DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/12/18 through 12/14/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Two complaints were investigated during the survey. .	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/12/18 through 12/14/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 101 certified bed facility was 91 at the time of the survey. The survey sample consisted of 19 current Resident reviews and 4 closed record reviews.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	**F550- Resident Rights/ Exercise of Rights** 1. Resident #5 interviewed on 1/17/2019 by Regional Director of Clinical Services (RDCS) with facility Social Service Director present. Resident feels safe at the facility and feels staff treat him with dignity and respect. 2. The RDCS and UMs completed quality reviews interviews of all current residents (cognitively impaired residents' representatives were contacted) to ensure residents are provided care in a respectful and dignified manner on 1/22/19 Follow up based on findings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mason Layne — TITLE: Executive Director — (X6) DATE: 1-24-19

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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review, and facility document review, the facility failed to ensure resident rights and dignity were met for 1 of 23 Residents in the survey sample, Resident #5. The findings included: The facility staff failed to ensure the safety and dignity of Resident #5 was maintained. Another resident's family member cornered Resident # 5 in his room, verbally threatened and belittled him	F 550	3. The RDCS provided the facility ED 1 to 1 re-education on the federal regulations and guidelines related to the resident's right to a dignified existence, self-determination and exercise of rights on 1/23/19. The DSS and or DDCS will provide re-education to the facility staff on the federal regulations and guidelines related to the Resident s Rights and the Resident's Exercise of their rights by 1/28/19. 4. DCS and or ADCS will conduct random resident and or their representative interviews 3 times per week for 4 weeks, then weekly for 3 months, to ensure residents are provided care in a dignified manner and their ability to exercise their rights is respected. Findings will be reviewed by QAPI committee monthly and Quality Monitoring updated as indicated. 5. Date of Compliance 1/28/2019.	

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F 550	Continued From page 2 and caused him to urinate on himself. Resident # 5 was a 40-year-old-male who was admitted to the facility on 4/20/18, with a readmission date of 8/27/18. Diagnoses included but were not limited to, hypertension, major depressive disorder, anxiety disorder, and benign prostatic hyperplasia. The clinical record for Resident # 5 was reviewed on 12/13/18 at 10:41 am. The most recent MDS (minimum data set) assessment for Resident # 5 was a quarterly assessment with an ARD (assessment reference date) of 9/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 5 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 15 was cognitively intact. The plan of care for Resident # 5 was reviewed and revised on 11/9/18. The facility staff documented a focus area for Resident # 5 as, "Resident # 5 is independent on staff for activities, cognitive stimulation, social interaction r/t (related to) anxiety, depression, PTSD (post traumatic stress disorder) limited mobility, quadriplegia, pain, participating in activities of choice, self acts in room such as TV (television), computer, phone, sitting on porch, parties, bingo, music, socializes with staff and residents. Resident # 5 goes by cab on community outings." Interventions included but were not limited to; "Report resident c/o (complaint of) pain, discomfort, breathing difficulties or any other c/o that interferes with the resident's ability to participate in activities to the nurse prn (as needed)." The surveyor reviewed the entire plan	F 550		

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F 550	Continued From page 3 of care for Resident # 5 and did not see an update that Resident # 5 made statements that are untrue. On 12/13/18 at 7:55 am, the surveyor was in Resident # 5's room conducting a Resident interview. During the interview Resident # 5 reported to the surveyor that on 12/8/18, the alleged perpetrator (his former roommate's sister) "Got in my face, yelled at me and blocked the bathroom and wouldn't let me use the bathroom." Resident # 5 stated that he was going back to his room to get hot chocolate for a group of Residents that he was socializing with and to use the bathroom because he is on a bladder-retraining program. Resident # 5 stated that when he got to his room, the alleged perpetrator asked him "What's going on with you and (Resident's name withheld)? Resident # 5 stated that he told the alleged perpetrator nothing was going on and that he did not know what she was talking about. Resident # 5 then stated that the alleged perpetrator got in his face and began to yell at him stating that Resident # 5's former roommate told the alleged perpetrator that Resident # 5 had been treating him differently and that Resident # 5 was going to tell her what was going on. Resident # 5 stated that he told the alleged perpetrator that he needed to use the bathroom. Resident # 5 stated that the alleged perpetrator stood in front of the bathroom door and told him he was not going to use the bathroom until she was done with him. Resident # 5 stated that he told the alleged perpetrator, "This is our room and you are a guest here." "You need to get out of here." Resident # 5 stated that the alleged perpetrator continued to block the door to the bathroom. Resident # 5 stated that he began to urinate on himself. Resident # 5 stated, "I felt	F 550		

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F 550	Continued From page 4 awful. I cried." Resident # 5 stated that the alleged perpetrator finally allowed him to go into the bathroom after he had urinated on himself and stated to him, "I am going to be right here when you get out because you are going to tell me what's going on with you and (Resident's name withheld). Resident # 5 stated that the alleged perpetrator continued to yell at him through the door while he was in the bathroom. Resident # 5 stated that he called the police. Resident # 5 stated that the police came and "She threw a fit." Resident # 5 stated that the police made her leave that evening but it would be up to "them" (the facility) if they bar her from the facility. Resident # 5 stated that later that same evening other family members of his former roommate came in and "intimidated" him. Resident # 5 stated that his former roommate's family members sat on the other side of the room saying mean things to him and stated, "If something happens to (Resident's name withheld) their asses is mine." Resident # 5 stated, "They made me feel like I was a piece of crap." Resident # 5 stated the next day "They came back in here like it was nothing." Resident # 5 stated that the day after the incident that the alleged perpetrator approached him as he was sitting at a square table in the hallway outside of their room and "jerked the table away from me." Resident # 5 stated that he asked a staff member why the alleged perpetrator was allowed to come back into the facility after what she did to him. Resident # 5 stated that he was told she has a right to visit her family member. Resident # 5 stated that he spoke with the facility executive director on Monday and the facility executive director told Resident # 5 they would move him to a different room. Resident # 5 stated that the facility executive director stated to him, "we got it	F 550		

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F 550	Continued From page 5 all handled." Resident # 5 stated that he replied, "It handles the room but it doesn't handle what she did to me." Resident # 5 stated that the facility executive director stated to him, "You let me handle that." "I got 2 days to investigate that." Resident # 5 then stated to the surveyor, "It does not make any sense how she treated me." "It made me feel like I was worthless, and they let her come back in here like it was nothing after the law put her out." "I thought with me being a patient here I would be protected more." The surveyor observed at this time that Resident # 5 became tearful. Resident # 5 stated, "What happens when she attacks somebody else?" Are you just going to put people in another room and say that settles that." On 12/13/18 at 9:58 am, the surveyor interviewed unit manager RN # 1 (registered nurse) about the allegations of abuse reported by Resident # 5. Unit manager RN # 1 stated, "I am aware briefly, I only know that the family was acting inappropriate and threatened him (Resident # 5) and the police were involved." On 12/13/18 at 10:00 am, the surveyor interviewed the facility executive director about the allegations of abuse reported by Resident # 5. The facility executive director stated, "I was called Saturday night saying the police had to come to the facility saying there was a yelling match with Resident # 5 and the alleged perpetrator." "We had the daughters (the alleged perpetrator and her sister) come in Monday and we spoke to them and Resident # 5." The facility executive director informed the surveyor that he was in the process of investigating the incident and that a FRI (facility reported incident) was submitted. The facility executive director then stated that	F 550		

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F 550	Continued From page 6 Resident # 5 had been known to lie and then come back and admit to lying and saying that he was sorry. The facility executive director also stated that the nurse that called him at home to report the incident had issues with the alleged perpetrator and her family and called him that night to report the incident. She asked if he was going to have them barred from the facility. The facility executive director stated, "I don't really have any evidence. "There were no eye witnesses." "I will be finishing this investigation by Monday but I can't see where any abuse occurred." On 12/13/18 at 10:15 am, the surveyor observed a progress note documented in the clinical record for Resident # 5 on 12/9/18 at 3:29 pm. The progress note was documented as "Resident is on medi part b total care with adls (activities of daily living) incontinent of bowel and bladder uses walker for ambulation upset due to incident with roommate family of them yelling and getting into his face refusing to let him use the bathroom police was called due to roommate family being nasty and inappropriate by yelling and getting in his face." On 12/13/18 at 10:28 am, the surveyor interviewed LPN # 1 (licensed practical nurse) about the allegation of abuse reported by Resident # 5. The surveyor asked LPN # 1 if she was working and responsible for providing care to Resident # 5 on 12/8/18. LPN # 1 stated, "Yes." The surveyor asked LPN # 1 if she was aware of an incident that occurred involving the alleged perpetrator and Resident # 5. LPN # 1 stated, "Yes." LPN # 1 stated that Resident # 5 was in the therapy room playing games with the other Residents. LPN # 1 stated that Resident # 5 was	F 550		

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F 550	Continued From page 7 coming out to go to the bathroom and get the hot chocolate from his room. LPN # 1 stated, as soon as Resident # 5 went in the room the alleged perpetrator started yelling at Resident # 5 and pinned him against the wall. LPN # 1 stated that she heard the alleged perpetrator state to Resident # 5, "You're not going to the bathroom. I'm not done with you." The surveyor asked LPN # 1 if she saw the alleged perpetrator pin Resident # 5 against the wall. LPN # 1 stated, "No but I heard it " LPN # 1 stated that she heard Resident # 5 tell the alleged perpetrator "I don't know what you are talking about." LPN # 1 stated that she heard the alleged perpetrator tell Resident # 5 again, "You can't use the bathroom until I am done with you." LPN # 1 stated that Resident # 5 came out into the hallway crying and asked her to call the police. LPN # 1 stated, "We called the police and they came and the alleged perpetrator was yelling at the police officer." LPN # 1 stated, "This was witnessed by Resident # 78's husband (Resident # 78 was not sampled) LPN # 1 stated that Resident # 78's husband stated to her, "This happens every night. Something needs to be done." LPN # 1 stated that the police had the alleged perpetrator leave after she made a scene with them. Surveyor asked LPN # 1 if she reported this information to anyone. LPN # 1 stated that she called the executive director at home to let him know what happened. LPN # 1 stated, "They never do anything about what we tell them. They don't want APS (adult protective services) to come in here." On 12/13/18 at 10:38 am, the surveyor reviewed the clinical record of the Resident #78 (not sampled) that LPN # 1 reported her husband witnessed the events. The surveyor observed	F 550		

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F 550	Continued From page 8	F 550		

documentation in the progress notes documented on 12/8/18 at 10:28 pm. The progress note was documented as "Resident family member was being talked to nasty by (room number withheld) family and was told this is the worst facility and his wife will not be taken care of because we are the worst and miss treat the residents and son to sister was very rude to staff and resident family to where he felt uneasy and there comments bothered him and he could not make a statement to staff after incident because he was being bullied by family he change his statement to loud commasion (commotion) after he told police she was yelling at roommate and in his face and this happened every night to not wanting to say nothing felt very uneasy."

On 12/13/18 at 3:08 pm, the surveyor interviewed CNA # 2 (certified nursing assistant). The surveyor asked CNA # 2 if she worked on the evening of 12/8/18 and if she was responsible for providing care to Resident # 5. CNA # 2 stated that she was on duty and responsible for providing care to Resident # 5 on 12/8/18. CNA# 2 stated, "Resident # 5 went into his room and within seconds, you heard all this yelling." CNA # 2 stated that she heard the alleged perpetrator state," You are not going to the bathroom until I am through with you." CNA # 2 stated, "I heard all this yelling and I told LPN #1 something is going on down there." CNA # 2 stated that Resident # 5 came down the hallway and said he wanted to call the police. CNA # 2 stated that Resident # 5 stated that the alleged perpetrator wouldn't let him use the bathroom. The surveyor asked CNA if Resident # 5 was incontinent at this time. CNA # 2 stated that Resident # 5 was incontinent. CNA # 2 also stated Resident # 5 was crying and upset. CNA # 2 stated that

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F 550	Continued From page 9 Resident # 5 had been working really hard trying bladder training because he wants to go home. CNA # 2 stated that another resident's husband was outside the room and heard the commotion and stated that she heard the alleged perpetrator tell Resident # 78's husband "If you say anything they will treat your wife bad." CNA # 2 stated, "I told the facility executive director what happened on Monday and he stated that he was investigating the issue." On 12/13/18 at 5:45 pm, the surveyor spoke with the facility executive director in the presence of the survey team and the facility administrative staff. The surveyor asked the facility executive director if he stated to her in an earlier conversation that he planned on closing the investigation on Monday and that he did not see where any abuse occurred. The facility executive director agreed to making that statement in the presence of the survey team. The surveyor asked the facility executive director to provide what evidence he had collected thus far in the investigation. On 12/13/18 at 6:03 pm, the facility executive director provided the surveyor with 4 pages of handwritten notes that were photocopied from a notepad. The notes were documented as follows: "12/10/18 Alleged perpetrator- she said the police escorted her out of the building. Resident # 5 came in the room. The alleged perpetrator asked if anything happened between (Resident's name withheld) and Resident # 5. Resident # 5 she very loud. This is my home you are not going to go around this place and talk about me. She wants to know who initiated the police call and why, what started it. LPN # 1 asked (Resident # 78	F 550		

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F 550	Continued From page 10 husband's name withheld) to write a statement. 12/10/18 Resident # 5- Resident # 5 went into the room alleged perpetrator waiting on him. Alleged perpetrator ask is there something wrong between you and (Resident name withheld) Resident # 5 said nothing. Alleged perpetrator-I want to know why you stopped paying attention to (Resident name withheld). You are not playing games with (Resident name withheld) Resident # 5-It's because the way your mom and (Resident name withheld) have been treating me and I am not (Resident name withheld) caregiver. Alleged perpetrator-Oh no you are not going to treat (resident name withheld) this way. Resident # 5 I am not doing anything to (Resident name withheld) Get out of the way I've got to go to the bathroom. Alleged perpetrator stepped in front of me and said you are going to talk to me. Resident # 5 move, I have got to use the bathroom. Alleged perpetrator you can wait a minute. Resident # 5 this is our room you need to get out of here you are just a guest. Alleged perpetrator-Oh know this is (Resident name withheld) room, he was here before you and he will be here after you. Resident # 5-he started urinating on himself and said get out of my way I have to use the bathroom. Alleged perpetrator -Go head but I will be out here waiting and you are going to talk to me she stepped out of the way from blocking the bathroom. Resident # 5 was in the bathroom he heard her telling (Resident name withheld) He is going to talk to me. Resident waited in the bathroom a long time he heard her say she was going to get his food. Resident # 5 came out of the bathroom when she left. Resident # 5 heard her say I am leaving but when I get back he is going to deal with me. Resident # 5 called the police. He went to the family room until they got	F 550		

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	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 550	Continued From page 11	F 550		

here. Resident # 5 said he felt she attacked him and it is not right.

