STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. BUILDING _____ B. WING _____	C 11/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(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 An unannounced Medicare/Medicaid abbreviated standard survey was conducted 11/1/17 through 11/3/17. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 158 at the time of the survey. The survey sample consisted of 4 current Resident reviews (Resident #1 through #3, and Resident #6) and 2 closed record reviews (Residents #4 and #5).	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of	F 225		

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

Robert Reeth | ADMINISTRATOR | 11-22-17

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 225	Continued From page 1 actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (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. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (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.	F 225	F225 1. Abuse allegations are being investigated and reported as per policy and procedure. 2. Any resident to resident incident has the potential to be identified as an allegation of abuse. 3. Staff will complete a written quiz to identify their understanding of what abuse is including resident to resident abuse. The facility's policy and procedure regarding abuse will be reviewed with management staff to communicate each person's role in reporting and documenting allegations of abuse. 4. Any allegation of abuse will be reviewed during the next monthly QAPI meeting for completeness of documentation and compliance with policy and procedure. 5. Compliance Date: 11/29/17	

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This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, clinical record review, facility document review and in the course of complaint investigation, it was determined the facility staff failed to investigate an allegation of abuse for two of six residents in the survey sample, Resident #2 and Resident #6.

The facility staff failed to investigate an incident that occurred sometime in May 2017 when Resident #2 stated that his brother, Resident #6, entered into his room in the middle of the night and tried to pull him out of his bed threatening to hit Resident #2.

The findings Include:

Resident #2 was admitted to the facility 10/4/12 with diagnoses that included, but were not limited to, spinal stenosis [1] (a narrowing of the spinal canal putting pressure on the spinal cord and nerves), anxiety, shortness of breath, depression and heart failure.

Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/17/17, coded Resident #2 as having a BIMS (brief interview for mental status) score of 15, indicating that Resident #2 is cognitively intact.

Resident #6 was admitted to the facility on 4/13/17 with diagnoses that included, but were not limited to: chronic kidney disease, difficulty swallowing, dementia, congestive heart failure and high blood pressure.

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Resident #6's most recent MDS, a quarterly assessment with an ARD of 9/26/17, coded Resident #6 as having a BIMS score of 15, indicating that Resident #6 is cognitively intact.

On 11/1/17 at 5:20 p.m. Resident #2 was observed in his room, seated in his wheelchair and self-propelling the wheelchair around his bed. Resident #2 was asked if he had any concerns regarding the care he received in the facility. Resident #2 stated, "I am afraid of my brother (a resident in the facility) Resident #6, he came into my room at 2:00 a.m. one morning and threated to pull me out of my bed, he wanted to fight me." Resident #2 was asked if he had told anyone about this incident. Resident #2 stated that the nursing staff had to remove his brother (Resident #6) from his room and "calm him down." Resident #2 further stated that he had told the administrator and the social worker but their response was that his brother (Resident #6) had rights too, "They wouldn't do anything." Resident #6 resides in the same wing, on a different hall.

On 11/1/17 at 5:30 p.m. Resident #6 was observed self-propelling in the hallway on wing C. When spoken to Resident #6 stated that he needed to "get out of here." Resident #6 was not willing to speak with this surveyor at that time.

On 11/2/17 at 8:58 a.m. an interview was conducted with ASM (administrative staff member) #3, the medical doctor. ASM #3 was asked if he was familiar with Resident #2. When asked if he was aware of any complaints from Resident #2 regarding threats from Resident #6. ASM #2 stated Resident #2 had not said anything to him about it. When asked if he was aware of an incident when Resident #6 entered Resident

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#2's room and threatened Resident #2. ASM #3 stated he was not.

On 11/2/17 at 11:56 a.m. an interview was conducted with OSM (other staff member) #1, the social worker. OSM #1 stated that she did work with Resident #2. When asked if she was aware of Resident #2 being threatened by his brother, Resident #6, OSM #1 stated she had not been told that. OSM #1 further stated, "He (Resident #2) does not get along with his brother (Resident #6), we keep them separated as much as possible. He (Resident #2) has not said that his brother (Resident #6) threatened him." OSM #1 was asked if she was aware of an incident when Resident #6 entered Resident #2 room in the middle of the night. OSM #1 stated, I had heard that, I talked to (name of Resident #2) about it. I think the other social worker (OSM #2) handled it. At this point OSM #1 was asked to provide documentation regarding her conversation regarding the incident with Resident #6 entering into Resident #2's room.

On 11/2/17 at 5:59 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing (DON). ASM #1 was asked if he was aware of an incident where Resident #6 had entered Resident #2's room and threatened Resident #2. ASM #1 stated, "(Name of Resident #2) had not talked about being threatened. I knew about his brother (Resident #6) going in his room. We did talk about his brother changing rooms but he (name of Resident #6) did not want to move. I really didn't think it was a problem." ASM #1 was asked if an investigation was done following the incident. ASM #1 stated, "No." ASM #1 further stated, "I have known (name of

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Resident #2) for a long time, I figured he would tell me if he had any concerns." ASM #2 was asked if the incident described by Resident #2 should have been documented in the progress notes. ASM #2 stated there should have been documentation. When asked if there was any documentation regarding the incident, ASM #2 stated it was not documented.

