STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495359	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND REHAB	120 DOGWOOD LANE ORANGE, VA 22960

(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 09/17/19 through 09/18/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/17/19 through 9/19/19. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 164 certified bed facility was 140 at the time of the survey. The survey sample consisted of 51 current residents, and three closed records.	F 000		
F 550 SS=D	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		10/18/19

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

Electronically Signed | 10/18/2019

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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 facility documentation review and staff interview, facility staff failed to preserve the dignity of two of 54 Residents in the survey sample, Residents #92 and #5. A facility staff member took unauthorized pictures of Resident #92 and #5 with a cell phone and shared them among other staff. The findings included: Resident #92 was admitted to the facility on 11/01/2016. Her diagnoses included depression, gastro-esophageal reflux disease (acid reflux),	F 550	Past noncompliance: no plan of correction required.	

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F 550	Continued From page 2	F 550		

and repeated falls. Resident #92's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 08/06/2019. The Brief Interview for Mental Status (BIMS) scored Resident #92 at a 00, indicating that the BIMS was not conducted, as the Resident is rarely or never understood. The Staff Assessment for Mental Status scored Resident #92 at a 3, indicating severe impairment. Resident #92 was coded as requiring total assistance of one person for ambulation and toileting, and extensive assistance of one person for eating.

Resident #5 was admitted to the 11/11/2017. Her diagnoses included instability of the right hip, heart disease, and insomnia. Resident #5's most recent MDS Assessment was a Significant Change Assessment with an ARD of 06/05/2019. The BIMS scored Resident #5 at a three, indicating profound impairment. Resident #5 was coded as requiring extensive assistance of two or more persons for dressing and toileting, and requiring limited assistance of one person for eating.

The records of Resident #92 and #5 were reviewed beginning on 09/17/2019 as part of an investigation of a Facility Reported Incident (FRI) and Complaint alleging a staff member took unauthorized photos of the residents with a cell phone, and distributed them to other members of the staff. The staff member who took the pictures was no longer employed at the facility, and was assigned the identifier Certified Nurse Aide (CNA) #20.

A review of the FRI sent to the Office of Licensure and Certification on 08/03/2018 detailed the

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F 550	Continued From page 3	F 550		

following:
Incident Date: 07/31/2018
Residents Involved: [RESIDENT #5] [RESIDENT #92]
Incident Type: a box indicating "HIPAA (Health Insurance Portability and Accountability Act) Violation" is checked.
Describe Incident, including location, and action taken: "While investigating an employee incident, it was found that a CNA had taken distorted pictures of two residents and sent the pictures to another employee."
Name of employee(s) involved and their positions: [CNA #20] CNA - took the pictures
Employee action taken or initiated: [CNA #20] was terminated.

On 09/19/2019 at 2:13p.m., an interview was conducted with CNA #3 regarding the incident. CNA #3 stated that another employee, CNA #20, had taken pictures of two residents and sent them to her on Facebook Messenger (an online instant messenger program, also available on phones). CNA #3 stated that she was off work on the day she received the pictures, but that she reported the incident to Administrative Staff Member (ASM) #2, the Director of Nursing, the next day when she reported to work. When asked if it was ever permissible to take photos of residents without getting consent, CNA #3 stated "absolutely not".

A review of Resident #92 and Resident #5's Comprehensive Care Plans revealed that the care plans for each resident were reviewed and updated following the event, with interventions to monitor for changes in mood or anxiety as a result of the incident.

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F 550	Continued From page 4	F 550		

A review of the facility policy on Dignity, with a review date of 01/2016, revealed the following: "Policy: The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." Under the heading "Procedure", the following line was noted: "12. Refraining from practices demeaning to residents."

ASM #1, the Executive Director, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 09/19/2019.

The administrator provided the following information:
1. The facility established a corrective action plan for Resident #92 and #5, staff member (CNA) #20 had taken unauthorized picture of residents with a cell phone and shared with another staff member. C.N.A. #20 was suspended pending investigation and terminated 8/1/18.

2. The other residents who reside at the facility have the potential to be affected.

3. Facility staff were reeducated on 8/20/18 on the abuse policy regarding resident rights to include dignity and Protected Health Information.