12/10/18 Call (Resident husband's name withheld) per facility executive director Called at 4:14 pm (Telephone number withheld) Nurse asked him about that he said he was one door out in the hall, he didn't see or hear anything if something went on it was in the room. Why happened? We are trying to investigate if something happened. He saw police.

12/10/18 Resident # 5- meeting with facility executive director and Resident # 5. Resident # 5 wants alleged perpetrator not to be able to come back in the building. The facility executive director offered Resident # 5 to move to room (room number withheld) until another semi-private room comes available. Resident # 5 agreed. But said he does not want alleged perpetrator to come back into the building.

The surveyor observed that there were no statements from LPN # 1 or CNA # 2 who both stated that they spoke with the facility executive director regarding the allegation of abuse reported by Resident # 5.

On 12/13/18 at 6:10 pm, the surveyor reviewed the visitor log kept in the front of the building. The surveyor observed that no visitors had signed the visitor log on 12/13/18.

On 12/13/18 at 6:15 pm, 2 surveyors toured the 600 hall and 700 hall of the facility. The two surveyors observed that Resident # 5 was in his room in the bathroom. The two surveyors also observed the alleged perpetrator, her mother, and grandson visiting with their loved one in the

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F 550	Continued From page 12 hallway outside of the resident's room. They were observed sitting at a square table that was outside of the resident's room playing a game. In the room directly beside where the alleged perpetrator was observed, the 2 surveyors observed a resident and a visitor sitting in the hallway. The visitor was identified as Resident # 78's husband that facility staff stated was bullied by the alleged perpetrator. On 12/14/18 at 8:36 am, the surveyor interviewed Resident # 5 again about his allegations of abuse. The surveyor asked Resident # 5 if he had any contact with the alleged perpetrator after the incident that occurred on 12/8/18. Resident # 5 stated, "That happened on Saturday night and they came back in here Sunday and she jerked the table from underneath me." Resident # 5 stated, "I went and talked to unit manager RN # 1 (registered nurse) and told her I couldn't believe she was in here after what she did to me, and she said it's his family they can come visit." Resident # 5 stated, "I have the right to be protected." The surveyor asked Resident # 5 if he has had any contact with the alleged perpetrator since he was moved to his new room. Resident # 5 stated, "No to be honest I have stayed in my room except for meals and therapy." The surveyor asked Resident # 5 if staying in his room is something that he normally does. Resident # 5 stated, "No." The surveyor asked Resident # 5 why he was staying in his room if this is not something he normally does. Resident # 5 stated, "I don't want to run into them." On 12/14/18 at 9:02 am, the surveyor interviewed the facility social services manager. The surveyor asked the facility social services manager if she was aware of the allegations of abuse reported by	F 550		

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F 550	Continued From page 13 Resident # 5. The facility social services manager stated, "Yes I found out Monday." The facility social services manager stated that the alleged perpetrator called her on Monday morning and that is how she found out about the incident. The surveyor asked the facility social services manager what the alleged perpetrator reported to her. The facility social services manager stated that the alleged perpetrator stated that the police were called for her on Saturday and she was escorted out of the building. The facility social service manager stated that the alleged perpetrator told her that she asked Resident # 5 what happened between him and (Resident's name withheld) and the alleged perpetrator stated that Resident # 5 started talking loudly and that Resident # 5 attacked her verbally said that she didn't know what happened. The facility social services manager stated that during her telephone call with the alleged perpetrator, the alleged perpetrator stated that her brother (Resident's name withheld) told her that for the past two weeks Resident # 5 has been treating him differently. The surveyor asked the facility social services manager if talking loudly and verbally attacking someone is a behavior that Resident # 5 would normally display. The facility social services manager stated, "No he would not." "Resident # 5 is usually very soft spoken." The surveyor asked the facility social services manager if she interviewed LPN # 1. The facility social services manager stated, "I think she wrote a statement." The surveyor asked the facility social services manager if she interviewed Resident # 78's husband that the facility staff members reported witnessed the incident. The facility social services manager stated, "I called (Resident # 78 husband's name withheld) and he said he didn't hear anything and didn't see	F 550		

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PHEASANT RIDGE NURSING & REHAB CENTER	4365 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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F 550	Continued From page 14 anything." The surveyor asked the facility social services manager if she interviewed Resident # 5. The facility social services manager stated that she and the facility executive director met with Resident # 5 on Monday and wanted to make sure he felt safe. The facility social services manager stated that Resident # 5 was moved to a different room on Monday following the incident that had occurred on the previous Saturday. The facility social services manager stated that Resident # 5 said that he didn't want the alleged perpetrator to come back and the facility executive director said we had to complete the investigation. On 12/14/18 at 9:23 am, the surveyor interviewed the unit manager RN # 1. The surveyor asked the unit manager RN # 1 if she had a conversation with Resident # 5 where he expressed concerns about the alleged perpetrator being allowed back into the building. Unit manager RN # 1 stated that she did speak with Resident # 5 and he asked why was the alleged perpetrator still being allowed in the building after what she did to him. Unit manager RN # 1 stated that she told Resident # 5 that the facility executive director was aware and investigating the situation but she could not tell the alleged perpetrator that she could not visit her loved one. Unit manager RN # 1 told the surveyor that the facility did 15-minute safety checks on Resident # 5 to ensure he was safe. The surveyor requested a copy of the safety checks. On 12/14/18 at 9:39 am, the surveyor interviewed the director of clinical services regarding the allegation of abuse reported by Resident # 5 on 12/8/18. The director of nursing stated, "It happened on the weekend. I didn't do any of the	F 550		

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F 550	Continued From page 15 interviews." The director of clinical services stated that the facility executive director and the facility social services manager did the interviews. The surveyor asked the director of clinical services if she was aware that Resident # 5 reported abuse. The director of clinical services stated, "Of course his perception is his perception." The surveyor asked the director of clinical services how long does the facility have to report suspected abuse. The director of clinical services stated, "2 hours typically." The surveyor asked the director of clinical services what is the procedure for suspected resident to resident abuse. The director of clinical services stated they are automatically separated and if needed we can do one to one. The surveyor asked the director of clinical services what was the procedure to staff to resident abuse. The director of clinical services stated that the employee is suspended pending investigation. The surveyor asked the director of clinical services what was the procedure for allegations of visitor to resident abuse. The director of clinical services stated we ask them to leave the facility until the investigation is complete. The surveyor asked the director of clinical services why the alleged perpetrator was allowed to return to the facility if the investigation into Resident # 5's allegation of abuse had not been completed. The director of clinical services stated, "There's a fine line when telling them they can't visit their loved one. They haven't had contact." The director of clinical services stated, "I wish I could give you more information but the investigation is not complete." On 12/14/18 at 11:05 am, the surveyor interviewed the facility executive director in the presence of the survey team. The surveyor asked the facility executive director what the procedure	F 550		

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F 550	Continued From page 16 was for allegations of resident to resident abuse. The facility executive director stated, "Separate and investigate." The surveyor asked the facility executive director what the procedure was for allegations of staff to resident abuse. The facility executive director stated that the employee was to be suspended pending investigation. The surveyor asked the facility executive director what was the procedure for allegations of visitor to resident abuse. The facility executive director stated, that a facility reported incident would be submitted, the incident would be investigated, and the visitor would be asked to stay away until the investigation is complete. The surveyor asked the facility executive director why the family was not asked to stay away during the investigation of the allegation of abuse reported by Resident # 5. The facility executive director stated, "Or they meet with me and the director of nursing and we determine if they can come back. I met with the family on Monday and with Resident # 5's history of 3 or 4 occasions that he has lied, the residents were separated and Resident # 5 was moved to another room. I decided that the alleged perpetrator could return to the building." The surveyor asked the facility executive director how he could make that determination when the investigation had not been completed. The facility executive director stated, "I don't think it happened. Resident # 5 tells lies. In the past he has made accusations and said this happened and he comes back 3 or 4 days later and says he is sorry. I am more concerned with this nurse LPN # 1, I think she put Resident # 5 up to calling the police. It's a lot of drama involved in this with CNA # 2 and LPN # 1. They have issues with the family. My issue is more with LPN # 1 and I will deal with her after this is over." The surveyor asked the facility executive director if he	F 550		

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F 550	Continued From page 17 interviewed CNA # 2. The facility executive director stated that he did not. The facility executive director stated that the facility social services manager interviewed CNA # 2. On 12/14/18 at 11:20 am, unit manager RN # 1 provided the surveyor with a copy of the "Resident Safety Check" log for Resident # 5. The surveyor observed that the facility staff did not begin documenting resident safety checks for Resident # 5 until 12/12/18 at 7:00 am which was 4 days after the initial allegation of abuse that was reported by Resident # 5, and 2 days after he was transferred into a different room. The surveyor observed that the facility staff did not document 15 minute safety checks for Resident # 5 from 11:00 pm on 12/12/18 through 7:00 am on 12/13/18. There were no documented safety checks from 11:00 pm on 12/13/18 through 7:00 am on 12/14/18. Also there were no documented checks on 12/14/18 at 11:00 am and 11:15 am. On 12/14/18 at 11:47 am, two surveyors met with the facility executive director per his request. The facility executive director stated, "I felt bad about how I came across about not believing him. We always believe him. It may turn out that it's true. I wouldn't have done anything differently. We separated them. We met with the family." The surveyor stated to the facility executive director that the alleged perpetrator returned to the building on Sunday and Resident # 5 stated that she jerked the table from under him. The facility executive director stated, "No she wasn't, I was here all day and no one came in. I drove staff back and forth to the hotel." The surveyor asked the facility executive director if he knows for a fact that the alleged perpetrator did not enter the building because on 12/13/18 after viewing the	F 550		

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F 550	Continued From page 18 visitor sign in log and seeing that no one had signed in as a visitor, 2 surveyors toured the facility saw the alleged perpetrator along with her mother and grandson visiting with their loved one in the hallway at the same table that Resident # 5 said the alleged perpetrator jerked from underneath him. The facility executive director did not respond. The surveyor informed the facility executive director that Resident # 5 became tearful during the interview when he reported what happened. The surveyor told the facility executive director that Resident # 5 had been working on his toileting and stated that the alleged perpetrator yelled at him and prevented him from using the bathroom causing him to urinate on himself. The facility executive director stated, "She says she sat on the bed talking to him." The surveyor stated to the facility executive director that he stated that Resident # 5 tells lies but the facility is still obligated to protect him. The surveyor informed that facility executive director that Resident # 5 stated that he isn't coming out of his room like he normally does and is only coming out for meals because he does not want to run into the alleged perpetrator and this is not a normal behavior for Resident # 5. The facility executive director stated, "I don't know what the solution is. (Resident name withheld) has been in that room forever and he doesn't want to move. They fought for years to get him back to that unit." The surveyor told the facility executive director that she was unable to advise him on what to do but he has an obligation to protect Resident # 5 and all residents. The facility policy on "Abuse, Neglect, Exploitation & Misappropriation" contained documentation that included but was not limited to: ..."Mental and verbal abuse include but are not	F 550		

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limited to:
Harassing a resident
Mocking, insulting, ridiculing
Yelling or hovering over a resident, with intent to intimidate
Threatening residents, depriving a resident of care or withholding a resident from contact with family and friends
Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to:

Failure to take precautionary measures to protect the health and safety of the resident

Procedure Acts of abuse directed against residents are absolutely prohibited. Such acts are cause for disciplinary action, including dismissal and possible prosecution. Questions may arise as to what actions constitute abuse of a resident. Any action that may cause or causes actual physical psychological or emotional harm, which is not caused by simple negligence, constitutes abuse. Actions such as striking a resident, restraining a resident improperly or without authorization, and other such acts which can be seen as causing physical pain to a resident are strictly forbidden. Acts such as teasing, humiliating, degrading, or intentionally ignoring a resident may constitute abuse and will be dealt with no less severely than acts causing physical harm. Non-action, which results in emotional, psychological, or physical injury in the same manner as that caused by improper or excessive action. All actions in which employees engage with residents must have as their legitimate goal, the healthful, proper, and humane care and

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F 550	Continued From page 20 treatment of the resident. Furthermore, the Administration of the company recognizes that resident abuse can be committed by other residents, visitors, or volunteers. Employee Obligation All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no 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 or do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated abuse coordinator. An employee shall be deemed to have violated his obligations in paragraph "1A" (above) if he does any of the following: Harasses or otherwise retaliates against any resident, employee, or other person who discloses information or participates in an investigation of an act of resident abuse. 5. Investigation The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A social Service representative may be offered in the role of resident advocate during any	F 550		

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F 550	Continued From page 21 questioning of or interviewing of residents. Investigations will be accomplished in the following manner. Immediately upon the allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation resident of the allegation. Protection Increased supervision of the alleged victim and residents." ... On 12/14/18 at 2:02 pm, the administrative team was made aware of the findings as stated above. No further information regarding this incident was provided to the survey team prior to the exit conference on 12/14/18.	F 550		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600	**F600- Free from Abuse and Neglect** 1. Residents #5 & 89 were interviewed on 1/17/2019 by Regional Director of Clinical Services (RDCS) with facility DSS present. Residents #5 & #89 feel safe at the facility and feel that staff treat them with dignity and respect. 2. The RDCS and UMs completed quality reviews interviews of all current residents (cognitively impaired residents' representatives were contacted) to ensure residents are provided care in a respectful and dignified manner on 1/22/19 Follow up based on findings.	

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PHEASANT RIDGE NURSING & REHAB CENTER	4358 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(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 600	Continued From page 22 Based on staff interview, resident interview, facility document review and clinical record review, the facility staff failed to ensure 2 of 23 residents were free from abuse and neglect, Resident #5 and Resident # 89. The findings included: 1. The facility staff failed to ensure that Resident # 5 was free from abuse as evidenced by another resident's family member cornered Resident # 5 in his room, verbally threatened and belittled him and caused him to urinate on himself. Resident # 5 was a 40-year-old-male who was admitted to the facility on 4/20/18, with a readmission date of 8/27/18. Diagnoses included but were not limited to, hypertension, major depressive disorder, anxiety disorder, and benign prostatic hyperplasia. The clinical record for Resident # 5 was reviewed on 12/13/18 at 10:41 am. The most recent MDS (minimum data set) assessment for Resident # 5 was a quarterly assessment with an ARD (assessment reference date) of 9/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 5 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 15 was cognitively intact. The plan of care for Resident # 5 was reviewed and revised on 11/9/18. The facility staff documented a focus area for Resident # 5 as, "Resident # 5 is independent on staff for activities, cognitive stimulation, social interaction r/t (related to) anxiety, depression, PTSD (post	F 600	3. The DCS, ADCS, RDCS and UMs will re-educate facility staff on federal regulations and guidelines for Freedom from Abuse, Neglect, and Exploitation by 1/28/19. 4. DCS and or ADCS will conduct random resident and or their representative interviews 3 times per week for 4 weeks, then weekly for 3 months, to ensure residents are provided care in a dignified manner and their ability to exercise their rights is respected. Findings will be reviewed by QAPI committee monthly and Quality Monitoring updated as indicated. 5. Date of Compliance 1/28/2019.	