On 11/3/17 at 9:27 a.m. an interview was conducted with OSM #3, the ombudsman. OSM #3 was asked if she was aware of an incident involving Resident #2. OSM #3 stated, "I met him (Resident #2) after the social worker reached out to me about (name of Resident #2). We talked about the brother (Resident #6) and how (name of Resident #2) stated that his brother (Resident #6) was a constant problem." OSM #3 was asked if she was aware of the incident when Resident #6 entered Resident #2's room in the middle of the night. OSM #3 stated, "(Name of Resident #6) went into Resident #2's room in the middle of the night. He was pulling on (name of Resident #2) and told him to get up and they were going to fight. He tried to get (name of Resident #2) out of his bed. (Name of Resident #2) stated that his brother (Resident #6) was verbally harassing him but I did not get the impression that he (Resident #2) was concerned for his safety." OSM #3 was asked what was done to ensure Resident' #2's safety. OSM #3 stated, "I think that his brother (Resident #6) was moved to a different hallway." OSM #3 was asked what was documented about the incident. OSM #3 stated, "I thought a FRI (facility reported incident) was completed." OSM #3 was asked what had been done to manage the situation between Resident #2 and his brother. OSM #3 stated, "I talked to (name of ASM (administrative staff

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member) #1, the administrator, name of ASM #2 the director of nursing, and name of OSM #2, social worker) in a meeting." OSM #3 was asked what was done after that meeting. OSM #3 stated, "We focused on Resident #6, he wanted to go home." When asked about follow up with Resident #2, OSM #3 stated, "I did visit (name of Resident #2) and talked to him several times. His (Resident #2's) goal was to get his brother, Resident #6, out of the facility." OSM #3 was asked if she was concerned about Resident #2's safety, OSM #3 stated, "No." When asked if there should have been an investigation, OSM #3 stated, "There should have been an incident report completed. It was an allegation of abuse and there should have been documentation as to what happened."

On 11/3/17 at 10:15 a.m. an interview was conducted with OSM #2, social worker. OSM #2 was asked if she was aware of an incident that concerned between Resident #2 and Resident #6. OSM #2 stated that she was made aware the day after the incident occurred. OSM #2 was asked what she learned, OSM #2 stated, "I was made aware the next day that (name of Resident #6) had gone into (name of Resident #2's) room during the night. I found out in morning meeting from the DON, it was on the 24-hour report." OSM #2 was asked what date the incident occurred. OSM #2 stated that she did not know the date, "It was right after (name of Resident #6) was admitted." OSM #2 was asked what she did after learning about the incident. OSM #2 stated, "I talked to (name of Resident #6) about changing rooms. He said no and he asked why he was being asked to move. I talked to him with the administrator and we discussed the reason why (going into Resident #2's room in the middle of

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the night), He (Resident #6) was upset that his brother (Resident #2) accused him of that." OSM #2 was asked if an investigation was initiated, OSM #2 stated that it was not. OSM #2 was asked what should have been done, OSM #2 stated, "I should have completed an incident report which would have prompted an investigation." When asked why an investigation was warranted in this case, OSM #2 stated, "This is considered abuse. We failed to document the incident in the progress notes and did not initiate an investigation."

On 11/3/17 at 10:37 a.m. an interview was conducted with LPN (licensed practical nurse) #1, the wing C unit manager. LPN #1 was asked if she was aware of an incident that occurred when Resident #6 went into Resident #2's room in the middle of the night. LPN #1 stated she was not aware of any incidents. LPN #1 was asked to describe the process staff follows when a resident to resident altercation is witnessed. LPN #1 stated, "I would separate the residents, contact the administrator and DON (director of nursing) for next steps. I would document the incident in the progress notes and put on the 24-hour report for morning meeting. I would initiate an incident/ behavior report that would go to the DON (director of nursing) for an investigation to be conducted." When asked why an incident report / investigation was necessary in this case. LPN #1 stated, "This is considered resident to resident verbal abuse.

A review of the facility policy titled "Resident Abuse" revealed, in part, the following documentation, "All incidents of resident abuse are to be reported immediately to the Licensed Nurse in Charge, Director of Nursing, or the

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Administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigation. The Administration recognizes that preliminary reports of abuse can sometimes be clouded by biases and other factors that are relevant and need to be explored during a full investigation in order to obtain a clear picture of what actually happened. Investigations will be accomplished in the following manner. 1. Preliminary investigation: a. Immediately upon report of an incident to the individual in charge, the suspect(s) shall be segregated from the resident. d. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. 2. Investigation: a. The abuse Coordinator and / or Director of Nursing shall take written statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence."

On 11/3/17 at approximately 11:15 a.m. a meeting was held with ASM #1, the administrator, and ASM #2, the DON, to discuss the complaint regarding Resident #2 and Resident #6. When asked if ASM #1 or ASM #2 knew the date that the incident occurred and whether or not an investigation had been conducted. ASM #1 and ASM #2 both stated they did not have an exact date, the incident occurred sometime after Resident #6 was admitted to the facility and an investigation had not been conducted.

No further information was provided prior to the end of the survey process.

