STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. BUILDING _____ B. WING _____	C 12/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT HARRISONBURG TRANSITIONAL CARE & REHAB CT	94 SOUTH AVENUE HARRISONBURG, VA 22801

(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 12/18/18 through 12/19/18. Two complaints were investigated during the survey. Corrections are required for complaince with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 117 bed facility was 105 at the time of the survey. The survey sample consisted of two current resident reviews (Resident #1 and #2).	F 000		
F 600 SS=D	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 and facility document review the facility staff failed to ensure one of 2 residents in the survey sample was free from verbal and physical abuse that included restraint. A contracted Physical Therapist yelled and presented himself in a physically intimidating	F 600	1. Corrective action was taken upon identification of this deficiency on July 30, 2018 when the allegation of abuse was made. The employee was placed on administrative leave pending investigation. Once the allegation had been	1/2/19

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

Electronically Signed | 01/03/2019

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F 600	Continued From page 1 manner by placing his face in Resident #1's face and asking the resident to punch him on the chin. The Physical Therapist also restrained Resident #1 by grabbing the wheelchair handles and pulling Resident #1 backwards into the hall. The findings include: Resident #1 was originally admitted to the facility on 9/11/12 and most recently admitted on 11/28/18 with diagnoses that included acute kidney failure, type 2 diabetes, hypertension, anxiety disorder, muscle weakness, difficulty walking, dementia with behavioral disturbances, major depressive disorder, unspecified psychosis, methicillin resistant staphylococcus aureus infection (MRSA), and cellulitis. The minimum data set (MDS) dated 10/31/18 assessed Resident #1 as severely cognitively impaired and having fluctuating periods of disorganized thinking. A facility reported incident (FRI) form dated 07/30/18 documented the following "therapist allegedly yelled at resident (Resident #1) in residents room. Investigation is underway. {Involved employee's name] Employee suspended until investigation complete." The facility's investigation of this incident dated 8/3/18 documented that Resident #1 was verbally abused and physically restrained by way of resident's wheelchair by a contracted Physical Therapist. The facility's investigation documented the following conclusion: "After through investigation, including interviews with staff present at time of the incident as well as residents, the facility finds the allegation substantiated. [Physical Therapist] yelled at	F 600	substantiated, Reliant Health was notified of the findings and the employee was not permitted to return to the facility and subsequently terminated from Reliant Health. 2. Safe surveys were conducted at the time of the allegation on all residents the therapist may have encountered that were identified through the case load as well as unit the therapist worked on. All residents felt safe. 3. Department Heads and Unit Managers will retrain all staff on Curis abuse and reporting policy. All facility staff will be retrained utilizing a different test than the test given post-abuse allegation on August 1st and 2nd, 2018. Reliant Health rehabilitation staff will be retrained by Reliant Health on December 20, 2018. The training will include types of abuse, how to recognize, and report. 4. Department Heads will conduct SMART rounds Monday through Friday in assigned rooms and audit residents for potential abuse x one month, Tuesday and Thursday x one month, and once weekly x one month. Audit results will be presented to the Quality Assurance Committee monthly. 5. January 2, 2019.	

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[Resident #1] and presented himself in a physically intimidated manner by placing his face in [Resident #1's] and asking the resident to punch him on the chin. [Physical Therapist] also restrained the resident by grabbing the handles and pulled the wheelchair backwards into the hall despite [Resident #1] protest. Reeducate staff has been in-serviced on abuse and reporting standards have been reviewed." Following the investigation the Physical Therapist was terminated from working at the facility.

Written witness statements of the incident were as follows:

Contracted agency LPN-"Therapist was standing in front of [name of resident's room]; [Resident #1] was trying to get into the room. The therapist was loud and aggressive stating "I am a grown man and you will not talk to me like that" I as a nurse felt he was abusive towards resident."

Occupational Therapist (OT)-"[Physical Therapist] was witnessed from 100' (100 feet) away at the far end of the hallway. [Physical Therapist] was yelling into a residents room from the hall. I asked him what was wrong. He replied unkindly about the husband of the roommate of the patient he had come for. Something about he had attempted to stop him from entering the room because his patient was dressing."

CNA #1-"I was walking toward nursing station on A wing: I was between Rms 12 &13, when I turned and saw a Therapist member pull [Resident #1] wheelchair backwards, and [Resident #1] swung at the Therapist. I said to the Therapist that he might want to leave the resident alone. The Therapist said something to

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me, but I couldn't hear, so I walked down where the therapist was at when I got there [Resident #1] was telling the Therapist to leave him alone before he knocked the hell out of him, but the Therapist got in [Resident #1] face and told him to hit right here pointing at his jaw. Then looked at me and said do you see this, I want you to report this. The Therapist said to [Resident #1] I don't care who you tell and then the therapist said to [Resident #1] I can take my license and wipe my own A_ _ with it and then the therapist said this is why I hate this job because I got to work with people like you. By this time I turned and saw [Employee] and said to her I need the [names of Unit Manager, Administrator and Rehab Manager]. ...."