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F 600	Continued From page 23 traumatic stress disorder) limited mobility, quadriplegia, pain, participating in activities of choice, self acts in room such as TV (television), computer, phone, sitting on porch, parties, bingo. music, socializes with staff and residents. Resident # 5 goes by cab on community outings." Interventions included but were not limited to; "Report resident c/o (complaint of) pain, discomfort, breathing difficulties or any other c/o that interferes with the resident's ability to participate in activities to the nurse prn (as needed)." The surveyor reviewed the entire plan of care for Resident # 5 and did not see an update that Resident # 5 made statements that are untrue. On 12/13/18 at 7:55 am, the surveyor was in Resident # 5's room conducting a Resident interview. During the interview Resident # 5 reported to the surveyor that on 12/8/18, the alleged perpetrator (his former roommate's sister) "Got in my face, yelled at me and blocked the bathroom and wouldn't let me use the bathroom." Resident # 5 stated that he was going back to his room to get hot chocolate for a group of Residents that he was socializing with and to use the bathroom because he is on a bladder-retraining program. Resident # 5 stated that when he got to his room, the alleged perpetrator asked him "What's going on with you and (Resident's name withheld)? Resident # 5 stated that he told the alleged perpetrator nothing was going on and that he did not know what she was talking about. Resident # 5 then stated that the alleged perpetrator got in his face and began to yell at him stating that Resident # 5's former roommate told the alleged perpetrator that Resident # 5 had been treating him differently and that Resident # 5 was going to tell her what was	F 600		

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F 600	Continued From page 24	F 600		

going on. Resident # 5 stated that he told the alleged perpetrator that he needed to use the bathroom. Resident # 5 stated that the alleged perpetrator stood in front of the bathroom door and told him he was not going to use the bathroom until she was done with him. Resident # 5 stated that he told the alleged perpetrator, "This is our room and you are a guest here. You need to get out of here." Resident # 5 stated that the alleged perpetrator continued to block the door to the bathroom. Resident # 5 stated that he began to urinate on himself. Resident # 5 stated, "I felt awful, I cried." Resident # 5 stated that the alleged perpetrator finally allowed him to go into the bathroom after he had urinated on himself and stated to him, "I am going to be right here when you get out because you are going to tell me what's going on with you and (Resident's name withheld). Resident # 5 stated that the alleged perpetrator continued to yell at him through the door while he was in the bathroom. Resident # 5 stated that he called the police. Resident # 5 stated that the police came and "She threw a fit." Resident # 5 stated that the police made her leave that evening but it would be up to "them" (the facility) if they bar her from the facility. Resident # 5 stated that later that same evening other family members of his former roommate came in and "intimidated" him. Resident # 5 stated that his former roommate's family members sat on the other side of the room saying mean things to him and stated, "If something happens to (Resident's name withheld) their asses is mine." Resident # 5 stated, "They made me feel like I was a piece of crap." Resident # 5 stated the next day "They came back in here like it was nothing." Resident # 5 stated that the day after the incident that the alleged perpetrator approached him as he was

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F 600	Continued From page 25	F 600		

sitting at a square table in the hallway outside of their room and "jerked the table away from me." Resident # 5 stated that he asked a staff member why the alleged perpetrator was allowed to come back into the facility after what she did to him. Resident # 5 stated that he was told she has a right to visit her family member. Resident # 5 stated that he spoke with the facility executive director on Monday and the facility executive director told Resident # 5 they would move him to a different room. Resident # 5 stated that the facility executive director stated to him, "we got it all handled." Resident # 5 stated that he replied, "It handles the room but it doesn't handle what she did to me." Resident # 5 stated that the facility executive director stated to him, "You let me handle that." "I got 2 days to investigate that." Resident # 5 then stated to the surveyor, "It does not make any sense how she treated me. It made me feel like I was worthless, and they let her come back in here like it was nothing after the law put her out. I thought with me being a patient here I would be protected more." The surveyor observed at this time that Resident # 5 became tearful. Resident # 5 stated, "What happens when she attacks somebody else?" Are you just going to put people in another room and say that settles that."

On 12/13/18 at 9:58 am, the surveyor interviewed unit manager RN # 1 (registered nurse) about the allegations of abuse reported by Resident # 5. Unit manager RN # 1 stated, "I am aware briefly, I only know that the family was acting inappropriate and threatened him (Resident # 5) and the police were involved."

On 12/13/18 at 10:00 am, the surveyor interviewed the facility executive director about

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the allegations of abuse reported by Resident # 5. The facility executive director stated, "I was called Saturday night saying the police had to come to the facility saying there was a yelling match with Resident # 5 and the alleged perpetrator." "We had the daughters (the alleged perpetrator and her sister) come in Monday and we spoke to them and Resident # 5." The facility executive director informed the surveyor that he was in the process of investigating the incident and that a FRI (facility reported incident) was submitted. The facility executive director then stated that Resident # 5 had been known to lie and then come back and admit to lying and saying that he was sorry. The facility executive director also stated that the nurse that called him at home to report the incident had issues with the alleged perpetrator and her family and called him that night to report the incident. She asked if he was going to have them barred from the facility. The facility executive director stated, "I don't really have any evidence. There were no eye witnesses. I will be finishing this investigation by Monday but I can't see where any abuse occurred."

On 12/13/18 at 10:15 am, the surveyor observed a progress note documented in the clinical record for Resident # 5 on 12/9/18 at 3:29 pm. The progress note was documented as "Resident is on medi part b total care with adls (activities of daily living) incontinent of bowel and bladder uses walker for ambulation upset due to incident with roommate family of them yelling and getting into his face refusing to let him use the bathroom police was called due to roommate family being nasty and inappropriate by yelling and getting in his face."

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F 600	Continued From page 27 On 12/13/18 at 10:28 am, the surveyor interviewed LPN # 1 (licensed practical nurse) about the allegation of abuse reported by Resident # 5. The surveyor asked LPN # 1 if she was working and responsible for providing care to Resident # 5 on 12/8/18. LPN # 1 stated, "Yes." The surveyor asked LPN # 1 if she was aware of an incident that occurred involving the alleged perpetrator and Resident # 5. LPN # 1 stated, "Yes." LPN # 1 stated that Resident # 5 was in the therapy room playing games with the other Residents. LPN # 1 stated that Resident # 5 was coming out to go to the bathroom and get the hot chocolate from his room. LPN # 1 stated, as soon as Resident # 5 went in the room the alleged perpetrator started yelling at Resident # 5 and pinned him against the wall. LPN # 1 stated that she heard the alleged perpetrator state to Resident # 5, "You're not going to the bathroom." "I'm not done with you." The surveyor asked LPN # 1 if she saw the alleged perpetrator pin Resident # 5 against the wall. LPN # 1 stated, "No but I heard it." LPN # 1 stated that she heard Resident # 5 tell the alleged perpetrator "I don't know what you are talking about." LPN # 1 stated that she heard the alleged perpetrator tell Resident # 5 again, "You can't use the bathroom until I am done with you." LPN # 1 stated that Resident # 5 came out into the hallway crying and asked her to call the police. LPN # 1 stated, "We called the police and they came and the alleged perpetrator was yelling at the police officer." LPN # 1 stated, "This was witnessed by Resident # 78's husband (Resident # 78 was not sampled) LPN # 1 stated that Resident # 78's husband stated to her, "This happens every night." "Something needs to be done." LPN # 1 stated that the police had the alleged perpetrator leave after she made a scene with them. Surveyor	F 600		

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F 600	Continued From page 28	F 600		

asked LPN # 1 if she reported this information to anyone. LPN # 1 stated that she called the executive director at home to let him know what happened. LPN # 1 stated, "They never do anything about what we tell them. They don't want APS (adult protective services) to come in here."

On 12/13/18 at 10:38 am, the surveyor reviewed the clinical record of the Resident #78 (not sampled) that LPN # 1 reported her husband witnessed the events. The surveyor observed documentation in the progress notes documented on 12/8/18 at 10:28 pm. The progress note was documented as "Resident family member was being talked to nasty by (room number withheld) family and was told this is the worst facility and his wife will not be taken care of because we are the worst and miss treat the residents and son to sister was very rude to staff and resident family to where he felt uneasy and there comments bothered him and he could not make a statement to staff after incident because he was being bullied by family he change his statement to loud commasion (commotion) after he told police she was yelling at roommate and in his face and this happened every night to not wanting to say nothing felt very uneasy.

On 12/13/18 at 3:08 pm, the surveyor interviewed CNA # 2 (certified nursing assistant) The surveyor asked CNA # 2 if she worked on the evening of 12/8/18 and if she was responsible for providing care to Resident # 5. CNA # 2 stated that she was on duty and responsible for providing care to Resident # 5 on 12/8/18. CNA# 2 stated, "Resident # 5 went into his room and within seconds, you heard all this yelling." CNA # 2 stated that she heard the alleged perpetrator

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state," You are not going to the bathroom until I am through with you." CNA # 2 stated, "I heard all this yelling and I told LPN #1 something is going on down there." CNA # 2 stated that Resident # 5 came down the hallway and said he wanted to call the police. CNA # 2 stated that Resident # 5 stated that the alleged perpetrator wouldn't let him use the bathroom. The surveyor asked CNA if Resident # 5 was incontinent at this time. CNA # 2 stated that Resident # 5 was incontinent. CNA # 2 also stated Resident # 5 was crying and upset. CNA # 2 stated that Resident # 5 had been working really hard trying bladder training because he wants to go home. CNA # 2 stated that another resident's husband was outside the room and heard the commotion and stated that she heard the alleged perpetrator tell Resident # 78's husband "If you say anything they will treat your wife bad." CNA # 2 stated, "I told the facility executive director what happened on Monday and he stated that he was investigating the issue."

On 12/13/18 at 5:45 pm, the surveyor spoke with the facility executive director in the presence of the survey team and the facility administrative staff. The surveyor asked the facility executive director if he stated to her in an earlier conversation that he planned on closing the investigation on Monday and that he did not see where any abuse occurred. The facility executive director agreed to making that statement in the presence of the survey team. The surveyor asked the facility executive director to provide what evidence he had collected thus far in the investigation.

On 12/13/18 at 6:03 pm, the facility executive director provided the surveyor with 4 pages of

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F 600	Continued From page 30 handwritten notes that were photocopied from a notepad. The notes were documented as follows: "12/10/18 Alleged perpetrator- she said the police escorted her out of the building. Resident # 5 came in the room. The alleged perpetrator asked if anything happened between (Resident's name withheld) and Resident # 5. Resident # 5 she very loud. This is my home you are not going to go around this place and talk about me. She wants to know who initiated the police call and why, what started it. LPN # 1 asked (Resident # 78 husband's name withheld) to write a statement. 12/10/18 Resident # 5- Resident # 5 went into the room alleged perpetrator waiting on him. Alleged perpetrator ask is there something wrong between you and (Resident name withheld) Resident # 5 said nothing. Alleged perpetrator-I want to know why you stopped paying attention to (Resident name withheld). You are not playing games with (Resident name withheld) Resident # 5-It's because the way your mom and (Resident name withheld) have been treating me and I am not (Resident name withheld) caregiver. Alleged perpetrator-Oh no you are not going to treat (resident name withheld) this way. Resident # 5 I am not doing anything to (Resident name withheld) Get out of the way I've got to go to the bathroom. Alleged perpetrator stepped in front of me and said you are going to talk to me. Resident # 5 move, I have got to use the bathroom. Alleged perpetrator you can wait a minute. Resident # 5 this is our room you need to get out of here you are just a guest. Alleged perpetrator-Oh know this is (Resident name withheld) room, he was here before you and he will be here after you. Resident # 5-he started urinating on himself and said get out of my way I have to use the	F 600		

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F 600	Continued From page 31 bathroom. Alleged perpetrator -Go head but I will be out here waiting and you are going to talk to me she stepped out of the way from blocking the bathroom. Resident # 5 was in the bathroom he heard her telling (Resident name withheld) He is going to talk to me. Resident waited in the bathroom a long time he heard her say she was going to get his food. Resident # 5 came out of the bathroom when she left. Resident # 5 heard her say I am leaving but when I get back he is going to deal with me. Resident # 5 called the police. He went to the family room until they got here. Resident # 5 said he felt she attacked him and it is not right. 12/10/18 Call (Resident husband's name withheld) per facility executive director. Called at 4:14 pm (Telephone number withheld) Nurse asked him about that he said he was one door out in the hall, he didn't see or hear anything if something went on it was in the room. Why happened? We are trying to investigate if something happened. He saw police. 12/10/18 Resident # 5- meeting with facility executive director and Resident # 5. Resident # 5 wants alleged perpetrator not to be able to come back in the building. The facility executive director offered Resident # 5 to move to room (room number withheld) until another semi-private room comes available. Resident # 5 agreed. But said he does not want alleged perpetrator to come back into the building." The surveyor observed that there were no statements from LPN # 1 or CNA # 2 who both stated that they spoke with the facility executive director regarding the allegation of abuse reported by Resident # 5.	F 600		

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F 600	Continued From page 32 On 12/13/18 at 6:10 pm, the surveyor reviewed the visitor log kept in the front of the building. The surveyor observed that no visitors had signed the visitor log on 12/13/18. On 12/13/18 at 6:15 pm, 2 surveyors toured the 600 hall and 700 hall of the facility. The two surveyors observed that Resident # 5 was in his room in the bathroom. The two surveyors also observed the alleged perpetrator, her mother, and grandson visiting with their loved one in the hallway outside of the resident's room. They were observed sitting at a square table that was outside of the resident's room playing a game. In the room directly beside where the alleged perpetrator was observed, the 2 surveyors observed a resident and a visitor sitting in the hallway. The visitor was identified as Resident # 78's husband that facility staff stated was bullied by the alleged perpetrator. On 12/14/18 at 8:36 am, the surveyor interviewed Resident # 5 again about his allegations of abuse. The surveyor asked Resident # 5 if he had any contact with the alleged perpetrator after the incident that occurred on 12/8/18. Resident # 5 stated, "That happened on Saturday night and they came back in here Sunday and she jerked the table from underneath me." Resident # 5 stated, "I went and talked to unit manager RN # 1 (registered nurse) and told her I couldn't believe she was in here after what she did to me, and she said it's his family they can come visit." Resident # 5 stated, "I have the right to be protected." The surveyor asked Resident # 5 if he has had any contact with the alleged perpetrator since he was moved to his new room. Resident # 5 stated, "No to be honest I have stayed in my room except for	F 600		

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F 600	Continued From page 33 meals and therapy." The surveyor asked Resident # 5 if staying in his room is something that he normally does. Resident # 5 stated, "No." The surveyor asked Resident # 5 why he was staying in his room if this is not something he normally does. Resident # 5 stated, "I don't want to run into them." On 12/14/18 at 9:02 am, the surveyor interviewed the facility social services manager. The surveyor asked the facility social services manager if she was aware of the allegations of abuse reported by Resident # 5. The facility social services manager stated, "Yes I found out Monday." The facility social services manager stated that the alleged perpetrator called her on Monday morning and that is how she found out about the incident. The surveyor asked the facility social services manager what the alleged perpetrator reported to her. The facility social services manager stated that the alleged perpetrator stated that the police were called for her on Saturday and she was escorted out of the building. The facility social service manager stated that the alleged perpetrator told her that she asked Resident # 5 what happened between him and (Resident's name withheld) and the alleged perpetrator stated that Resident # 5 started talking loudly and that Resident # 5 attacked her verbally said that she didn't know what happened. The facility social services manager stated that during her telephone call with the alleged perpetrator, the alleged perpetrator stated that her brother (Resident's name withheld) told her that for the past two weeks Resident # 5 has been treating him differently. The surveyor asked the facility social services manager if talking loudly and verbally attacking someone is a behavior that Resident # 5 would normally display. The facility	F 600		

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F 600	Continued From page 34	F 600		

social services manager stated, "No he would not. Resident # 5 is usually very soft spoken." The surveyor asked the facility social services manager if she interviewed LPN # 1. The facility social services manager stated, "I think she wrote a statement." The surveyor asked the facility social services manager if she interviewed Resident # 78's husband that the facility staff members reported witnessed the incident. The facility social services manager stated, "I called (Resident # 78 husband's name withheld) and he said he didn't hear anything and didn't see anything." The surveyor asked the facility social services manager if she interviewed Resident # 5. The facility social services manager stated that she and the facility executive director met with Resident # 5 on Monday and wanted to make sure he felt safe. The facility social services manager stated that Resident # 5 was moved to a different room on Monday following the incident that had occurred on the previous Saturday. The facility social services manager stated that Resident # 5 said that he didn't want the alleged perpetrator to come back and the facility executive director said we had to complete the investigation.