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F 225	Continued From page 9 [1] This information was obtained from the following website https://www.mayoclinic.org/diseases-conditions/spinal-stenosis/symptoms-causes/syc-20352961	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse	F 226	F226 1. Abuse allegations are being investigated and reported as per policy and procedure. 2. Any resident to resident incident has the potential to be identified as an allegation of abuse. 3. The facility's policy and procedure regarding abuse will be reviewed with management staff to communicate each person's role in reporting and documenting allegations of abuse. 4. Any allegation of abuse will be reviewed during the next monthly QAPI meeting for completeness of documentation and compliance with policy and procedure. 5. Compliance Date: 11/29/17	

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prevention.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, clinical record review, facility document review and in the course of complaint investigation, it was determined the facility staff failed to implement the facility policies and procedures for incidents of abuse for two of six residents in the survey sample, Resident #2 and Resident #6.

The facility staff failed to implment the abuse policies and procedures to investigate an allegation of abuse reported to staff by Resident #2. Resident #2 reported to staff that sometime in May 2017, his brother Resident #6, entered his room in the middle of the night and tried to pull him out of his bed and was threatening to hit Resident #2.

The findings include:

Resident #2 was admitted to the facility 10/4/12 with diagnoses that included, but were not limited to, spinal stenosis [1] (a narrowing of the spinal canal putting pressure on the spinal cord and nerves), anxiety, shortness of breath, depression and heart failure.

Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/17/17, coded Resident #2 as having a BIMS (brief interview for mental status) score of 15, indicating that Resident #2 is cognitively intact.

Resident #6 was admitted to the facility on 4/13/17 with diagnoses that included, but were

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not limited to: chronic kidney disease, difficulty swallowing, dementia, congestive heart failure and high blood pressure.

Resident #6's most recent MDS, a quarterly assessment with an ARD of 9/26/17, coded Resident #6 as having a BIMS score of 15, indicating that Resident #6 is cognitively intact.

On 11/1/17 at 5:20 p.m. Resident #2 was observed in his room, seated in his wheelchair and self-propelling the wheelchair around his bed. Resident #2 was asked if he had any concerns regarding the care he received in the facility. Resident #2 stated, "I am afraid of my brother (a resident in the facility) Resident #6, he came into my room at 2:00 a.m. one morning and threated to pull me out of my bed, he wanted to fight me." Resident #2 was asked if he had told anyone about this incident. Resident #2 stated that the nursing staff had to remove his brother (Resident #6) from his room and "calm him down." Resident #2 further stated that he had told the administrator and the social worker but their response was that his brother (Resident #6) had rights too, "They wouldn't do anything." Resident #6 resides in the same wing, on a different hall.

On 11/1/17 at 5:30 p.m. Resident #6 was observed self-propelling in the hallway on wing C. When spoken to Resident #6 stated that he needed to "get out of here." Resident #6 was not willing to speak with this surveyor at that time.

On 11/2/17 at 8:58 a.m. an interview was conducted with ASM (administrative staff member) #3, the medical doctor. ASM #3 was asked if he was familiar with Resident #2. When asked if he was aware of any complaints from

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Resident #2 regarding threats from Resident #6. ASM #2 stated Resident #2 had not said anything to him about it. When asked if he was aware of an incident when Resident #6 entered Resident #2's room and threatened Resident #2. ASM #3 stated he was not.

On 11/2/17 at 11:56 a.m. an interview was conducted with OSM (other staff member) #1, the social worker. OSM #1 stated that she did work with Resident #2. When asked if she was aware of Resident #2 being threatened by his brother, Resident #6, OSM #1 stated she had not been told that. OSM #1 further stated, "He (Resident #2) does not get along with his brother (Resident #6), we keep them separated as much as possible. He (Resident #2) has not said that his brother (Resident #6) threatened him." OSM #1 was asked if she was aware of an incident when Resident #6 entered Resident #2 room in the middle of the night. OSM #1 stated, I had heard that, I talked to (name of Resident #2) about it. I think the other social worker (OSM #2) handled it. At this point OSM #1 was asked to provide documentation regarding her conversation regarding the incident with Resident #6 entering into Resident #2's room.

On 11/2/17 at 5:59 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing (DON). ASM #1 was asked if he was aware of an incident where Resident #6 had entered Resident #2's room and threatened Resident #2. ASM #1 stated, "(Name of Resident #2) had not talked about being threatened. I knew about his brother (Resident #6) going in his room. We did talk about his brother changing rooms but he (name of Resident #6) did not want

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to move. I really didn't think it was a problem." ASM #1 was asked if an investigation was done following the incident. ASM #1 stated, "No." ASM #1 further stated, "I have known (name of Resident #2) for a long time, I figured he would tell me if he had any concerns." ASM #2 was asked if the incident described by Resident #2 should have been documented in the progress notes. ASM #2 stated there should have been documentation. When asked if there was any documentation regarding the incident, ASM #2 stated it was not documented.

