to update following any changes in resident condition.

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DON/Designee will place all changes to the resident care plan and Kardex on the 24-hour report for 72 hours.

4. Monitoring of corrective action to ensure the deficient practice does not reoccur:

Reports of the findings from the audits will be reported by the Director of Nursing to the QAPI meeting for review until

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F 689	Continued From page 19 no problem transferring her on 3/6. She stated the resident had a little pad on the chair. CNA-B stated "She got up around noon, 12:30, on Tuesday" and she "Did not put her back to bed on 7-3 shift." On 3/12/18 at 3:55 p.m. an interview was conducted with CNA-E who worked 3/6/17 on the 3 p.m.-11 p.m. shift. CNA-E was assigned to Resident #1. When asked to describe her normal work routine, CNA-E explained, when she gets in, she gets the linen cart and sets up resident rooms for night-time, she then checks if anyone is wet or needs changing. CNA-E stated she would talk with Resident #1, had to sweet talk her into eating, she read to her and laughed with her. When asked how she found Resident #1 on 3/6/17 CNA-E stated "Resident was in wheelchair from start of shift and at approximately 3:30 (p.m.) I put her in the bed, checked her and she was dry." When asked to describe the rest of her interactions with Resident #1 that shift, she stated "Approximately 7:30 p.m. I put her in bed, brief was wet, I cleaned her with 3-in-1 soap, dry, barrier cream and applied brief." CNA-E stated she transferred the resident by lift pivot and had no problems transferring the resident by herself. She stated she had "No problem lifting her myself, she's light, someone else might need two people." On 3/12/18 at 4:20 p.m. Resident #1's clinical record was reviewed and revealed a Care Plan originally dated 3/8/17 with a "Problem/Need listed as: (Resident Name) is totally dependent in her ADL's..." and an updated "Approaches" dated 12/18/17 which included: "Staff education on transfers and lifting resident total care resident...use the lift (mechanical) for transfers..."	F 689	thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	

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F 689	Continued From page 20 The "RESIDENT STATUS SHEET" also known as the CNA Kardex with an "updated" date of "10/18/17" did not include the directive to use a mechanical lift. On 3/13/18 at 11:00 a.m. an interview was conducted with CNA-D. When asked how she'd know to care for a resident, she stated "In the ADL book (Kardex) at the (nursing) desk." CNA-D showed inspector a "RESIDENT STATUS SHEET" which included areas for grooming, speech, etc. When asked where lift use would be noted CNA-D stated "Locomotion area." When asked if the resident had a change of status who would make the changes on the status sheet, CNA-D explained if there was a change the nurses would update the kardex, On 3/13/18 at 12:05 p.m. at an end of day meeting with the Administer and Director of Nursing were informed that the nursing staff that were interviewed did not use a mechanical lift as directed by Resident #1's plan of care. No further information was provided by facility staff. Severity/Scope = 2/1	F 689		