Resident Statement (Resident who resided in bed A of the room where the incident took place)-"Therapist came to get me and I wasn't ready, Roommate husband came to see her and just came in the room. Therapist asked him to wait and he got angry and told therapist to get out the way or he was going to bust him with his fist. Therapist said go ahead and hit me. He continued to try to come in. Therapist held his w/c after asking him to wait till resident was ready. He was asking for help (the therapist) and nobody came. Therapist shut the door and kept him outside until I was done. They fused outside the door. I had clothes on and was getting ready."

Resident Statement (Resident #1's spouse, who resided in bed B of the room where the incident took place)-" I just heard a lot of arguing. He was antagonizing [Resident #1].

Written investigation statements from the facility administrator and Director of Rehab Manager

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(DOR) as follows:

Administrator-..."On Monday July 30, 2017 (sic-2018), [Employee, LPN#1), Wing A Unit Manager came to my office and asked me to assist her with an issue on her wing. Upon arrival on A Wing, the Director of Rehabilitation was walking with [Physical Therapist] away from the unit. I asked what was going on ad was informed that [Physical Therapist] was involved in a verbal altercation with a resident [Resident #1]. Upon questioning [Physical Therapist] informed me that he tried to stop [Resident #1] from entering the room because the resident scheduled for rehab was getting ready. [Resident #1] responded by telling [Physical Therapist] that he was going to punch him if he wasn't allowed to enter the room and attempted to enter the room despite instruction not to from the staff. [Resident #1] asked the resident [Physical Therapist] was waiting on if it was okay that he entered, to which she responded it was fine. [Physical Therapist] took the handles of [Resident #1's wheelchair and pulled him backwards into the hall, telling him he had to wait. This agitated [Resident #1] even more. [Physical Therapist] then told me that [Resident #1] was cursing at him and calling him names and making threats to punch him. [Physical Therapist] responded to this by stating he got in [Resident #1] face and told him to punch him in the jaw. When [Resident #1] stated he was going to have [Physical Therapist's] license. [Physical Therapist] stated he told [Resident #1] he did not care and that he would wipe his ass with his license."

DOR-"Around 10 am, restorative CNA (CNA #1) came into the rehab gym stating that PTA [Physical Therapist] was in the hallway screaming

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at patient [Resident #1]. On my arrival the incident was over. [Physical Therapist] reported that [Resident #1] insisted on entering his wife's room. [Physical Therapist] stated he advised [Resident #1] that the other patient in room was dressing. [Resident #1] insisted on entering the room anyway at which point [Physical Therapist] reported trying to restrain the patient by holding the back of his wheelchair to prevent him from entering. Per staff report therapist was verbally abusive as was patient. Within 10 minutes of incident therapist was interviewed by DOR, Facility Administrator {Name] and B wing unit manager [LPN #1]. Therapist recounted the details of the incident. Therapist was relived of duty and asked to leave the building prior to 1100 am."

On 12/18/18 at 4:22 p.m., the Occupational Therapist (OT) who witnessed the incident of 7/30/18 was interviewed. The OT stated he was at the end of the hall and could hear the Physical Therapist was very loud when responding to Resident #1 about not going into his wife's room. The OT stated he could not remember the exact words used, but he was shocked at the tone the Physical Therapist was using toward Resident #1.

On 12/19/18 at 8:20 a.m., Resident #1 was interviewed regarding the incident on 7/30/18. Resident #1 was observed laying in his bed. Resident #1 smiled and said hello. Resident #1 was asked how he was feeling. Resident #1 said "so, so". Resident #1 was asked about his life at the facility. Resident #1 mumbled some words incoherently and said "it's all strange, you know" and smiled. Resident #1 was asked did he feel safe at the facility and he said again, "it's all strange, you know" and smiled. Resident #1 was

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asked if he had any concerns since he been at the facility and again he mumbled some more incoherent words. Resident #1 then looked at his wall and pointed to a decoration of a Christmas tree on his wall above his television. Resident #1 smiled and turned over on his back and said "thank you". No additional attempts to interview Resident #1 were made due to his cognitive status.