On 11/3/17 at 9:27 a.m. an interview was conducted with OSM #3, the ombudsman. OSM #3 was asked if she was aware of an incident involving Resident #2. OSM #3 stated, "I met him (Resident #2) after the social worker reached out to me about (name of Resident #2). We talked about the brother (Resident #6) and how (name of Resident #2) stated that his brother (Resident #6) was a constant problem." OSM #3 was asked if she was aware of the incident when Resident #6 entered Resident #2's room in the middle of the night. OSM #3 stated, "(Name of Resident #6) went into Resident #2's room in the middle of the night. He was pulling on (name of Resident #2) and told him to get up and they were going to fight. He tried to get (name of Resident #2) out of his bed. (Name of Resident #2) stated that his brother (Resident #6) was verbally harassing him but I did not get the impression that he (Resident #2) was concerned for his safety." OSM #3 was asked what was done to ensure Resident' #2's safety. OSM #3 stated, "I think that his brother (Resident #6) was moved to a different hallway." OSM #3 was asked what was documented about the incident. OSM #3 stated, "I thought a FRI (facility reported incident)

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was completed." OSM #3 was asked what had been done to manage the situation between Resident #2 and his brother. OSM #3 stated, "I talked to (name of ASM (administrative staff member) #1, the administrator, name of ASM #2 the director of nursing, and name of OSM #2, social worker) in a meeting." OSM #3 was asked what was done after that meeting. OSM #3 stated, "We focused on Resident #6, he wanted to go home." When asked about follow up with Resident #2, OSM #3 stated, "I did visit (name of Resident #2) and talked to him several times. His (Resident #2's) goal was to get his brother, Resident #6, out of the facility." OSM #3 was asked if she was concerned about Resident #2's safety, OSM #3 stated, "No." When asked if there should have been an investigation, OSM #3 stated, "There should have been an incident report completed. It was an allegation of abuse and there should have been documentation as to what happened."

On 11/3/17 at 10:15 a.m. an interview was conducted with OSM #2, social worker. OSM #2 was asked if she was aware of an incident that concerned between Resident #2 and Resident #6. OSM #2 stated that she was made aware the day after the incident occurred. OSM #2 was asked what she learned, OSM #2 stated, "I was made aware the next day that (name of Resident #6) had gone into (name of Resident #2's) room during the night. I found out in morning meeting from the DON, it was on the 24-hour report." OSM #2 was asked what date the incident occurred. OSM #2 stated that she did not know the date, "It was right after (name of Resident #6) was admitted." OSM #2 was asked what she did after learning about the incident. OSM #2 stated, "I talked to (name of Resident #6) about changing

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rooms. He said no and he asked why he was being asked to move. I talked to him with the administrator and we discussed the reason why (going into Resident #2's room in the middle of the night), He (Resident #6) was upset that his brother (Resident #2) accused him of that." OSM #2 was asked if an investigation was initiated, OSM #2 stated that it was not. OSM #2 was asked what should have been done, OSM #2 stated, "I should have completed an incident report which would have prompted an investigation." When asked why an investigation was warranted in this case, OSM #2 stated, "This is considered abuse. We failed to document the incident in the progress notes and did not initiate an investigation."

On 11/3/17 at 10:37 a.m. an interview was conducted with LPN (licensed practical nurse) #1, the wing C unit manager. LPN #1 was asked if she was aware of an incident that occurred when Resident #6 went into Resident #2's room in the middle of the night. LPN #1 stated she was not aware of any incidents. LPN #1 was asked to describe the process staff follows when a resident to resident altercation is witnessed. LPN #1 stated, "I would separate the residents, contact the administrator and DON (director of nursing) for next steps. I would document the incident in the progress notes and put on the 24-hour report for morning meeting. I would initiate an incident/ behavior report that would go to the DON (director of nursing) for an investigation to be conducted." When asked why an incident report / investigation was necessary in this case. LPN #1 stated, "This is considered resident to resident verbal abuse.

A review of the facility policy titled "Resident

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Abuse" revealed, in part, the following documentation, "All incidents of resident abuse are to be reported immediately to the Licensed Nurse in Charge, Director of Nursing, or the Administrator. Once reported to one of those three officials, the prescribed forms are to be completed and delivered to the Abuse Coordinator or his/her designee for an investigation. The Administration recognizes that preliminary reports of abuse can sometimes be clouded by biases and other factors that are relevant and need to be explored during a full investigation in order to obtain a clear picture of what actually happened. Investigations will be accomplished in the following manner. 1. Preliminary investigation: a. Immediately upon report of an incident to the individual in charge, the suspect(s) shall be segregated from the resident. d. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. 2. Investigation: a. The abuse Coordinator and / or Director of Nursing shall take written statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence."

On 11/3/17 at approximately 11:15 a.m. a meeting was held with ASM #1, the administrator, and ASM #2, the DON, to discuss the complaint regarding Resident #2 and Resident #6. When asked if ASM #1 or ASM #2 knew the date that the incident occurred and whether or not an investigation had been conducted. ASM #1 and ASM #2 both stated they did not have an exact date, the incident occurred sometime after Resident #6 was admitted to the facility and an investigation had not been conducted.

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No further information was provided prior to the end of the survey process.