On 12/14/18 at 9:23 am, the surveyor interviewed the unit manager RN # 1. The surveyor asked the unit manager RN # 1 if she had a conversation with Resident # 5 where he expressed concerns about the alleged perpetrator being allowed back into the building. Unit manager RN # 1 stated that she did speak with Resident # 5 and he asked why was the alleged perpetrator still being allowed in the building after what she did to him. Unit manager RN # 1 stated that she told Resident # 5 that the facility executive director was aware and investigating the situation but she

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F 600	Continued From page 35 could not tell the alleged perpetrator that she could not visit her loved one. Unit manager RN # 1 told the surveyor that the facility did 15-minute safety checks on Resident # 5 to ensure he was safe. The surveyor requested a copy of the safety checks. On 12/14/18 at 9:39 am, the surveyor interviewed the director of clinical services regarding the allegation of abuse reported by Resident # 5 on 12/8/18. The director of nursing stated, "It happened on the weekend." "I didn't do any of the interviews." The director of clinical services stated that the facility executive director and the facility social services manager did the interviews. The surveyor asked the director of clinical services if she was aware that Resident # 5 reported abuse. The director of clinical services stated, "Of course his perception is his perception." The surveyor asked the director of clinical services how long does the facility have to report suspected abuse. The director of clinical services stated, "2 hours typically." The surveyor asked the director of clinical services what is the procedure for suspected resident to resident abuse. The director of clinical services stated they are automatically separated and if needed we can do one to one. The surveyor asked the director of clinical services what was the procedure to staff to resident abuse. The director of clinical services stated that the employee is suspended pending investigation. The surveyor asked the director of clinical services what was the procedure for allegations of visitor to resident abuse. The director of clinical services stated we ask them to leave the facility until the investigation is complete. The surveyor asked the director of clinical services why the alleged perpetrator was allowed to return to the facility if the investigation	F 600		

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F 600	Continued From page 36 into Resident # 5's allegation of abuse had not been completed. The director of clinical services stated, "There's a fine line when telling them they can't visit their loved one. They haven't had contact." The director of clinical services stated, "I wish I could give you more information but the investigation is not complete." On 12/14/18 at 11:05 am, the surveyor interviewed the facility executive director in the presence of the survey team. The surveyor asked the facility executive director what the procedure was for allegations of resident to resident abuse. The facility executive director stated, "Separate and investigate." The surveyor asked the facility executive director what the procedure was for allegations of staff to resident abuse. The facility executive director stated that the employee was to be suspended pending investigation. The surveyor asked the facility executive director what was the procedure for allegations of visitor to resident abuse. The facility executive director stated, that a facility reported incident would be submitted, the incident would be investigated, and the visitor would be asked to stay away until the investigation is complete. The surveyor asked the facility executive director why the family was not asked to stay away during the investigation of the allegation of abuse reported by Resident # 5. The facility executive director stated, "Or they meet with me and the director of nursing and we determine if they can come back. I met with the family on Monday and with Resident # 5's history of 3 or 4 occasions that he has lied, the residents were separated and Resident # 5 was moved to another room. I decided that the alleged perpetrator could return to the building." The surveyor asked the facility executive director how he could make that determination when the	F 600		

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F 600	Continued From page 38	F 600		

wouldn't have done anything differently. We separated them. We met with the family." The surveyor stated to the facility executive director that the alleged perpetrator returned to the building on Sunday and Resident # 5 stated that she jerked the table from under him. The facility executive director stated, "No she wasn't, I was here all day and no one came in. I drove staff back and forth to the hotel." The surveyor asked the facility executive director if he knows for a fact that the alleged perpetrator did not enter the building because on 12/13/18 after viewing the visitor sign in log and seeing that no one had signed in as a visitor, 2 surveyors toured the facility saw the alleged perpetrator along with her mother and grandson visiting with their loved one in the hallway at the same table that Resident # 5 said the alleged perpetrator jerked from underneath him. The facility executive director did not respond. The surveyor informed the facility executive director that Resident # 5 became tearful during the interview when he reported what happened. The surveyor told the facility executive director that Resident # 5 had been working on his toileting and stated that the alleged perpetrator yelled at him and prevented him from using the bathroom causing him to urinate on himself. The facility executive director stated, "She says she sat on the bed talking to him." The surveyor stated to the facility executive director that he stated that Resident # 5 tells lies but the facility is still obligated to protect him. The surveyor informed that facility executive director that Resident # 5 stated that he isn't coming out of his room like he normally does and is only coming out for meals because he does not want to run into the alleged perpetrator and this is not a normal behavior for Resident # 5. The facility executive director stated, "I don't know what the

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F 600	Continued From page 39 solution is. (Resident name withheld) has been in that room forever and he doesn't want to move. They fought for years to get him back to that unit." The surveyor told the facility executive director that she was unable to advise him on what to do but he has an obligation to protect Resident # 5 and all residents The facility policy on "Abuse, Neglect, Exploitation & Misappropriation" contained documentation that included but was not limited to: .."Mental and verbal abuse include but are not limited to: Harassing a resident Mocking, insulting, ridiculing Yelling or hovering over a resident, with intent to intimidate Threatening residents, depriving a resident of care or withholding a resident from contact with family and friends Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include put are not limited to: Failure to take precautionary measures to protect the health and safety of the resident. Procedure Acts of abuse directed against residents are absolutely prohibited. Such acts are cause for disciplinary action, including dismissal and possible prosecution. Questions may arise as to what actions constitute abuse of a resident. Any action that may cause or causes actual physical psychological or emotional harm, which is not caused by simple negligence, constitutes abuse. Actions such as striking a resident, restraining a resident improperly or without	F 600		

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F 600	Continued From page 40 authorization, and other such acts which can be seen as causing physical pain to a resident are strictly forbidden. Acts such as teasing, humiliating, degrading, or intentionally ignoring a resident may constitute abuse and will be dealt with no less severely than acts causing physical harm. Non-action, which results in emotional, psychological, or physical injury in the same manner as that caused by improper or excessive action. All actions in which employees engage with residents must have as their legitimate goal, the healthful, proper, and humane care and treatment of the resident. Furthermore, the Administration of the company recognizes that resident abuse can be committed by other residents, visitors, or volunteers. Employee Obligation All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no 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 or do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated abuse coordinator. An employee shall be deemed to have violated his obligations in paragraph "1A" (above) if he	F 600		

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F 600	Continued From page 41 does any of the following: Harasses or otherwise retaliates against any resident, employee, or other person who discloses information or participates in an investigation of an act of resident abuse. 5. Investigation The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. Investigations will be accomplished in the following manner. Immediately upon the allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation resident of the allegation. Protection Increased supervision of the alleged victim and residents." .. On 12/14/18 at 2:02 pm, the administrative team was made aware of the findings as stated above. No further information regarding this incident was provided to the survey team prior to the exit conference on 12/14/18. 2. For Resident #89, facility staff failed to ensure the resident was free from unnecessary restraint and misappropriation of property. Resident #89 was admitted to the facility on 3/28/17. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following subarachnoid hemorrhage, dysphagia, encounter	F 600		

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F 600	Continued From page 42 for care of tracheostomy, atherosclerotic heart disease, post-traumatic stress disorder, bipolar disorder, atherosclerotic heart disease, diabetes mellitus type I, and chronic obstructive pulmonary heart disease. On the quarterly minimum data set assessment with assessment reference date 10/10/2018, the resident scored 15/15 on the brief interview for mental status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting self or others. The resident's latest safe smoking assessment was dated 9/26/18 and indicated the resident was able to smoke independently. The resident was acting as her own responsible party. During an interview on 12/13/18, the resident reported being generally content with physical care received, but indicated a desire to transfer to another facility prior to the planned ban on smoking starting in February 2019. The resident reported having asked several times about progress toward the transfer, but having no timeline for the transfer. The resident also reported being sent to the hospital for tracheostomy revision the month before. The resident said she had been given no written notice of the reasons for transfer to the hospital. Clinical record review reveled that on 11/2/18, a staff member took the resident's cigarettes. The CNA and nurse on duty told the resident she could not smoke as a safety concern. The resident's smoking assessment from 9/23/28 indicated the resident was safe as an independent smoker. The resident requested to leave AMA (against medical advice), signed paperwork indicating that was her intent, and started calling family and friends for a ride. Staff called the resident's father (this was not a	F 600		

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F 600	Continued From page 43 guardianship situation) and he said not to let her leave and to get her a psychiatric evaluation Staff requested a ECO (emergency commitment order) and called an ambulance to take the resident to the hospital. There was no indication the resident's physician was notified of the situation or that there was a change of condition requiring hospitalization. In the hospital discharge summary, the hospital psychiatrist assessment dated 11/2/18 said the resident was exhibiting no symptoms, but wanted her to stay at the hospital until APS could talk to her- concern was the resident's safety from facility staff. The hospital note included in history that nursing home staff called the police and reported Resident #89 was trying to blow up the building and kill residents. Police declined to remove her from the building after interviewing the resident and her room mate (who said the resident had not said that, but the nurse had). A nurse's note dated 11/3/18 indicated that the resident asked to smoke and the nurse refused to give her cigarettes, saying that the resident was told she couldn't take off her oxygen because saturation levels might drop and the resident was given a sedative medication instead. During a summary meeting on 12/13/18, the surveyor reported to the administrator, director of clinical (DCS) and the corporate regional director for clinical services the concern with the situation on 11/2 described in the record. The surveyor asked about the policy followed when a resident signed out AMA. The facility had no procedure for that event. No one acknowledged the resident was sent for ECO after she signed out AMA. The administrator stated the resident didn't have any	F 600		

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F 600	Continued From page 44 place to go. When asked about the resident's cigarettes being confiscated and the police being called when the resident signed out AMA, the DCS stated she was unaware of the resident ever not being allowed to smoke when she wanted to do so.	F 600	**F607- Develop/Implement Abuse/Neglect, etc., Policies** 1. Facility submitted a FRI (Facility Reportable Incident) for Resident #89 on 1/21/2019.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and clinical record review, the facility staff failed to ensure 1 of 23 residents was free from abuse by taking property and preventing decisions important to the resident (#89). Resident ECO#89 was admitted to the facility on 3/28/17. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following subarachnoid hemorrhage, dysphagia, encounter for care of tracheostomy, atherosclerotic heart disease, post-traumatic stress disorder, bipolar disorder, atherosclerotic heart disease, diabetes mellitus type I, and chronic obstructive pulmonary heart disease. On the quarterly minimum data	F 607	2. The RDCS and UMs completed quality reviews interviews of all current residents (cognitively impaired residents' representatives were contacted) to ensure residents are provided care in a respectful and dignified manner on 1/22/19 Follow up based on findings. 3. The DCS, ADCS, RDCS and UMs will re-educate facility staff on federal regulations and guidelines for Freedom from Abuse, Neglect, and Exploitation by 1/28/19. 4. DCS and or ADCS will conduct random resident and or their representative interviews 3 times per week for 4 weeks, then weekly for 3 months, to ensure residents are provided care in a dignified manner and their ability to exercise their rights is respected. Findings will be reviewed by QAPI committee monthly and Quality Monitoring updated as indicated. 5. Date of Compliance 1/28/2019.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(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 607	Continued From page 45 set assessment with assessment reference date 10/10/2018 the resident scored 15/15 on the brief interview for mental status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting self or others. The resident's latest safe smoking assessment was dated 9/26/18 and indicated the resident was able to smoke independently. The resident was acting as her own responsible party. During an interview on 12/13/18, the resident reported being generally content with physical care received, but indicated a desire to transfer to another facility prior to the planned ban on smoking starting in February 2019. The resident reported having asked several times about progress toward the transfer, but having no timeline for the transfer. The resident also reported being sent to the hospital for tracheostomy revision the month before. The resident said she had been given no written notice of the reasons for transfer to the hospital. Clinical record review reveled that on 11/2/18, a staff member took the resident's cigarettes. The CNA and nurse on duty told the resident she could not smoke as a safety concern. The resident's smoking assessment from 9/23/28 indicated the resident was safe as an independent smoker. The resident requested to leave AMA (against medical advice), signed paperwork indicating that was her intent, and started calling family and friends for a ride. Staff called the resident's father (this was not a guardianship situation) and he said not to let her leave and to get her a psychiatric evaluation. Staff requested a ECO (emergency commitment order) and called an ambulance to take the resident to the hospital. There was no indication	F 607		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4365 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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F 607	Continued From page 46 the resident's physician was notified of the situation or that there was a change of condition requiring hospitalization. In the hospital discharge summary, the hospital psychiatrist assessment dated 11/2/18 said the resident was exhibiting no symptoms, but wanted her to stay at the hospital until Adult Protective Services could talk to her- concern was the resident's safety from facility staff. The hospital note included in history that nursing home staff called the police and reported Resident #89 was trying to blow up the building and kill residents. Police declined to remove her from the building after interviewing the resident and her room mate (who said the resident had not said that, but the nurse had). A nurse's note dated 11/3/18 indicated that the resident asked to smoke and the nurse refused to give her cigarettes, saying that the resident was told she couldn't take off her oxygen because saturation levels might drop and the resident was given a sedative medication instead. During a summary meeting on 12/13/18, the surveyor reported to the administrator, director of clinical (DCS) and the corporate regional director for clinical services the concern with the situation on 11/2 described in the record. The surveyor asked about the policy followed when a resident signed out AMA. The facility had no procedure for that event. No one acknowledged the resident was sent for ECO after she signed out AMA. The administrator stated the resident didn't have any place to go. When asked about the resident's cigarettes being confiscated and the police being called when the resident signed out AMA, the DCS stated she was unaware of the resident ever	F 607		