On 12/19/18 at 8:35 a.m., CNA #1 that witnessed the incident of 7/30/18. CNA #1 stated she she was on the upper end of the hall when she heard what sounded like arguing. She stated she looked down the hall and saw the Physical Therapist and Resident #1 outside of Resident #1's wife room. CNA #1 stated she saw the Physical Therapist pull Resident #1's wheelchair backwards while Resident #1 was yelling. CNA #1 stated she walked down the hall and told the Physical Therapist to leave Resident #1 alone because he was noticeably upset as he was yelling at the Physical Therapist and threatening to hit him. CNA #1 stated the Physical Therapist got down in Resident #1's face and said "go ahead and hit me right here" pointing toward his chin. CNA #1 stated Resident #1 looked at her and said "you see this, I want you to report this." CNA #1 stated the Physical Therapist then said to Resident #1 "I don't care who you tell, I can wipe my ass with my license. This is why I hate my job because I have to work with people like you". CNA #1 stated she asked the residents who resided in the room if she could close the door because she didn't feel it was appropriate for them to have to witness such behavior from the Physical Therapist. CNA #1 stated she saw another employee and told them to ask the administrator, unit manager and rehab manager to come to the room immediately

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because she felt the Physical Therapist was being abusive towards Resident #1. CNA #1 stated the Physical Therapist would often make negative statements about his job and had a negative tone when working with certain residents, especially those with dementia.

On 12/19/18 at 8:55 a.m., Resident #1's spouse was interviewed regarding the incident of 7/30/18. Resident #1's spouse resided in bed B of the room where the incident took place. Resident #1's spouse stated she did not physically see the incident because the privacy curtain was closed because her roommate was getting dressed. She stated she knew the Physical Therapist was waiting for her roommate to finish getting dressed for therapy. She continued and stated she could hear some of the yelling and knew it was her husband because she knows his voice. She said her husband visits her often and asked her roommate if he could came in the room and was told yes. Resident #1's spouse stated because Resident #1 was in Vietnam and has dementia, the staff knows how to work with him and not upset him. She continued and stated the Physical Therapist was provoking her husband to hit him.

On 12/19/18 at 9:15 a.m., the resident who resided in bed A of the room where the incident took place was interviewed. The resident stated she was combing her hair when Resident #1 came to visit his wife. She continued and stated the Physical Therapist told Resident #1 he could no come in the room because she was not dressed. She continued and said "he [Resident #1] often comes to visit his wife during the day". The resident stated she had told Resident #1 it was okay for him to come in because she was

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almost finished dressing. She stated the Physical Therapist told him that he could not come in the room and this is when Resident #1 got upset. The resident continued and stated she did not remember everything that was said but the Physical Therapist and Resident #1 were both yelling at each other. She continued and said one of CNAs came to the room and asked if they were ok and asked to close the door until they could figure out what was going on.

The contracted agency LPN who was the charge nurse the day of the incident of 7/30/18 was no longer employed by the facility and not available for interview. The director of rehab who completed a written investigative statement on the day of the incident of 7/30/18 was no longer employed by the facility and not available for interview.

On 12/19/18, the facility administrator was interviewed regarding the incident on 7/30/18. The administrator stated he been employed at the facility for approximately 2 weeks when the incident happened. He stated upon being notified of the incident he immediately started his investigation and suspended the Physical Therapist. He continued and stated based on the investigation it was determined the Physical Therapist did verbally abuse and physically restrain Resident #1. The administrator stated based on his conversation with the previous rehab manager, the Physical Therapist was terminated from the contracted agency as well as from the facility.

Resident #1's plan of care initiated on 08/17/15 and reviewed on 10/11/18 documented the following focus area: Potential to demonstrate

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F 600	Continued From page 9 physical behaviors r/t hallucinations. Interventions documented "When [Resident #1] becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later." The facility's policy titled Abuse, Neglect, Exploitation and Injuries of Unknown Origin Policy (Effective Date 03/01/2017) documented, "Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The resident has the right to be free from mistreatment, neglect and misappropriation of property. Residents must not be subject to abuse by anyone including, but not limited to: facility staff, other residents, consultants, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends or other individuals. It is the policy of this facility that all residents be free from these incidents and that the resident's right to privacy and dignity is maintained...." No other information was presented to the survey team prior to the exit conference on 12/19/18 at 10:00 a.m.	F 600		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		1/2/19