F 280 SS=D 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP — F 280

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

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F 280	Continued From page 18 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 280	F280 1. Resident #2 and #6 comprehensive care plan has been revised. 2. Residents' who have been assessed as having behavior or cognition triggers have the potential of being affected. 3. Each social worker will review the behavior and cognition section of the MDS for accuracy. Any revisions identified will be made and the comprehensive care plan will be revised. The social worker will print the behavior and cognition section of the MDS, sign and date as reviewed and that the comprehensive care plan is accurate. 4. Resident to resident incidents will be reviewed during the morning meeting to review interventions, documentation, comprehensive care plan revisions and compliance with policy and procedure. 5. Compliance Date: 11/29/17	

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(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to review and revise the comprehensive care plan for two of six residents in the survey sample, Resident #2 and Resident #6.

1. The facility staff failed to review and revise Resident #2's comprehensive care plan following an incident where another resident entered into his room in the middle of the night.

2. The facility staff failed to review and revise Resident #6's comprehensive care plan following an incident where Resident #6 entered into another resident's room in the middle of the night.

The findings include;

1. The facility staff failed to review and revise Resident #2's comprehensive care plan following an incident where another resident entered into his room in the middle of the night.

Resident #2 was admitted to the facility 10/4/12 with diagnoses that included, but were not limited to, spinal stenosis [1] (a narrowing of the spinal canal putting pressure on the spinal cord and nerves), anxiety, shortness of breath, depression and heart failure.

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Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/17/17, coded Resident #2 as having a BIMS (brief interview for mental status) score of 15, indicating that Resident #2 is cognitively intact.

On 11/1/17 at 5:20 p.m. Resident #2 was observed in his room, seated in his wheelchair and self-propelling the wheelchair around his bed. Resident #2 was asked if he had any concerns regarding the care he received in the facility. Resident #2 stated, "I am afraid of my brother (a resident in the facility) Resident #6, he came into my room at 2:00 a.m. one morning and threated to pull me out of my bed, he wanted to fight me." Resident #2 was asked if he had told anyone about this incident. Resident #2 stated that the nursing staff had to remove his brother (Resident #6) from his room and "calm him down." Resident #2 further stated that he had told the administrator and the social worker but their response was that his brother (Resident #6) had rights too, "They wouldn't do anything." Resident #6 resides in the same wing (wing C), on a different hall.

On 11/3/17 at 10:02 a.m. an interview was conducted with RN (registered nurse) #2, the MDS coordinator. RN #2 was asked who was responsible for reviewing and revising the care plan. RN #2 stated, "A number of people, the unit manager may do, but people are assigned different sections." RN #2 was asked when a review and / or revision of the care plan is conducted. RN #2 stated, "Whenever we do a scheduled MDS assessment we usually do a review and revision at that time. Usually the person involved in the incident or the change in

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care will review the care plan and make the appropriate revisions. We do review nursing notes / progress notes, but if we don't know about an incident or it is not documented we cannot make sure that the care plan is updated."

On 11/3/17 at 10:15 a.m. an interview was conducted with OSM #2, social worker. OSM #2 was asked if she was aware of an incident that occurred between Resident #2 and another resident in the facility. OSM #2 stated that she was made aware the day after the incident occurred, a resident entered into Resident #2's room in the middle of the night and threated Resident #2. OSM #2 was asked what date the incident occurred. OSM #2 stated that she did not know the date, "It was right after the other resident was admitted." OSM #2 was asked what she did after learning about the incident. OSM #2 stated, "I talked to (the name of the resident who entered Resident #2's room about changing rooms. OSM #2 was asked if an investigation was initiated, OSM #2 stated that it was not. OSM #2 was asked what should have been done, OSM #2 stated, "I should have completed an incident report which would have prompted an investigation." When asked why an investigation was warranted in this case, OSM #2 stated, "This is considered abuse. We failed to document the incident in the progress notes and did not initiate an investigation." OSM #2 was asked what areas of the care plan she was responsible for completing, OSM #2 stated, "Behaviors and cognition." OSM #2 was asked if behaviors and cognition included resident to resident altercations. OSM #2 stated, "Yes." OSM #2 was asked if she reviewed and revised Resident #2's comprehensive care plan. OSM #2 stated that she did not, OSM #2 further stated that the other

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social worker was responsible for Resident #2. When asked whether or not the care plan should have been revised to reflect the incident. OSM #2 stated, "Yes, but it wasn't done."

On 11/3/17 at 10:30 a.m. an interview was conducted with OSM #1. OSM #1 was asked if she was responsible for Resident #2, OSM #1 stated that she was. OSM #1 was asked if she was aware of an incident that occurred between Resident #2 and another resident in the facility. OSM #1 stated, "I was out on medical leave at that time so I was not involved. (Name of OSM #2) and the ombudsman handled that situation."

On 11/3/17 at approximately 10:45 a.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above referenced concern. ASM #2 was asked whether or not Resident #2's comprehensive care plan should have been reviewed and revised following the incident where another resident entered his room and threatened him, ASM #2 stated that it should have been done. A policy was requested that addressed the completion, review and revision of comprehensive care plans.

On 11/3/17 at 11:03 a.m. OSM #5, medical records, approached this writer and stated that the facility did not have a policy for completing comprehensive care plans and that the facility used the RAI (resident assessment instrument) manual.

No further information was provided prior to the end of the survey process.