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F 607	Continued From page 47 not being allowed to smoke when she wanted to do so. The surveyor informed the DCS that lack of management awareness of the situation indicated that facility policies failed to protect the resident.	F 607	**F609- Reporting of Alleged Violations** 1. Facility submitted a FRI for Resident #5 on 12/11/2018. Facility submitted a FRI (Facility Reportable Incident) for Resident #89 on 1/21/2019. 2. On 1/22/2019 the Clinical Quality Specialist (CQS) completed quality review of facility reportable incidents in the last 30 days to ensure incidents were reported in a timely manner. On 1/22/19 the RDCS and UMs completed quality review/interviews of all current residents (cognitively impaired residents' representatives were contacted) to ensure residents are free from abuse and neglect. Follow up based on findings. 3. On 1/21/2019 the RDCS provided 1 on 1 re-education to the facility ED on the federal regulations and guidelines for reporting Abuse and Neglect and the Elder Justice Act. The ADCS and RDCS will provide re-education to facility staff on the federal regulations and guidelines for reporting Abuse and Neglect and the Elder Justice Act by 1/28/19.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		

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F 609	Continued From page 48 Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to report allegations of abuse within a timely manner for 2 of 23 Residents in the survey sample, Resident # 5 and Resident # 89. The findings included: 1. The facility staff failed to report allegations of visitor to Resident abuse within a timely manner for Resident # 5. Resident # 5 was a 40-year-old-male who was admitted to the facility on 4/20/18, with a readmission date of 8/27/18. Diagnoses included but were not limited to, hypertension, major depressive disorder, anxiety disorder, and benign prostatic hyperplasia. The clinical record for Resident # 5 was reviewed on 12/13/18 at 10:41 am. The most recent MDS (minimum data set) assessment for Resident # 5 was a quarterly assessment with an ARD (assessment reference date) of 9/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 5 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 15 was cognitively intact. On 12/13/18 at 7:55 am, the surveyor was in Resident # 5's room conducting a Resident interview. During the interview Resident # 5 reported to the surveyor that on 12/8/18, the alleged perpetrator (his former roommate's sister) "Got in my face, yelled at me and blocked the bathroom and wouldn't let me use the bathroom."	F 609	4. ED and or DCS will conduct random quality monitoring of Grievances/Concerns to ensure incidents/allegations are reported timely, 3 times per week for 4 weeks, then weekly for 3 months. DCS and or ADCS will conduct random resident and or their representative interviews 3 times per week for 4 weeks, then weekly for 3 months, to ensure residents are free from Abuse, Neglect and Exploitation. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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F 609	Continued From page 49	F 609		

Resident # 5 stated that he was going back to his room to get hot chocolate for a group of Residents that he was socializing with and to use the bathroom because he is on a bladder-retraining program. Resident # 5 stated that when he got to his room, the alleged perpetrator asked him "What's going on with you and (Resident's name withheld)? Resident # 5 stated that he told the alleged perpetrator nothing was going on and that he did not know what she was talking about. Resident # 5 then stated that the alleged perpetrator got in his face and began to yell at him stating that Resident # 5's former roommate told the alleged perpetrator that Resident # 5 had been treating him differently and that Resident # 5 was going to tell her what was going on. Resident # 5 stated that he told the alleged perpetrator that he needed to use the bathroom. Resident # 5 stated that the alleged perpetrator stood in front of the bathroom door and told him he was not going to use the bathroom until she was done with him. Resident # 5 stated that he told the alleged perpetrator, "This is our room and you are a guest here." "You need to get out of here." Resident # 5 stated that the alleged perpetrator continued to block the door to the bathroom. Resident # 5 stated that he began to urinate on himself. Resident # 5 stated, "I felt awful, I cried." Resident # 5 stated that the alleged perpetrator finally allowed him to go into the bathroom after he had urinated on himself and stated to him, "I am going to be right here when you get out because you are going to tell me what's going on with you and (Resident's name withheld). Resident # 5 stated that the alleged perpetrator continued to yell at him through the door while he was in the bathroom. Resident # 5 stated that he called the police. Resident # 5 stated that the police came and

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F 609	Continued From page 50	F 609		

"She threw a fit." Resident # 5 stated that the police made her leave that evening but it would be up to "them" (the facility) if they bar her from the facility. Resident # 5 stated that later that same evening other family members of his former roommate came in and "intimidated" him. Resident # 5 stated that his former roommate's family members sat on the other side of the room saying mean things to him and stated, "If something happens to (Resident's name withheld) their asses is mine." Resident # 5 stated, "They made me feel like I was a piece of crap." Resident # 5 stated the next day "They came back in here like it was nothing." Resident # 5 stated that the day after the incident that the alleged perpetrator approached him as he was sitting at a square table in the hallway outside of their room and "jerked the table away from me." Resident # 5 stated that he asked a staff member why the alleged perpetrator was allowed to come back into the facility after what she did to him. Resident # 5 stated that he was told she has a right to visit her family member. Resident # 5 stated that he spoke with the facility executive director on Monday and the facility executive director told Resident # 5 they would move him to a different room. Resident # 5 stated that the facility executive director stated to him, "we got it all handled." Resident # 5 stated that he replied, "It handles the room but it doesn't handle what she did to me." Resident # 5 stated that the facility executive director stated to him, "You let me handle that." "I got 2 days to investigate that." Resident # 5 then stated to the surveyor, "It does not make any sense how she treated me." "It made me feel like I was worthless, and they let her come back in here like it was nothing after the law put her out." "I thought with me being a patient here I would be protected more." The

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F 609	Continued From page 51 surveyor observed at this time that Resident # 5 became tearful. Resident # 5 stated, "What happens when she attacks somebody else?" Are you just going to put people in another room and say that settles that." On 12/13/18 at 9:58 am, the surveyor interviewed unit manager RN # 1 (registered nurse) about the allegations of abuse reported by Resident # 5. Unit manager RN # 1 stated, "I am aware briefly, I only know that the family was acting inappropriate and threatened him (Resident # 5) and the police were involved." On 12/13/18 at 10:00 am, the surveyor interviewed the facility executive director about the allegations of abuse reported by Resident # 5. The facility executive director stated, "I was called Saturday night saying the police had to come to the facility saying there was a yelling match with [Resident # 5] and [Resident # 5's] former roommate's sister." "We had the daughters (referring to Resident # 5's former roommate's sisters) come in Monday and we spoke to them and Resident # 5." The facility executive director informed the surveyor that he was in the process of investigating the incident and that a FRI (facility reported incident) was submitted. The facility executive director then stated that Resident # 5 had been known to lie and then come back and admit to lying and saying that he was sorry. The facility executive director also stated that the nurse that called him at home to report the incident had issues with Resident # 5's former roommate's family and called him that night to report the incident she asked if he was going to have them barred from the facility. The facility executive director stated, I don't really have any evidence there were no eye witnesses. I will be	F 609		

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F 609	Continued From page 52 finishing this investigation by Monday but I can't see where any abuse occurred." The facility executive director provided the surveyor with a copy of a "Facility Reported Incident (FRI)" form. The Facility Reported Incident form contained documentation that included but was not limited to, ..." Report date 12-11-18, Incident date 12-8-18 Incident type Allegation of abuse/mistreat" .. The facility policy on "Abuse, Neglect, Exploitation & Misappropriation" contained documentation that included but was not limited to, ..."7. Reporting/Response Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no 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 and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated abuse coordinator. Once the allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations." ... On 12/13/18 at 5:45 pm, the administrative team was made aware of the findings as stated above.	F 609		

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F 609	Continued From page 53 No further information regarding this incident was provided to the survey team prior to the exit conference on 12/14/18. 2. For Resident #89, facility staff failed to report to the agency that the resident reported abuse of rights and property to staff on 11/3/18 as indicated by nursing notes on that date. Resident #89 was admitted to the facility on 3/28/17. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following subarachnoid hemorrhage, dysphagia, encounter for care of tracheostomy, atherosclerotic heart disease, post-traumatic stress disorder, bipolar disorder, atherosclerotic heart disease, diabetes mellitus type I, and chronic obstructive pulmonary heart disease. On the quarterly minimum data set assessment with assessment reference date 10/10/2018, the resident scored 15/15 on the brief interview for mental status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting self or others. The resident's latest safe smoking assessment was dated 9/26/18 and indicated the resident was able to smoke independently. The resident was acting as her own responsible party. During an interview on 12/13/18, the resident reported being generally content with physical care received, but indicated a desire to transfer to another facility prior to the planned ban on smoking starting in February 2019. The resident reported having asked several times about progress toward the transfer, but having no timeline for the transfer. The resident also reported being sent to the hospital for tracheostomy revision the month before. The resident said she had been given no written	F 609		

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F 609	Continued From page 54 notice of the reasons for transfer to the hospital. Clinical record review revealed that on 11/2/18, a staff member took the resident's cigarettes. The CNA and nurse on duty told the resident she could not smoke as a safety concern. The resident's smoking assessment from 9/23/28 indicated the resident was safe as an independent smoker. The resident requested to leave AMA (against medical advice), signed paperwork indicating that was her intent, and started calling family and friends for a ride. Staff called the resident's father (this was not a guardianship situation) and he said not to let her leave and to get her a psychiatric evaluation. Staff requested a ECO (emergency commitment order) and called an ambulance to take the resident to the hospital. There was no indication the resident's physician was notified of the situation or that there was a change of condition requiring hospitalization. In the hospital discharge summary, the hospital psychiatrist assessment dated 11/2/18 said the resident was exhibiting no symptoms, but wanted her to stay at the hospital until Adult Protective Services (APS) could talk to her- concern was the resident's safety from facility staff. The hospital note included in history that nursing home staff called the police and reported Resident #89 was trying to blow up the building and kill residents. Police declined to remove her from the building after interviewing the resident and her room mate (who said the resident had not said that, but the nurse had). A nurse's note dated 11/2/18 indicated that the resident reported to staff that she felt staff was stealing from her and that the resident signed	F 609		

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F 609	Continued From page 55 paperwork indicating intention to leave before staff called police to deal with the situation (it was unclear whether the police were supposed to remove the resident or prevent her from leaving, but that she would not be allowed to leave with the person of her choice). A nurse's note dated 11/3/18 indicated that the resident asked to smoke and the nurse refused to give her cigarettes, saying that the resident was told she couldn't take off her oxygen because saturation levels might drop and the resident was given a sedative medication instead. During a summary meeting on 12/13/18, the surveyor reported to the administrator, director of clinical (DCS) and the corporate regional director for clinical services the concern with the situation on 11/2 described in the record. The surveyor asked about the policy followed when a resident signed out AMA. The facility had no procedure for that event. No one acknowledged the resident was sent for ECO after she signed out AMA. The administrator stated the resident didn't have any place to go. When asked about the resident's cigarettes being confiscated and the police being called when the resident signed out AMA, the DCS stated she was unaware of the resident ever not being allowed to smoke when she wanted to do so. The surveyor informed the DCS that lack of management awareness of the situation indicated that facility policies failed to protect the resident. The facility failed to report the staff's allegations of threats and the resident's allegations of staff abuse of rights to the appropriate agencies.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

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F 610	Continued From page 56 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to thoroughly investigate allegations of abuse for 1 of 23 Residents in the survey sample, Resident # 5. The findings included: 1. The facility staff failed to maintain documentation of a complete and thorough investigation into an allegation of abuse reported by Resident # 5. 2. The facility staff failed to prevent further potential abuse while the investigation was in process as evidenced by, the allegation occurred on 12/8/18, Resident # 5 was not transferred to another room until 12/10/18, and the alleged perpetrator was allowed to return to the facility	F 610	**F610- Investigate/Prevent/Correct Alleged Violations** 1. Facility investigation related to Resident #5's allegation was completed by ED on 12/17/2018. Resident #5 interviewed on 1/17/2019 by RDCS with facility SSD present. Resident feels safe at the facility and feels that staff treats them with dignity and respect. 2. CQS completed quality review of facility reportable incidents in the last 30 days on 1/22/201 to ensure incidents are thoroughly investigated. Follow up based on findings. 3. On 1/21/2019 the RDCS provided 1 on 1 re-education to the facility ED on the federal regulations and guidelines for reporting Abuse and Neglect and the Elder Justice Act. The ADCS and RDCS will provide re-education to facility staff on the federal regulations and guidelines for reporting Abuse and Neglect and the Elder Justice Act by 1/28/19.	

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F 610	Continued From page 57 and have access to Resident # 5 and other Residents and the investigation had not been completed. Resident # 5 was a 40-year-old-male who was admitted to the facility on 4/20/18, with a readmission date of 8/27/18. Diagnoses included but were not limited to, hypertension, major depressive disorder, anxiety disorder, and benign prostatic hyperplasia. The clinical record for Resident # 5 was reviewed on 12/13/18 at 10:41 am. The most recent MDS (minimum data set) assessment for Resident # 5 was a quarterly assessment with an ARD (assessment reference date) of 9/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 5 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 15 was cognitively intact. The plan of care for Resident # 5 was reviewed and revised on 11/9/18. The facility staff documented a focus area for Resident # 5 as, "Resident # 5 is independent on staff for activities, cognitive stimulation, social interaction r/t (related to) anxiety, depression, PTSD (post traumatic stress disorder) limited mobility, quadriplegia, pain, participating in activities of choice, self acts in room such as TV (television), computer, phone, sitting on porch, parties, bingo, music, socializes with staff and residents. Resident # 5 goes by cab on community outings." Interventions included but were not limited to: "Report resident c/o (complaint of) pain, discomfort, breathing difficulties or any other c/o that interferes with the resident's ability to	F 610	4. ED and or DCS will conduct random quality monitoring of Grievances/Concerns to ensure incidents/allegations are reported timely, 3 times per week for 4 weeks, then weekly for 3 months. DCS and or ADCS will conduct random resident and or their representative interviews 3 times per week for 4 weeks, then weekly for 3 months, to ensure residents are free from Abuse, Neglect and Exploitation. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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participate in activities to the nurse prn (as needed)." The surveyor reviewed the entire plan of care for Resident # 5 and did not see an update that Resident # 5 made statements that are untrue.