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F 758	Continued From page 10 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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F 758	Continued From page 11 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for one of two residents in the survey sample (Resident # 2), to ensure the resident was free of unnecessary psychotropic medications. Resident # 2 had a PRN (as needed) order for Clonazepam that extended for longer than 14 days, and without an end date. The findings were: Resident # 2, a 77 year-old male, was admitted to the facility on 6/29/16, and most recently readmitted on 3/23/18 with diagnoses that included hypertension, diabetes mellitus, Non-Alzheimer's Dementia, Parkinson's Disease, anxiety disorder, depression, gastroesophageal reflux disease, obesity, impulsiveness, and chronic kidney disease. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 10/2/18, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Review of the Electronic Medication Administration Record (EMAR) in Resident # 2's Electronic Health Record for the month of December 2018 revealed the following order: Clonazepam Tablet 0.5 mg (milligram). Give 1 tablet by mouth every four hours as needed for chronic intermittent anxiety with behavior. The	F 758	1. Immediate action was taken upon identification of this deficiency. The affected resident's medication was reviewed by the Physician and medication was discontinued. 2. Medication audits were conducted December 14, 2018 to identify all facility residents with PRN psychotropic medications. Orders from the Medical Director discontinue the PRN psychotropics on December 19, 2018. 3. Director of Nursing Services or designee will review newly ordered psychotropic medications in the daily clinical morning meeting Monday through Friday to verify orders for PRN antipsychotic and anxiolytic medications have 14-day stop dates. 4. The Director of Nursing Services will audit psychotropic medication orders once weekly x one month, bi-weekly x one month, and monthly x one month. Audit results will be presented to the Quality Assurance Committee monthly. 5. January 2, 2019.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT HARRISONBURG TRANSITIONAL CARE & REHAB CT	94 SOUTH AVENUE HARRISONBURG, VA 22801

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F 758	Continued From page 12 order was dated 11/12/18. There was no end date. (NOTE: Clonazepam is an anticonvulsant with an unlabeled use for anxiety. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 277.) According to the EMAR for the month of November 2018, the resident received one dose of Clonazepam on 11/24/18. As of 12/18/18, the date of record review, the resident had not received Clonazepam during the month of December 2018. At 4:05 p.m. on 12/18/18, the Director of Nursing (DON) was interviewed regarding the PRN order for Clonazepam. "I did not know it was written without a stop order," the DON stated. "I will take care of it," the DON added. At 4:30 p.m. on 12/18/18, during a meeting with the survey team, the Administrator was advised of the PRN order for Clonazepam without an end date for Resident # 2.	F 758		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		1/2/19

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§483.70(i)(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

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches

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F 842	Continued From page 14 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (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, and clinical record review and during a complaint investigation, the facility staff failed to ensure a complete and accurate record for two of 2 residents (Resident #1 and #2) in the survey sample. 1. There was no documentation in Resident #1's clinical record regarding the allegation of abuse and/or follow-up with Resident #1. 2. Resident #2's clinical record did not document an allegation of abuse in a timely manner nor on the correct date. The findings include: 1. Resident #1 was admitted to the facility on 9/11/12 and most recently readmitted on 11/28/18 with diagnoses that included acute kidney failure, type 2 diabetes, hypertension, anxiety disorder, muscle weakness, difficulty walking, dementia with behavioral disturbances, major depressive	F 842	1. Immediate action was taken upon identification of this deficiency. A late note was entered into the electronic health record for the identified residents. The Executive Director or Director of Nursing will enter incidents requiring completion of a Facility Reported Incident into the electronic health record. 2. Residents that require a Facility Reported Incident was completed on are at risk for this deficient practice. 3. The Director of Nursing Services will educate Licensed Nursing Staff on documentation, notifications, and assessment of residents involved in a Facility Reported Incident. 4. The Director of Nursing Services will audit any Facility Reported Incident x three months to verify completion of documentation in the electronic health record. Audit results will be presented to the Quality Assurance Committee monthly.	

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F 842	Continued From page 15 disorder, unspecified psychosis, methicillin resistant staphylococcus aureus infection (MRSA), and cellulitis. The minimum data set (MDS) dated 10/31/18 assessed Resident #1 as severely cognitively impaired and having fluctuating periods of disorganized thinking. A facility reported incident (FRI) form dated 07/30/18 documented the following "therapist allegedly yelled at resident (Resident #1) in residents room. Investigation is underway. {Involved employee's name] Employee suspended until investigation complete". The facility's investigation of this incident dated 8/3/18 documented that Resident #1 was verbally abused and physically restrained by way of resident's wheelchair by a contracted Physical Therapist. The facility's investigation documented the following conclusion: "After through investigation, including interviews with staff present at time of the incident as well as residents, the facility finds the allegation substantiated. [Physical Therapist] yelled at [Resident #1] and presented himself in a physically intimidated manner by placing his face in [Resident #1's] and asking the resident to punch him on the chin. [Physical Therapist] also restrained the resident by grabbing the handles and pulled the wheelchair backwards into the hall despite [Resident #1] protest. Reeducate staff has been in-serviced on abuse and reporting standards have been reviewed". Following the investigation the Physical Therapist was terminated from working at the facility. On 12/18/18 a review of Resident #1's clinical record was completed. Review of the clinical record documented no progress notes regarding	F 842	5. January 2, 2019.	