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2. The facility staff failed to review and revise Resident #6's comprehensive care plan following an incident where Resident #6 entered into another resident's room in the middle of the night.

Resident #6 was admitted to the facility on 4/13/17 with diagnoses that included, but were not limited to, chronic kidney disease, difficulty swallowing, dementia, congestive heart failure and high blood pressure.

Resident #6's most recent MDS, a quarterly assessment with an ARD of 9/26/17, coded Resident #6 as having a BIMS score of 15, indicating that Resident #6 is cognitively intact.

On 11/3/17 at 10:02 a.m. an interview was conducted with RN (registered nurse) #2, the MDS coordinator. RN #2 was asked who was responsible for reviewing and revising the care plan. RN #2 stated, "A number of people, the unit manager may do, but people are assigned different sections." RN #2 was asked when a review and / or revision of the care plan is conducted. RN #2 stated, "Whenever we do a scheduled MDS assessment we usually do a review and revision at that time. Usually the person involved in the incident or the change in care will review the care plan and make the appropriate revisions. We do review nursing notes / progress notes, but if we don't know about an incident or it is not documented we cannot make sure that the care plan is updated."

On 11/3/17 at 10:15 a.m. an interview was conducted with OSM #2, social worker. OSM #2 was asked if she was aware of an incident that concerned between Resident #6 and another resident in the facility. OSM #2 stated that she

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was made aware the day after the incident occurred, Resident #6 entered into another resident's room in the middle of the night and threated the resident while he was lying in bed. OSM #2 was asked what date the incident occurred. OSM #2 stated that she did not know the date, "It was right after Resident #6 was admitted." OSM #2 was asked what she did after learning about the incident. OSM #2 stated, "I talked to Resident #6 about possibly changing rooms. OSM #2 was asked if an investigation was initiated, OSM #2 stated that it was not. OSM #2 was asked what should have been done, OSM #2 stated, "I should have completed an incident report which would have prompted an investigation." When asked why an investigation was warranted in this case, OSM #2 stated, "This is considered abuse. We failed to document the incident in the progress notes and did not initiate an investigation." OSM #2 was asked what areas of the care plan she was responsible for completing, OSM #2 stated, "Behaviors and cognition." OSM #2 was asked if behaviors and cognition included resident to resident altercations. OSM #2 stated, "Yes." OSM #2 was asked if she reviewed and revised Resident #6's comprehensive care plan. OSM #2 stated that she did not. When asked whether or not the care plan should have been revised to reflect the incident. OSM #2 stated, "Yes, but it wasn't done."

On 11/3/17 at approximately 10:45 a.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above referenced concern. ASM #2 was asked whether or not Resident #6's comprehensive care plan should

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have been reviewed and revised following the incident where he entered another resident's room in the middle of the night and threatened him, ASM #2 stated that it should have been done. A policy was requested that addressed the completion, review and revision of comprehensive care plans.

On 11/3/17 at 11:03 a.m. OSM #5, medical records, approached this writer and stated that the facility did not have a policy for completing comprehensive care plans and that the facility used the RAI (resident assessment instrument) manual.

No further information was provided prior to the end of the survey process.

F 514 SS=E 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

(i) Medical records.
(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

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(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined the facility staff failed to ensure a complete and accurate clinical record for four of six residents in the survey sample, Resident #1, #2, #5 and #6.

1. The facility staff failed to document on Resident #1's TAR (treatment administration record) the application of a hand splint and left palm protector as ordered.

2. The facility staff failed to document an incident that occurred in late April, early May when another resident entered into Resident #2's room in the middle of the night and threatened to fight him.

3. The facility staff failed to document the completion of skin care on Resident #5's TAR (treatment assessment record).

1. (1) The application of hand splints and palm protectors are being documented on the TAR's. (2/4) Resident to resident incidents are being documented. (3) Completion of skin care is being documented on the TAR's.

2. Residents residing in the facility have the potential of being affected.

3. (1/3) Licensed staff will be re-educated on how to access the missing documentation report to identify any missed area of documentation. (2/4) Licensed staff will be re-educated on documenting resident to resident incidents.

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4. The facility staff failed to document when Resident #6 entered another resident's room and threatened him in the middle of the night.

The findings include;

1. The facility staff failed to document on Resident #1's TAR (treatment administration record) the application of a hand splint and left palm protector as ordered.

Resident #1 was admitted to the facility on 4/19/17 with diagnoses that included, but were not limited to, stroke, paralysis, high blood pressure, swelling of limbs, depression, behavior and difficulty swallowing.

Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/20/17, coded Resident #1 as having a BIMS (brief interview of mental status) of seven out of a possible 15, indicating that Resident #1 is moderately cognitively impaired.

A review of Resident #1's comprehensive care plan dated 4/19/2017 revealed, in part, the following documentation; "Focus: I have a physical functioning deficit related to: Mobility impairment, ROM (range of motion) limitation (L (left) non-dominant sided hemiparesis) Date Initiated: 5/2/17. Interventions: Left hand splint (resting hand splint) for day time positioning Date Initiated: 9/23/2017. Left palm protector for bedtime positioning Date Initiated: 9/13/2017."