On 12/13/18 at 7:55 am, the surveyor was in Resident # 5's room conducting a Resident interview. During the interview Resident # 5 reported to the surveyor that on 12/8/18, the alleged perpetrator (his former roommate's sister) "Got in my face, yelled at me and blocked the bathroom and wouldn't let me use the bathroom." Resident # 5 stated that he was going back to his room to get hot chocolate for a group of Residents that he was socializing with and to use the bathroom because he is on a bladder-retraining program. Resident # 5 stated that when he got to his room, the alleged perpetrator asked him "What's going on with you and (Resident's name withheld)? Resident # 5 stated that he told the alleged perpetrator nothing was going on and that he did not know what she was talking about. Resident # 5 then stated that the alleged perpetrator got in his face and began to yell at him stating that Resident # 5's former roommate told the alleged perpetrator that Resident # 5 had been treating him differently and that Resident # 5 was going to tell her what was going on. Resident # 5 stated that he told the alleged perpetrator that he needed to use the bathroom. Resident # 5 stated that the alleged perpetrator stood in front of the bathroom door and told him he was not going to use the bathroom until she was done with him. Resident # 5 stated that he told the alleged perpetrator, "This is our room and you are a guest here." "You need to get out of here." Resident # 5 stated that the alleged perpetrator continued to block the door to

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F 610	Continued From page 59 the bathroom. Resident # 5 stated that he began to urinate on himself. Resident # 5 stated, "I felt awful, I cried." Resident # 5 stated that the alleged perpetrator finally allowed him to go into the bathroom after he had urinated on himself and stated to him, "I am going to be right here when you get out because you are going to tell me what's going on with you and (Resident's name withheld). Resident # 5 stated that the alleged perpetrator continued to yell at him through the door while he was in the bathroom. Resident # 5 stated that he called the police. Resident # 5 stated that the police came and "She threw a fit." Resident # 5 stated that the police made her leave that evening but it would be up to "them" (the facility) if they bar her from the facility. Resident # 5 stated that later that same evening other family members of his former roommate came in and "intimidated" him. Resident # 5 stated that his former roommate's family members sat on the other side of the room saying mean things to him and stated, "If something happens to (Resident's name withheld) their asses is mine." Resident # 5 stated, "They made me feel like I was a piece of crap." Resident # 5 stated the next day "They came back in here like it was nothing." Resident # 5 stated that the day after the incident that the alleged perpetrator approached him as he was sitting at a square table in the hallway outside of their room and "jerked the table away from me." Resident # 5 stated that he asked a staff member why the alleged perpetrator was allowed to come back into the facility after what she did to him. Resident # 5 stated that he was told she has a right to visit her family member. Resident # 5 stated that he spoke with the facility executive director on Monday and the facility executive director told Resident # 5 they would move him to	F 610		

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a different room. Resident # 5 stated that the facility executive director stated to him, "we got it all handled." Resident # 5 stated that he replied, "It handles the room but it doesn't handle what she did to me." Resident # 5 stated that the facility executive director stated to him, "You let me handle that." "I got 2 days to investigate that." Resident # 5 then stated to the surveyor, "It does not make any sense how she treated me." "It made me feel like I was worthless, and they let her come back in here like it was nothing after the law put her out." "I thought with me being a patient here I would be protected more." The surveyor observed at this time that Resident # 5 became tearful. Resident # 5 stated, "What happens when she attacks somebody else?" Are you just going to put people in another room and say that settles that."

On 12/13/18 at 9:58 am, the surveyor interviewed unit manager RN # 1 (registered nurse) about the allegations of abuse reported by Resident # 5. Unit manager RN # 1 stated, "I am aware briefly, I only know that the family was acting inappropriate and threatened him (Resident # 5) and the police were involved."

On 12/13/18 at 10:00 am, the surveyor interviewed the facility executive director about the allegations of abuse reported by Resident # 5. The facility executive director stated, "I was called Saturday night saying the police had to come to the facility saying there was a yelling match with Resident # 5 and the alleged perpetrator. We had the daughters (the alleged perpetrator and her sister) come in Monday and we spoke to them and Resident # 5." The facility executive director informed the surveyor that he was in the process of investigating the incident and that a

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F 610	Continued From page 61 FRI (facility reported incident) was submitted. The facility executive director then stated that Resident # 5 had been known to lie and then come back and admit to lying and saying that he was sorry. The facility executive director also stated that the nurse that called him at home to report the incident had issues with the alleged perpetrator and her family and called him that night to report the incident. She asked if he was going to have them barred from the facility. The facility executive director stated, "I don't really have any evidence. There were no eye witnesses. I will be finishing this investigation by Monday but I can't see where any abuse occurred." On 12/13/18 at 10:15 am, the surveyor observed a progress note documented in the clinical record for Resident # 5 on 12/9/18 at 3:29 pm. The progress note was documented as "Resident is on medi part b total care with adls (activities of daily living) incontinent of bowel and bladder uses walker for ambulation upset due to incident with roommate family of them yelling and getting into his face refusing to let him use the bathroom police was called due to roommate family being nasty and inappropriate by yelling and getting in his face." On 12/13/18 at 10:28 am, the surveyor interviewed LPN # 1 (licensed practical nurse) about the allegation of abuse reported by Resident # 5. The surveyor asked LPN # 1 if she was working and responsible for providing care to Resident # 5 on 12/8/18. LPN # 1 stated, "Yes." The surveyor asked LPN # 1 if she was aware of an incident that occurred involving the alleged perpetrator and Resident # 5. LPN # 1 stated, "Yes." LPN # 1 stated that Resident # 5 was in the	F 610		

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therapy room playing games with the other Residents. LPN # 1 stated that Resident # 5 was coming out to go to the bathroom and get the hot chocolate from his room. LPN # 1 stated that as soon as Resident # 5 went in the room the alleged perpetrator started yelling at Resident # 5 and pinned him against the wall. LPN # 1 stated that she heard the alleged perpetrator state to Resident # 5, "You're not going to the bathroom. I'm not done with you." The surveyor asked LPN # 1 if she saw the alleged perpetrator pin Resident # 5 against the wall. LPN # 1 stated, "No but I heard it." LPN # 1 stated that she heard Resident # 5 tell the alleged perpetrator "I don't know what you are talking about." LPN # 1 stated that she heard the alleged perpetrator tell Resident # 5 again, "You can't use the bathroom until I am done with you." LPN # 1 stated that Resident # 5 came out into the hallway crying and asked her to call the police. LPN # 1 stated, "We called the police and they came and the alleged perpetrator was yelling at the police officer." LPN # 1 stated, "This was witnessed by Resident # 78's husband (Resident # 78 was not sampled) LPN # 1 stated that Resident # 78's husband stated to her, "This happens every night. Something needs to be done." LPN # 1 stated that the police had the alleged perpetrator leave after she made a scene with them. Surveyor asked LPN # 1 if she reported this information to anyone. LPN # 1 stated that she called the executive director at home to let him know what happened. LPN # 1 stated, "They never do anything about what we tell them. They don't want APS (adult protective services) to come in here."

On 12/13/18 at 10:38 am, the surveyor reviewed the clinical record of the Resident #78 (not

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F 610	Continued From page 63 sampled) that LPN # 1 reported her husband witnessed the events. The surveyor observed documentation in the progress notes documented on 12/8/18 at 10:28 pm. The progress note was documented as "Resident family member was being talked to nasty by (room number withheld) family and was told this is the worst facility and his wife will not be taken care of because we are the worst and miss treat the residents and son to sister was very rude to staff and resident family to where he felt uneasy and there comments bothered him and he could not make a statement to staff after incident because he was being bullied by family he change his statement to loud commasion (commotion) after he told police she was yelling at roommate and in his face and this happened every night to not wanting to say nothing felt very uneasy." On 12/13/18 at 3:08 pm, the surveyor interviewed CNA # 2 (certified nursing assistant) The surveyor asked CNA # 2 if she worked on the evening of 12/8/18 and if she was responsible for providing care to Resident # 5. CNA # 2 stated that she was on duty and responsible for providing care to Resident # 5 on 12/8/18. CNA# 2 stated, "[Resident # 5] went into his room and within seconds, you heard all this yelling." CNA # 2 stated that she heard the alleged perpetrator state," You are not going to the bathroom until I am through with you." CNA # 2 stated, "I heard all this yelling and I told LPN #1 something is going on down there." CNA # 2 stated that Resident # 5 came down the hallway and said he wanted to call the police. CNA # 2 stated that Resident # 5 stated that the alleged perpetrator wouldn't let him use the bathroom. The surveyor asked CNA if Resident # 5 was incontinent at this time. CNA # 2 stated that Resident # 5 was	F 610		

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F 610	Continued From page 64 incontinent. CNA # 2 also stated Resident # 5 was crying and upset. CNA # 2 stated that Resident # 5 had been working really hard trying bladder training because he wants to go home. CNA # 2 stated that another resident's husband was outside the room and heard the commotion and stated that she heard the alleged perpetrator tell Resident # 78's husband "If you say anything they will treat your wife bad." CNA # 2 stated, "I told the facility executive director what happened on Monday and he stated that he was investigating the issue." On 12/13/18 at 5:45 pm, the surveyor spoke with the facility executive director in the presence of the survey team and the facility administrative staff. The surveyor asked the facility executive director if he stated to her in an earlier conversation that he planned on closing the investigation on Monday and that he did not see where any abuse occurred. The facility executive director agreed to making that statement in the presence of the survey team. The surveyor asked the facility executive director to provide what evidence he had collected thus far in the investigation. On 12/13/18 at 6:03 pm, the facility executive director provided the surveyor with 4 pages of handwritten notes that were photocopied from a notepad. The notes were documented as follows "12/10/18 Alleged perpetrator- she said the police escorted her out of the building. Resident # 5 came in the room. The alleged perpetrator asked if anything happened between (Resident's name withheld) and Resident # 5. Resident # 5 she very loud. This is my home you are not going to go around this place and talk about me. She wants	F 610		

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F 610	Continued From page 65 to know who initiated the police call and why, what started it. LPN # 1 asked (Resident # 78 husband's name withheld) to write a statement. 12/10/18 Resident # 5- Resident # 5 went into the room alleged perpetrator waiting on him. Alleged perpetrator ask is there something wrong between you and (Resident name withheld) Resident # 5 said nothing. Alleged perpetrator-I want to know why you stopped paying attention to (Resident name withheld). You are not playing games with (Resident name withheld) Resident # 5-It's because the way your mom and (Resident name withheld) have been treating me and I am not (Resident name withheld) caregiver. Alleged perpetrator-Oh no you are not going to treat (resident name withheld) this way. Resident # 5 I am not doing anything to (Resident name withheld) Get out of the way I've got to go to the bathroom. Alleged perpetrator stepped in front of me and said you are going to talk to me. Resident # 5 move, I have got to use the bathroom. Alleged perpetrator you can wait a minute. Resident # 5 this is our room you need to get out of here you are just a guest. Alleged perpetrator-Oh know this is (Resident name withheld) room, he was here before you and he will be here after you. Resident # 5-he started urinating on himself and said get out of my way I have to use the bathroom. Alleged perpetrator -Go head but I will be out here waiting and you are going to talk to me she stepped out of the way from blocking the bathroom. Resident # 5 was in the bathroom he heard her telling (Resident name withheld) He is going to talk to me. Resident waited in the bathroom a long time he heard her say she was going to get his food. Resident # 5 came out of the bathroom when she left. Resident # 5 heard her say I am leaving but when I get back he is	F 610		

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F 610	Continued From page 66 going to deal with me. Resident # 5 called the police. He went to the family room until they got here. Resident # 5 said he felt she attacked him and it is not right. 12/10/18 Call (Resident husband's name withheld) per facility executive director. Called at 4:14 pm (Telephone number withheld) Nurse asked him about that he said he was one door out in the hall, he didn't see or hear anything if something went on it was in the room. Why happened? We are trying to investigate if something happened. He saw police. 12/10/18 Resident # 5- meeting with facility executive director and Resident # 5. Resident # 5 wants alleged perpetrator not to be able to come back in the building. The facility executive director offered Resident # 5 to move to room (room number withheld) until another semi-private room comes available. Resident # 5 agreed. But said he does not want alleged perpetrator to come back into the building." The surveyor observed that there were no statements from LPN # 1 or CNA # 2 who both stated that they spoke with the facility executive director regarding the allegation of abuse reported by Resident # 5. On 12/13/18 at 6:10 pm, the surveyor reviewed the visitor log kept in the front of the building. The surveyor observed that no visitors had signed the visitor log on 12/13/18. On 12/13/18 at 6:15 pm, 2 surveyors toured the 600 hall and 700 hall of the facility. The two surveyors observed that Resident # 5 was in his room in the bathroom. The two surveyors also	F 610		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4365 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(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 610	Continued From page 67 observed the alleged perpetrator, her mother, and grandson visiting with their loved one in the hallway outside of the resident's room. They were observed sitting at a square table that was outside of the resident's room playing a game. In the room directly beside where the alleged perpetrator was observed, the 2 surveyors observed a resident and a visitor sitting in the hallway. The visitor was identified as Resident # 78's husband that facility staff stated was bullied by the alleged perpetrator. On 12/14/18 at 8:36 am, the surveyor interviewed Resident # 5 again about his allegations of abuse. The surveyor asked Resident # 5 if he had any contact with the alleged perpetrator after the incident that occurred on 12/8/18. Resident # 5 stated, "That happened on Saturday night and they came back in here Sunday and she jerked the table from underneath me." Resident # 5 stated, "I went and talked to unit manager RN # 1 (registered nurse) and told her I couldn't believe she was in here after what she did to me, and she said it's his family they can come visit.' Resident # 5 stated, "I have the right to be protected." The surveyor asked Resident # 5 if he has had any contact with the alleged perpetrator since he was moved to his new room. Resident # 5 stated, "No to be honest I have stayed in my room except for meals and therapy." The surveyor asked Resident # 5 if staying in his room is something that he normally does. Resident # 5 stated, "No " The surveyor asked Resident # 5 why he was staying in his room if this is not something he normally does. Resident # 5 stated, "I don't want to run into them." On 12/14/18 at 9:02 am, the surveyor interviewed the facility social services manager. The surveyor	F 610		

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asked the facility social services manager if she was aware of the allegations of abuse reported by Resident # 5. The facility social services manager stated, "Yes I found out Monday." The facility social services manager stated that the alleged perpetrator called her on Monday morning and that is how she found out about the incident. The surveyor asked the facility social services manager what the alleged perpetrator reported to her. The facility social services manager stated that the alleged perpetrator stated that the police were called for her on Saturday and she was escorted out of the building. The facility social service manager stated that the alleged perpetrator told her that she asked Resident # 5 what happened between him and (Resident's name withheld) and the alleged perpetrator stated that Resident # 5 started talking loudly and that Resident # 5 attacked her verbally said that she didn't know what happened. The facility social services manager stated that during her telephone call with the alleged perpetrator, the alleged perpetrator stated that her brother (Resident's name withheld) told her that for the past two weeks Resident # 5 has been treating him differently. The surveyor asked the facility social services manager if talking loudly and verbally attacking someone is a behavior that Resident # 5 would normally display. The facility social services manager stated, "No he would not. Resident # 5 is usually very soft spoken." The surveyor asked the facility social services manager if she interviewed LPN # 1. The facility social services manager stated, "I think she wrote a statement." The surveyor asked the facility social services manager if she interviewed Resident # 78's husband that the facility staff members reported witnessed the incident. The facility social services manager stated, "I called

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F 610	Continued From page 69 (Resident # 78 husband's name withheld) and he said he didn't hear anything and didn't see anything." The surveyor asked the facility social services manager if she interviewed Resident # 5. The facility social services manager stated that she and the facility executive director met with Resident # 5 on Monday and wanted to make sure he felt safe. The facility social services manager stated that Resident # 5 was moved to a different room on Monday following the incident that had occurred on the previous Saturday. The facility social services manager stated that Resident # 5 said that he didn't want the alleged perpetrator to come back and the facility executive director said we had to complete the investigation. The surveyor observed that the facility social services manager was reading notes from a notepad during the interview. The surveyor identified the notes that the social services manager had obtained were the same photocopied notes that the facility executive director had presented previously as the evidence that had been obtained in the investigation of the allegation of abuse that had been Reported by Resident # 5. On 12/14/18 at 9:23 am, the surveyor interviewed the unit manager RN # 1. The surveyor asked the unit manager RN # 1 if she had a conversation with Resident # 5 where he expressed concerns about the alleged perpetrator being allowed back into the building. Unit manager RN # 1 stated that she did speak with Resident # 5 and he asked why was the alleged perpetrator still being allowed in the building after what she did to him. Unit manager RN # 1 stated that she told Resident # 5 that the facility executive director was aware and investigating the situation but she could not tell the alleged perpetrator that she	F 610		

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F 610	Continued From page 70	F 610		

could not visit her loved one. Unit manager RN # 1 told the surveyor that the facility did 15-minute safety checks on Resident # 5 to ensure he was safe. The surveyor requested a copy of the safety checks.