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the incident and no follow-up with the resident regarding the incident on 7/30/18.

On 12/18/18 at 4:00 p.m., the Director of Nursing (DON) was interviewed regarding the lack of documentation of the abuse allegation in Resident #1's clinical record. The DON stated she was not employed at the facility at the time of the incident and it would be best to speak with the Administrator regarding the incident.

On 12/18/18 at 4:30 p.m., during a meeting with the survey team, the Administrator said his expectation was that all incidents be documented in the resident's electronic medical record.

On 12/19/18 at 8:40 a.m., the unit manager (LPN #1) was interviewed regarding the incident on 07/30/18. LPN #1 stated she did not witness the incident. LPN #1 stated the charge nurse on duty notified her of the incident. The charge nurse who was on duty the day of the incident was a contracted agency employee and was no longer employed at the facility. LPN #1 was asked what was her expectation regarding the documentation of the incident. LPN #1 stated she would expect for the incident to be documented in the resident's record. LPN #1 was asked if there was any follow-up with Resident #1 after the incident on 7/30/18. LPN #1 stated she did remember the resident was agitated the reminder of the day (7/30/18). LPN #1 stated staff should have monitored and followed-up with Resident #1 after the incident and documented their findings.

No additional information was presented to survey team prior to exit conference on 12/19/18 at 10:00 a.m.

2. Resident # 2, a 77 year-old male, was

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admitted to the facility on 6/29/16, and most recently readmitted on 3/23/18 with diagnoses that included hypertension, diabetes mellitus, Non-Alzheimer's Dementia, Parkinson's Disease, anxiety disorder, depression, gastroesophageal reflux disease, obesity, impulsiveness, and chronic kidney disease. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 10/2/18, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

On 11/29/18, the facility submitted a Facility Reported Incident (FRI) to the State Agency (Office of Licensure and Certification) reporting an incident that occurred on 11/29/18 concerning Resident #2 that noted the following, "Resident states he was slapped on the face by a CNA in the television room." The employee identified by Resident #2 as a CNA was subsequently identified as LPN #2. The LPN #2 was suspended pending the outcome of the facility investigation.

On 12/3/18, the facility submitted the results of their investigation to the State Agency, which included the following conclusion, "Statements taken from all staff who interacted with resident do not substantiate the allegation of abuse...The resident was evaluated and found to have no indications or evidence of an altercation to include bruising, skin tear, or discoloration. After a thorough investigation, we are unable to substantiate the resident's allegation of physical abuse." Following the investigation, LPN # 2 was returned to duty.

During review of Resident #2's Electronic Health

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Record (EHR), no Progress (Nurses) Notes were found regarding the resident's allegation of abuse on 11/29/18.

At 3:35 p.m. on 12/18/18, the Director of Nursing (DON) was interviewed regarding the lack of documentation of the abuse allegation in Resident #2's EHR. "I was not here at that time, I was out of state. (Name of Administrator) was here." Asked what her expectation was regarding documentation, the DON said, "I would expect the incident to be documented in the resident's record." The DON then said that LPN #2, who was named in the investigation, was working at the present time.

At 3:50 p.m. on 12/18/18, LPN #2 was interviewed regarding the 11/29/18 incident. Asked why she didn't make a Progress (Nurses) Notes entry at the time of the incident, LPN #2 said, "I couldn't remember when it happened, so I put it on the 16th (11/16/18)."

Following the interview with LPN #2, the Progress (Nurses) Notes in Resident #2's EHR were reviewed again, and the following entry was noted:

11/16/18 - 0600 (6:00 a.m.) "Late Entry: Resident was sleeping in TV room when nurse approached resident to give meds (medications). Resident was startled and became irate and combative, nurse attempted to explain to resident that she was coming in to give him his meds, resident still being combative. Nurse put her hands up to protect herself from resident hitting her and left the room. Nurse re-approached resident outside of TV room with meds and resident took meds from nurse."

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F 842	Continued From page 19 At 4:30 p.m. on 12/18/18, during a meeting with the survey team, the Administrator said his expectation was that all incidents be documented in the resident EHR's. The Administrator went on to say that he told LPN # 2 to make an entry in Resident # 2's EHR regarding the 11/29/18 incident.	F 842		