A review of Resident #1's order summary report signed and dated by the physician on 10/1/17 revealed, in part, the following physician orders,

4. (1/3) The missing documentation report will be accessed seven times a week. The DNS (or designee) will review the report for timely completion. (2/4) Resident to resident incidents will be reviewed during the morning meeting to review intervention's, documentation, comprehensive care plan revisions and compliance with policy and procedure.

5. Compliance Date: 11/29/17

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"Left hand splint (resting hand splint) for day time positioning two times a day. Order Date 9/13/17. Start Date 9/13/17. Left palm protector for bedtime positioning two times a day. Order Date 9/13/17. Start Date 9/13/17."

A review of Resident #1's clinical record revealed, in part, a TAR (treatment assessment record) dated 9/1/17 - 9/30/17 and 10/1/18 - 10/31/17. The following orders were documented on the TAR;
- "Left hand splint (resting hand splint) for day time positioning two times a day. Order Date 9/13/2017 1315 (1:15 p.m.)" On 9/14/17 there was no documentation to indicate the hand splint was "on".
- "Left palm protector for bedtime positioning two times a day. Order Date. 9/24/2017 1319 (1:19 p.m.)" On 9/15/17, 9/18/17, 9/29/17, 10/13/17, 10/16/17, 10/22/17 and 10/27/17 there was no documentation to indicate the palm protector was "on".

On 11/3/17 at 9:15 a.m. an interview was conducted with LPN (licensed practical nurse) #3, a floor nurse. LPN #3 was asked to state what she was to do when a physician gave an order. LPN #3 stated, "I follow the order." LPN #3 was asked to state under what circumstance she would not follow the order. LPN #3 stated, "If there were parameters and if the treatment was not therapeutic, then I would hold and call the physician." LPN #3 was asked when a treatment order would not be followed, LPN #3 stated, "I can't think of any reason you would not follow a treatment order." LPN #3 was asked if a treatment was not given what should the nurse do. LPN #3 stated, "I would document in the progress notes why it was not given." At this time

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LPN #3 reviewed Resident #1's TAR. LPN #3 was asked why there were blank spaces on the TAR for the application of a left hand splint and left palm protector. LPN #3 stated, "I don't know, I must have just forgotten to sign off on the application. I go every morning and check that he has the splint or the palm protector on, I don't know why they are not signed off."

On 11/3/17 at 10:45 a.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings. ASM #2 was asked whether or not the nursing staff were required to sign off on the application of the splints and the palm protector when applied. ASM #2 stated that the nursing staff were required to sign off on all treatments. A policy was requested at this time regarding documentation.

No further information was provided prior to the end of the survey process.

2. The facility staff failed to document an incident that occurred in late April, early May when another resident entered into Resident #2's room in the middle of the night and threatened to fight him.

Resident #2 was admitted to the facility 10/4/12 with diagnoses that included, but were not limited to, spinal stenosis [1] (a narrowing of the spinal canal putting pressure on the spinal cord and nerves), anxiety, shortness of breath, depression and heart failure.

Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/17/17, coded

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Resident #2 as having a BIMS (brief interview for mental status) score of 15, indicating that Resident #2 is cognitively intact.

On 11/1/17 at 5:20 p.m. Resident #2 was observed in his room, seated in his wheelchair and self-propelling the wheelchair around his bed. Resident #2 was asked if he had any concerns regarding the care he received in the facility. Resident #2 stated, "I am afraid of my brother (a resident in the facility), he came into my room at 2:00 a.m. one morning and threated to pull me out of my bed, he wanted to fight me." Resident #2 was asked if he had told anyone about this incident. Resident #2 stated that the nursing staff had to remove his brother from his room and "calm him down." Resident #2 further stated that he had told the administrator and the social worker but their response was that his brother had rights too, "They wouldn't do anything."

A review of the clinical record did not reveal any documentation regarding the incident in the progress notes.

On 11/3/17 at 10:15 a.m. an interview was conducted with OSM #2, social worker. OSM #2 was asked if she was aware of an incident that concerned between Resident #2 and another resident in the facility. OSM #2 stated that she was made aware the day after the incident occurred, a resident entered into Resident #2's room in the middle of the night and threatened Resident #2. OSM #2 was asked what date the incident occurred. OSM #2 stated that she did not know the date, "It was right after the other resident was admitted." OSM #2 was asked what she did after learning about the incident. OSM #2 stated, "I talked to (the name of the resident who

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entered Resident #2's room about changing rooms. OSM #2 was asked if an investigation was initiated, OSM #2 stated that it was not. OSM #2 was asked what should have been done, OSM #2 stated, "I should have completed an incident report which would have prompted an investigation." When asked why an investigation was warranted in this case, OSM #2 stated, "This is considered abuse. We failed to document the incident in the progress notes and did not initiate an investigation."

On 11/3/17 at 10:45 a.m. an interview was conducted with ASM #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concerns. ASM #2 was asked if she had any documentation concerning the incident. ASM #2 stated that she did not. When asked if the nursing staff should have documented the incident, ASM #2 stated that they should have documented the incident as it happened. A request was made at this time for a policy regarding documentation.

No further information was provided prior to the end of the survey process.