On 12/14/18 at 9:39 am, the surveyor interviewed the director of clinical services regarding the allegation of abuse reported by Resident # 5 on 12/8/18. The director of nursing stated, "It happened on the weekend. I didn't do any of the interviews." The director of clinical services stated that the facility executive director and the facility social services manager did the interviews. The surveyor asked the director of clinical services if she was aware that Resident # 5 reported abuse. The director of clinical services stated, "Of course his perception is his perception." The surveyor asked the director of clinical services how long does the facility have to report suspected abuse. The director of clinical services stated, "2 hours typically." The surveyor asked the director of clinical services what is the procedure for suspected resident to resident abuse. The director of clinical services stated they are automatically separated and if needed we can do one to one. The surveyor asked the director of clinical services what was the procedure to staff to resident abuse. The director of clinical services stated that the employee is suspended pending investigation. The surveyor asked the director of clinical services what was the procedure for allegations of visitor to resident abuse. The director of clinical services stated we ask them to leave the facility until the investigation is complete. The surveyor asked the director of clinical services why the alleged perpetrator was allowed to return to the facility if the investigation into Resident # 5's allegation of abuse had not

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been completed. The director of clinical services stated, "There's a fine line when telling them they can't visit their loved one. They haven't had contact." The director of clinical services stated, "I wish I could give you more information but the investigation is not complete."

On 12/14/18 at 11:05 am, the surveyor interviewed the facility executive director in the presence of the survey team. The surveyor asked the facility executive director what the procedure was for allegations of resident to resident abuse. The facility executive director stated, "Separate and investigate." The surveyor asked the facility executive director what the procedure was for allegations of staff to resident abuse. The facility executive director stated that the employee was to be suspended pending investigation. The surveyor asked the facility executive director what was the procedure for allegations of visitor to resident abuse. The facility executive director stated, that a facility reported incident would be submitted, the incident would be investigated, and the visitor would be asked to stay away until the investigation is complete. The surveyor asked the facility executive director why the family was not asked to stay away during the investigation of the allegation of abuse reported by Resident # 5. The facility executive director stated, "Or they meet with me and the director of nursing and we determine if they can come back. I met with the family on Monday and with [Resident # 5]'s history of 3 or 4 occasions that he has lied, the residents were separated and [Resident # 5] was moved to another room. I decided that the alleged perpetrator could return to the building." The surveyor asked the facility executive director how he could make that determination when the investigation had not been completed. The facility

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executive director stated, "I don't think it happened. [Resident # 5] tells lies. In the past he has made accusations and said this happened and he comes back 3 or 4 days later and says he is sorry. I am more concerned with this nurse LPN # 1. I think she put [Resident # 5] up to calling the police. It's a lot of drama involved in this with CNA # 2 and LPN # 1. They have issues with the family. My issue is more with LPN # 1 and I will deal with her after this is over." The surveyor asked the facility executive director if he interviewed CNA # 2. The facility executive director stated that he did not. The facility executive director stated that the facility social services manager interviewed CNA # 2.

On 12/14/18 at 11:20 am, unit manager RN # 1 provided the surveyor with a copy of the "Resident Safety Check" log for Resident # 5. The surveyor observed that the facility staff did not begin documenting resident safety checks for Resident # 5 until 12/12/18 at 7:00 am which was 4 days after the initial allegation of abuse that was reported by Resident # 5, and 2 days after he was transferred into a different room. The surveyor observed that the facility staff did not document 15 minute safety checks for Resident # 5 from 11:00 pm on 12/12/18 through 7:00 am on 12/13/18. There were no documented safety checks from 11:00 pm on 12/13/18 through 7:00 am on 12/14/18. Also there were no documented checks on 12/14/18 at 11:00 am and 11:15 am.

On 12/14/18 at 11:47 am, two surveyors met with the facility executive director per his request. The facility executive director stated, "I felt bad about how I came across about not believing him. We always believe him. It may turn out that it's true. I wouldn't have done anything differently. We

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separated them. We met with the family." The surveyor stated to the facility executive director that the alleged perpetrator returned to the building on Sunday and Resident # 5 stated that she jerked the table from under him. The facility executive director stated, "No she wasn't, I was here all day and no one came in. I drove staff back and forth to the hotel." The surveyor asked the facility executive director if he knows for a fact that the alleged perpetrator did not enter the building because on 12/13/18 after viewing the visitor sign in log and seeing that no one had signed in as a visitor, 2 surveyors toured the facility saw the alleged perpetrator along with her mother and grandson visiting with their loved one in the hallway at the same table that Resident # 5 said the alleged perpetrator jerked from underneath him. The facility executive director did not respond. The surveyor informed the facility executive director that Resident # 5 became tearful during the interview when he reported what happened. The surveyor told the facility executive director that Resident # 5 had been working on his toileting and stated that the alleged perpetrator yelled at him and prevented him from using the bathroom causing him to urinate on himself. The facility executive director stated, "She says she sat on the bed talking to him." The surveyor stated to the facility executive director that he stated that Resident # 5 tells lies but the facility is still obligated to protect him. The surveyor informed that facility executive director that Resident # 5 stated that he isn't coming out of his room like he normally does and is only coming out for meals because he does not want to run into the alleged perpetrator and this is not a normal behavior for Resident # 5. The facility executive director stated, "I don't know what the solution is. (Resident name withheld) has been in

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F 610	Continued From page 74 that room forever and he doesn't want to move. They fought for years to get him back to that unit." The surveyor told the facility executive director that she was unable to advise him on what to do but he has an obligation to protect Resident # 5 and all residents. The surveyor made the facility executive director aware that the investigation into the allegation of abuse did not have documentation of a thorough investigation and that the investigation had not been completed within a timely manner. The facility executive director stated, "I thought I had 5 working days from the FRI" The surveyor informed the facility executive director that the investigation was to be completed within 5 working days from the time of the incident. The facility policy on "Abuse, Neglect, Exploitation & Misappropriation" contained documentation that included but was not limited to: ..."Mental and verbal abuse include but are not limited to: Harassing a resident Mocking, insulting, ridiculing Yelling or hovering over a resident, with intent to intimidate Threatening residents, depriving a resident of care or withholding a resident from contact with family and friends Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include put are not limited to: Failure to take precautionary measures to protect the health and safety of the resident. Procedure Acts of abuse directed against	F 610		

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F 610	Continued From page 75 residents are absolutely prohibited. Such acts are cause for disciplinary action, including dismissal and possible prosecution. Questions may arise as to what actions constitute abuse of a resident. Any action that may cause or causes actual physical psychological or emotional harm, which is not caused by simple negligence, constitutes abuse. Actions such as striking a resident, restraining a resident improperly or without authorization, and other such acts which can be seen as causing physical pain to a resident are strictly forbidden. Acts such as teasing, humiliating, degrading, or intentionally ignoring a resident may constitute abuse and will be dealt with no less severely than acts causing physical harm. Non-action, which results in emotional, psychological, or physical injury in the same manner as that caused by improper or excessive action. All actions in which employees engage with residents must have as their legitimate goal, the healthful, proper, and humane care and treatment of the resident. Furthermore, the Administration of the company recognizes that resident abuse can be committed by other residents, visitors, or volunteers. Employee Obligation All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no 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	F 610		

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F 610	Continued From page 76 the events that cause the allegation do not involve abuse or do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated abuse coordinator. An employee shall be deemed to have violated his obligations in paragraph "1A" (above) if he does any of the following: Harasses or otherwise retaliates against any resident, employee, or other person who discloses information or participates in an investigation of an act of resident abuse. 5. Investigation The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. Investigations will be accomplished in the following manner. Immediately upon the allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation resident of the allegation. Protection Increased supervision of the alleged victim and residents. Review of Report Report the results of all investigations to the Executive Director 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	F 610		

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F 610	Continued From page 77 If the alleged violation is verified appropriate corrective action must be taken" ... On 12/14/18 at 2:02 pm, the administrative team was made aware of the findings as stated above. No further information regarding this incident was provided to the survey team prior to the exit conference on 12/14/18.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after	F 622	**F622- Transfer and Discharge Requirements** 1. Resident #98 discharged from facility on 10/22/2018. Resident #5 re-admitted to facility on 8/27/2018 and has not had any additional transfers. Resident #89 transferred to the hospital on 11/02/2018 and returned within 24 hours and has not had any additional transfers. 2. The UMs will complete quality review for residents transferred and/or discharged in the last 30 days to identify if the required documentation was provided to the resident or the responsible party when discharged home, to the receiving facility, transferred to the hospital or another facility by 1/25/2019. Follow up based on findings.	

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F 622	Continued From page 78 admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and	F 622	3. The ADCS and or RDCS will provide re-education to Licensed staff and Interdisciplinary team on federal regulations and guidelines on the transfer and discharge process to ensure when the facility transfers or discharges a resident, under any of the circumstances identified in federal regulation, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution and or provided to residents when discharged home by 1/28/2019. 4. DCS and or ADCS will conduct random quality monitoring of resident transfer discharge documentation, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

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F 622	Continued From page 79 (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide receiving provider all of the required documentation when a resident was transferred for 3 of 23 residents in the survey sample (Resident #98, #5 and #89). The findings included: 1. Resident #98 was admitted to the facility on 10/15/18 and discharged on 10/22/18. The only MDS (Minimum Data Set) available to review were the entry MDS and discharge MDS. Resident #98 had the following diagnoses of, but not limited to diabetes, high blood pressure, neuropathy and acute kidney failure. During the closed record review on 12/14/18, the surveyor noted a physician order dated for	F 622		

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F 622	Continued From page 80 10/19/18 which read, "Pt. (patient) to D/C (discharge) 10/22/18 to _____ (name of another facility)." The surveyor also noted that on 10/22/18 at 10:00 am, the nurses' notes read as follows: "Pt daughter d/cd (discharged) pt w/o (without) summary & scripts. Staff called daughter to come back & sign discharge summary. Daughter return to sign papers w/o pt." On 12/14/18 at 11 am, the surveyor requested copies of the discharge summary/transfer summary for this resident from the director of nursing (DON). The DON stated that she would get these for the surveyor. At 2 pm, the surveyor again requested a copy of the discharge summary/transfer summary that was sent to the receiving facility on 10/22/18 when Resident #98 was discharged. At 2:30 pm, the DON provided the surveyor with a "Transfer/Discharge Report" for Resident #98. The DON stated, ""that's all I can do right now is to show you what it looked like when I run that report." There was no information on it except for demographics of the resident. No further information was provided to the surveyor prior to the exit conference on 12/14/18. 2. The facility staff failed to ensure that comprehensive care plan goals were sent to the receiving facility when Resident # 5 was transferred to the hospital on 8/12/18. Resident # 5 was a 40-year-old-male who was admitted to the facility on 4/20/18, with a readmission date of 8/27/18. Diagnoses included but were not limited to, hypertension, major	F 622		

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F 622	Continued From page 81	F 622		

depressive disorder, anxiety disorder, and benign prostatic hyperplasia.

The clinical record for Resident # 5 was reviewed on 12/13/18 at 10:41 am. The most recent MDS (minimum data set) assessment for Resident # 5 was a quarterly assessment with an ARD (assessment reference date) of 9/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 5 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 15 was cognitively intact.

On 12/14/18 at 11:41 am, the surveyor reviewed the "Interdisciplinary Progress Notes" for Resident # 5. A note was documented on 8/12/18 at 2:30pm as "V/S (vital signs) 136/89, 130, 18, 97.6, 97% R/A (room air). Res (resident) c/o (complaining of) pain to sacral area with numbness to spine. Res requesting to be sent to ER (emergency room) Resident sent out 911 per Dr. (doctor) order. Res has no adverse reaction to abt (antibiotic treatment) for UTI (urinary tract infection)."

On 12/14/18 at 12:05 pm, the surveyor spoke with unit manager RN # 1 (registered nurse) and requested to see documentation of what information was sent to the receiving facility when Resident # 5 was transferred to the hospital on 8/12/18.