3. The facility staff failed to document the completion of skin care on Resident #5's TAR (treatment assessment record).

Resident #5 was admitted to the facility on 12/30/16 with diagnoses that included, but not limited to, Alzheimer's, anxiety, heart disease, anemia and diabetes.

Resident #5's most recent MDS (minimum data set), a significant change assessment with an

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ARD (assessment reference date) of 6/6/17, coded Resident #5 as having a BIMS (brief interview for mental status) score of three out of 15, indicating that Resident #5 is severely cognitively impaired.

A review of Resident #5's TARs (treatment administration record) dated 6/1/17 - 6/30/17 revealed, in part, the following order; "Cleanse open area to right buttock with wound cleanser and apply Zinc Oint (ointment) and Silver Sulfadiazine [1] (a sulfa drug used to prevent infections in wounds). The following dates did not have any nursing initials to document that the treatment was completed: 6/3/17, 6/4/17, 6/5/17, 6/9/17, 6/18/17 and 6/21/17.

On 11/3/17 at 9:15 a.m. an interview was conducted with LPN (licensed practical nurse) #3, a floor nurse. LPN #3 was asked to state what she was to do when a physician gave an order. LPN #3 stated, "I follow the order." LPN #3 was asked to state under what circumstance she would not follow the order. LPN #3 stated, "If there were parameters and if the treatment was not therapeutic, then I would hold and call the physician." LPN #3 was asked when a treatment order would not be followed, LPN #3 stated, "I can't think of any reason you would not follow a treatment order." LPN #3 was asked if a treatment was not given what should the nurse do. LPN #3 stated, "I would document in the progress notes why it was not given." At this time LPN #3 reviewed Resident #5's TAR dated 6/1/17 - 6/30/17. LPN #3 was asked why there were blank spaces on the TAR for the application of skin treatment to Resident #5's buttocks. LPN #3 stated, "I don't know, we must have just forgotten to sign off on the application. I know that this was

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done because we had the cream in her room with her so we could apply it at each incontinence event. I don't know why the treatment was not signed off on. We just forgot."

On 11/3/17 at 10:45 a.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings. ASM #2 was asked whether or not the nursing staff were required to sign off on the application of the splints and the palm protector when applied. ASM #2 stated that the nursing staff were required to sign off on all treatments. A policy was requested at this time regarding documentation.

[1] This information was obtained from the following website; https://medlineplus.gov/druginfo/meds/a682598.html

4. The facility staff failed to document when Resident #6 entered another resident's room and threatened him in the middle of the night.

Resident #6 was admitted to the facility on 4/13/17 with diagnoses that included, but were not limited to, chronic kidney disease, difficulty swallowing, dementia, congestive heart failure and high blood pressure.

Resident #6's most recent MDS, a quarterly assessment with an ARD of 9/26/17, coded Resident #6 as having a BIMS score of 15, indicating that Resident #6 is cognitively intact.

On 11/3/17 at 10:15 a.m. an interview was conducted with OSM #2, social worker. OSM #2

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was asked if she was aware of an incident that concerned between Resident #6 and another resident in the facility. OSM #2 stated that she was made aware the day after the incident occurred but was unable to state the exact date. Resident #6 entered into another resident's room in the middle of the night and threated the resident while he was lying in bed. OSM #2 was asked what date the incident occurred. OSM #2 stated that she did not know the date, "It was right after Resident #6 was admitted, sometime the end of April, beginning of May." OSM #2 was asked what she did after learning about the incident. OSM #2 stated, "I talked to Resident #6 about possibly changing rooms. OSM #2 was asked if an investigation was initiated, OSM #2 stated that it was not. OSM #2 was asked what should have been done, OSM #2 stated, "I should have completed an incident report which would have prompted an investigation." When asked why an investigation was warranted in this case, OSM #2 stated, "This is considered abuse. We failed to document the incident in the progress notes and did not initiate an investigation." OSM #2 was asked what areas of the care plan she was responsible for completing, OSM #2 stated, "Behaviors and cognition." OSM #2 was asked if behaviors and cognition included resident to resident altercations. OSM #2 stated, "Yes."

On 11/3/17 at 10:37 a.m. an interview was conducted with LPN (licensed practical nurse) #1, the wing C unit manager. LPN #1 was asked if she was aware of an incident that occurred when Resident #6 went into another resident's room in the middle of the night. LPN #1 stated she was not aware of any incidents. LPN #1 was asked to describe the process followed when a resident to resident altercation is witnessed. LPN #1 stated,

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"I would separate the residents, contact the administrator and DON for next steps. I would document the incident in the progress notes and put on the 24-hour report for morning meeting. I would initiate an incident/ behavior report that would go to the DON (director of nursing) for an investigation to be conducted." LPN #1 was asked to review Resident #6's progress notes for documentation regarding the incident that occurred sometime in April / May. LPN #1 was unable to find any documentation. LPN #1 was asked if the incident should have been documented, LPN #1 stated that it should have been.

On 11/3/17 at approximately 10:45 a.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above referenced concern. ASM #2 was asked whether or not documentation should have been entered in the progress notes regarding the incident when Resident #6's entered another resident's room in the middle of the night. ASM #2 stated that it should have been done.

No further information was provided prior to the end of the survey process.