On 12/14/18 at 1:46 pm, unit manager RN # 1 provided the surveyor with a copy of the "Nursing Home To Hospital Transfer Form" that was sent with Resident # 5. The surveyor reviewed the form and did not locate any documentation that

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F 622	Continued From page 82 supported that comprehensive care plan goals were sent to the receiving provider when Resident # 5 was transferred to the hospital on 8/12/18. On 12/14/18 at 2:02 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 12/14/18. 3. For Resident #89, facility staff failed to provide written notice of transfer when the resident was transferred to the hospital. Resident #89 was admitted to the facility on 3/28/17. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following subarachnoid hemorrhage, dysphagia, encounter for care of tracheostomy, atherosclerotic heart disease, post-traumatic stress disorder, bipolar disorder, atherosclerotic heart disease, diabetes mellitus type I, and chronic obstructive pulmonary heart disease. On the quarterly minimum data set assessment with assessment reference date 10/10/2018, the resident scored 15/15 on the brief interview for mental status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting self or others. The resident's latest safe smoking assessment was dated 9/26/18 and indicated the resident was able to smoke independently. The resident was acting as her own responsible party. During an interview on 12/13/18, the resident reported being generally content with physical care received, but indicated a desire to transfer to another facility prior to the planned ban on smoking starting in February 2019. The resident reported having asked several times about	F 622		

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F 622	Continued From page 83 progress toward the transfer, but having no timeline for the transfer. The resident also reported being sent to the hospital for tracheostomy revision the month before. The resident said she had been given no written notice of the reasons for transfer to the hospital. Clinical record review reveled that on 11/2/18, staff requested a ECO (emergency commitment order) and called an ambulance to take the resident to the hospital. There was no indication the resident's physician was notified of the situation or that there was a change of condition requiring hospitalization. During a summary meeting on 12/13/18, the surveyor reported to the administrator, director of clinical (DCS) and the corporate regional director for clinical services the concern with the situation on 11/2 described in the record. Facility staff indicated that residents and families were not routinely provided written notices including reason for transfer.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 623	**F623- Notice Requirements Before Transfer/Discharge** 1. Resident #89 transferred to the hospital on 11/02/2018 and returned within 24 hours and has not had any additional transfers. Resident #58 re-admitted to facility on 12/5/2018 and discharged 1/17/2019. Resident #22 re-admitted to facility on 11/10/2018 and has not had any additional transfers. Resident #5 re-admitted to facility on 8/27/2018 and has not had any additional transfers. Resident #55 re-admitted to facility on 11/21/2018 and has not had any additional transfers.	

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F 623	Continued From page 84 accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section, (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which	F 623	2. The UMs will complete quality review of residents transferred and/or discharged in the last 30 days to ensure appropriate notification was provided to Resident, Resident's Representative, and Ombudsman on 1/25/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed staff and Interdisciplinary team on the federal regulations/guidelines for transfer and discharge, including the facility sending a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman and record the reasons for the transfer or discharge in the resident's medical record, by 1/28/19. 4. DCS and or ADCS will conduct random quality monitoring of resident transfer discharge notification, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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F 623	Continued From page 85 receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as	F 623		

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F 623	Continued From page 86 well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide a written notice of transfer to the resident and resident representative when transferred to local hospitals and failed to notify the ombudsman of hospitalization and/or transfers to other facilities. Residents effected in a sample of 23 were Resident #89, Resident #58, Resident #22, Resident #5, and Resident #55. The findings included: 1. The facility staff failed to notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility staff failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. The facility staff failed to document in the medical record evidence that the notice was sent to the Ombudsman. Five residents were identified to have been transferred to local hospitals (Resident #89, Resident #58, Resident #22, Resident #5, and Resident #55). After reviewing the clinical record none of the five had documentation that written notice of transfer had been provided to the resident and the resident representative and the local ombudsman had not been notified of any transfers to the hospital or other institutions.	F 623		

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F 623	Continued From page 87 When a center transfers or discharges a resident the center must: " Notify the resident and resident representative (s) of the transfer or discharge and the reasons for the move in writing (In a language and manner they understand) " The Center must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Resident #58 was admitted to the facility 12/4/13 and readmitted 12/5/18 with diagnoses that included but not limited to adult failure to thrive, functional intestinal disorders, ileus, rectal tube, sacral ulcer stage 3, hypertension, paroxysmal atrial fibrillation, dementia without behavioral disturbances, pressure ulcers bilateral heels, unstageable, and chronic kidney disease. Resident #58's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/7/18 assessed the resident with a BIMS (brief interview for mental status) as 03/15. Section G Functional Status assessed the resident to need extensive assistance of one person for personal hygiene and was totally dependent on one person for bathing. Resident #58 was in the process of a significant change MDS and comprehensive care plan. Resident #58 was admitted to the hospital 11/28/18. The surveyor interviewed the assistant director of nursing (ADON) on 12/13/18 at 11:53 a.m. about where notification to the ombudsman was located. The ADON stated, "We are not notifying the ombudsman. Never heard we had to do that. As of today, we will start notifying." The surveyors met with the administrator, the	F 623		

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F 623	Continued From page 88 director of nursing, and the regional registered nurse on 12/13/18 at 4:29 p.m. The DON stated written transfer notification was not done and the ombudsman was not notified when residents are sent to the hospital. The surveyor requested the facility policy pertaining to transfers/discharge notification on 12/14/18. The surveyor interviewed the admissions staff on 12/14/18 at 11:25 a.m. The lead admission staff stated he was not providing written transfer notice to the resident or their representative. The lead admission staff stated if the resident was their own responsible party (RP), whom would the written notice of transfer be sent to? The policy titled "Transfer/Discharge Notification & Right to Appeal Effective Date: 09/23/2017 Revision Date: 3/26/2018" read in part "Transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements. Procedure: Notice Before Transfer: Before " Record the reasons for the transfer or discharge in the resident's medical record. Documentation: When the center transfers or discharges a resident under any of the circumstances listed above the facility will ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider." No further information was provided prior to the exit conference on 12/14/18. 2. The facility staff failed to provide written documentation of transfer to the resident and	F 623		

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F 623	Continued From page 89 resident representative and failed to notify the ombudsman when Resident #55 was transferred to the hospital. The clinical record of Resident #55 was reviewed 12/12/18 through 12/14/18. Resident #55 was admitted to the facility 8/22/18 and readmitted 10/19/18 and 11/21/18 with diagnoses that included but not limited to type 2 diabetes mellitus with hyperglycemia, cerebral infarction due to embolism of cerebral artery, dysphagia, mild cognitive impairment, lack of coordination, cognitive communication deficit, aphasia, acute cystitis without hematuria, anxiety, bipolar disorder, hyperlipidemia, major depressive disorder, hypertension, and migraines. Resident #55's 14-day minimum data set (MDS) with an assessment reference date (ARD) of 11/2/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #55's current comprehensive care plan identified the resident to be at nutrition/hydration risk r/t (related to) altered nutrient utilization AEB (as evidenced by) diagnoses include DM2 (diabetes mellitus 2) with poorly controlled serum glucose levels, HgbA1c (hemoglobin A1C) at 13.2% 8/18/18. Interventions included to obtain and monitor lab/diagnostic work as ordered. Report results to MD (medical doctor) and follow up as indicated. Date initiated 8/27/18 and revision on 12/12/18. Resident #55 was admitted to the hospital 11/12/18. The surveyor was unable to find documentation in the clinical record of required paperwork and notification and informed the unit manager licensed practical nurse #2 on 12/13/18.	F 623		

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	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

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F 623	Continued From page 90 The surveyor interviewed the assistant director of nursing (ADON) on 12/13/18 at 11:53 a.m. about where notification to the ombudsman was located. The ADON stated, "We are not notifying the ombudsman. Never heard we had to do that. As of today, we will start notifying." The surveyors met with the administrator, the director of nursing, and the regional registered nurse on 12/13/18 at 4:29 p.m. The DON stated written transfer notification was not done and the ombudsman was not notified when residents are sent to the hospital. The surveyor requested the facility policy pertaining to transfers/discharge notification on 12/14/18. The surveyor interviewed the admissions staff on 12/14/18 at 11:25 a.m. The lead admission staff stated he was not providing written transfer notice to the resident or their representative. The lead admission staff stated if the resident was their own responsible party (RP), whom would the written notice of transfer be sent to? The policy titled "Transfer/Discharge Notification & Right to Appeal Effective Date: 09/23/2017 Revision Date: 3/26/2018" read in part "Transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements. Procedure: Notice Before Transfer: Before a center transfers or discharges a resident the center must: " Notify the resident and resident representative (s) of the transfer or discharge and the reasons for the move in writing (in a language and manner they understand) " The Center must send a copy of the notice to	F 623		

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F 623	Continued From page 91 a representative of the Office of the State Long-Term Care Ombudsman " Record the reasons for the transfer or discharge in the resident's medical record. Documentation: When the center transfers or discharges a resident under any of the circumstances listed above the facility will ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider." No further information was provided prior to the exit conference on 12/14/18. 3. For Resident #89, facility staff failed to provide written notice of transfer when the resident was transferred to the hospital. Resident #89 was admitted to the facility on 3/28/17. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following subarachnoid hemorrhage, dysphagia, encounter for care of tracheostomy, atherosclerotic heart disease, post-traumatic stress disorder, bipolar disorder, atherosclerotic heart disease, diabetes mellitus type I, and chronic obstructive pulmonary heart disease. On the quarterly minimum data set assessment with assessment reference date 10/10/2018, the resident scored 15/15 on the brief interview for mental status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting self or others. The resident's latest safe smoking assessment was dated 9/26/18 and indicated the resident was able to smoke independently. The resident was acting as her own responsible party. During an interview on 12/13/18, the resident reported being generally content with physical	F 623		

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F 623	Continued From page 92 care received, but indicated a desire to transfer to another facility prior to the planned ban on smoking starting in February 2019. The resident reported having asked several times about progress toward the transfer, but having no timeline for the transfer. The resident also reported being sent to the hospital for tracheostomy revision the month before. The resident said she had been given no written notice of the reasons for transfer to the hospital. Clinical record review reveled that on 11/2/18, staff requested a ECO (emergency commitment order) and called an ambulance to take the resident to the hospital. There was no indication the resident's physician was notified of the situation or that there was a change of condition requiring hospitalization. During a summary meeting on 12/13/18, the surveyor reported to the administrator, director of clinical (DCS) and the corporate regional director for clinical services the concern with the situation on 11/2 described in the record. Facility staff indicated that the ombudsman was not routinely provided notices of transfer and discharge. 4. For Resident #22, the facility staff failed to provide a written notice of transfer when Resident #22 was transferred to a local hospital and failed to notify the ombudsman of hospitalization. Resident #22 is a 58-year-old male who was originally admitted to the facility on 08/04/16, with a readmission date of 11/10/18. Diagnoses included, but were not limited to, hypertension, acute kidney failure, major depressive disorder, diabetes, and complete traumatic amputation. The clinical record for Resident #22 was reviewed	F 623		

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F 623	Continued From page 93 on 12/13/18 at 8:00 am. The most recent MDS (minimum data set) assessment for Resident #22 was a quarterly assessment with an ARD (assessment reference date) of 10/03/18. In Section C0500, the facility staff documented that Resident #22 had a BIMS (brief interview for mental status) score of 15 out of 15. On 12/13/18 the surveyor reviewed Resident #22's progress notes. The clinical record contained a progress note dated 11/07/18 at 7:30 pm that read in part, "Resident continues to have large amount of dark brown coffee ground emesis, After speaking to the Resident multiple times throughout the shift Resident has agreed to go to the ED (emergency department) for evaluation . . ." The surveyor could not locate documentation in Resident #22's clinical record that indicated that Resident #22 was given a written copy of the transfer agreement upon transfer to the emergency room on 11/07/18. On 12/13/18 at 4:31 pm during end of day meeting with the executive director. the DON (director of nursing), and the regional nurse consultant. The administrative team was asked by the survey team how and if they notify the ombudsmen of transfers. The executive director voiced they do not notify the ombudsman of transfers to the hospital. The DON also agreed the ombudsman was not notified of transfers. The surveyor asked the administrative team if the Resident or responsible party were provided with a written transfer agreement at the time of transfer. The DON voiced that transfer agreements were not provided in writing at the time of transfer. The DON stated "We notify over	F 623		

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F 623	Continued From page 94 the phone and make a note but they are not given in writing". On 12/14/18 at 11:26 am, the surveyor spoke with DON (director of nursing) and it was clarified that the facility staff did not give transfer agreement in writing to Resident #22 upon transfer to the local hospital on 11/07/18. The administrative team was made aware of issue during a meeting with survey team on 12/14/18 at 2:00 pm. No further information regarding this issue was provided to the survey team prior to the exit conference on 12/14/18. 5. The facility staff failed to provide written notification to the resident and the resident representative and the ombudsman when Resident #5 was tranmsferred to the hospital 8/12/18. Resident # 5 was a 40-year-old-male who was admitted to the facility on 4/20/18, with a readmission date of 8/27/18. Diagnoses included but were not limited to, hypertension, major depressive disorder, anxiety disorder, and benign prostatic hyperplasia. The clinical record for Resident # 5 was reviewed on 12/13/18 at 10:41 am. The most recent MDS (minimum data set) assessment for Resident # 5 was a quarterly assessment with an ARD (assessment reference date) of 9/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 5 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 15 was cognitively	F 623		

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F 623	Continued From page 95 intact. The surveyors met with the administrator, the director of nursing, and the regional registered nurse on 12/13/18 at 4:29 p.m. The DON stated written transfer notification was not done and the ombudsman was not notified when residents are sent to the hospital. The surveyor requested the facility policy pertaining to transfers/discharge notification on 12/14/18. The policy titled "Transfer/Discharge Notification & Right to Appeal Effective Date: 09/23/2017 Revision Date: 3/26/2018" read in part "Transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements. Procedure: Notice Before Transfer. Before a center transfers or discharges a resident the center must: " Notify the resident and resident representative (s) of the transfer or discharge and the reasons for the move in writing (in a language and manner they understand) " The Center must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman " Record the reasons for the transfer or discharge in the resident's medical record. Documentation: When the center transfers or discharges a resident under any of the circumstances listed above the facility will ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider." On 12/14/18 at 2:02 pm, the administrative team was made aware of the findings as stated above.	F 623		

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F 623	Continued From page 96 No further information was provided prior to the exit conference on 12/14/18.	F 623		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide for a safe and orderly transfer for 1 of 23 residents (89). Resident #89 was admitted to the facility on 3/28/17. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following subarachnoid hemorrhage, dysphagia, encounter for care of tracheostomy, atherosclerotic heart disease, post-traumatic stress disorder, bipolar disorder, atherosclerotic heart disease, diabetes mellitus type I, and chronic obstructive pulmonary heart disease. On the quarterly minimum data set assessment with assessment reference date 10/10/2018, the resident scored 15/15 on the brief interview for mental status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting self or others. The resident's latest safe smoking assessment was dated 9/26/18 and indicated the resident was able to smoke independently. The resident was acting	F 624	**F624- Preparation for Safe/Orderly Transfer/Discharge** 1. Resident #89 transferred to the hospital on 11/02/2018 and returned within 24 hours and has not had any additional transfers. 2. The DCS and or UMs will complete a quality review of residents transferred and/or discharged in the last 30 days to ensure appropriate documentation is in the resident's medical record by 1/25/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed staff and Interdisciplinary team on federal regulations and guidelines for discharge and transfer, including the facility providing and documenting sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility, by 1/28/2019.	