4. To ensure compliance audits were conducted ongoing and this information was forwarded to QAPI (quality assurance and performance improvement) for review.

5. Compliance Date 8/31/18

No other occurrences were identified during the survey.

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F 550	Continued From page 5 Past noncompliance. COMPLAINT DEFICIENCY	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583		10/18/19

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F 583	Continued From page 6 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on facility documentation review and staff interview, facility staff failed to preserve the privacy of two of 54 Residents in the survey sample, Residents #5 and #92. For Resident #92 and #5, a staff member took unauthorized pictures of the Residents with a cell phone and shared them among other staff. The findings included: Resident #5 was admitted to the 11/11/2017. Her diagnoses included instability of the right hip, heart disease, and insomnia. Resident #5's most recent MDS Assessment was a Significant Change Assessment with an ARD of 06/05/2019. The BIMS scored Resident #5 at a three, indicating profound impairment. Resident #5 was coded as requiring extensive assistance of two or more persons for dressing and toileting, and requiring limited assistance of one person for eating. Resident #92 was admitted to the facility on 11/01/2016. Her diagnoses included depression, gastro-esophageal reflux disease (acid reflux), and repeated falls. Resident #92's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 08/06/2019. The Brief Interview for Mental Status (BIMS) scored Resident #92 at a 00, indicating that the BIMS was not conducted, as the Resident is rarely or never understood. The Staff Assessment for Mental Status scored Resident #92 at a 3, indicating severe impairment. Resident #92 was	F 583	Past noncompliance: no plan of correction required.	

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F 583	Continued From page 7	F 583		

coded as requiring total assistance of one person for ambulation and toileting, and extensive assistance of one person for eating.

The records of Resident #92 and #5 were reviewed beginning on 09/17/2019 as part of an investigation of a Facility Reported Incident (FRI) and Complaint alleging a staff member took unauthorized photos of the Residents with a cell phone, and distributed them to other members of the staff. The staff member who took the pictures was no longer employed at the facility, and was assigned the identifier Certified Nurse Aide (CNA) #20.

A review of the FRI sent to the Office of Licensure and Certification on 08/03/2018 detailed the following:
Incident Date: 07/31/2018
Residents Involved: [RESIDENT #5] [RESIDENT #92]
Incident Type: a box indicating "HIPAA (Health Insurance Portability and Accountability Act) Violation" is checked.
Describe Incident, including location, and action taken: "While investigating an employee incident, it was found that a CNA had taken distorted pictures of two residents and sent the pictures to another employee."
Name of employee(s) involved and their positions: [CNA #20] CNA - took the pictures
Employee action taken or initiated: [CNA #20] was terminated.

On 09/19/2019 at 2:13p.m., an interview was conducted with CNA #3 regarding the incident. CNA #3 stated that another employee, CNA #20, had taken pictures of two residents and sent them to her on Facebook Messenger (an online

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F 583	Continued From page 8	F 583		

instant messenger program, also available on phones). CNA #3 stated that she was off work on the day she received the pictures, but that she reported the incident to Administrative Staff Member (ASM) #2, the Director of Nursing, the next day when she reported to work. When asked if it was ever permissible to take photos of residents without getting consent, CNA #3 stated "absolutely not".

A review of Resident #92 and Resident #5's Comprehensive Care Plans revealed that the care plans for each resident were reviewed and updated following the event, with interventions to monitor for changes in mood or anxiety as a result of the incident.

On 09/19/2019 at 3:17p.m., Registered Nurse (RN) #8 stated that the facility did not have a specific policy on resident privacy.

A review of the facility policy on Dignity, with a review date of 01/2016, revealed the following: "Policy: The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." Under the heading "Procedure", the following line was noted: "12. Refraining from practices demeaning to residents."

ASM #1, the Executive Director, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 09/19/2019.

The administrator provided the following information:
1. The facility established a corrective action plan for Resident #92 and #5, staff member (CNA)

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F 583	Continued From page 9 #20 had taken unauthorized picture of residents with a cell phone and shared with another staff member. C.N.A. #20 was suspended pending investigation and terminated 8/1/18. 2. The other residents who reside at the facility have the potential to be affected. 3. Facility staff were reeducated on 8/20/18 on the abuse policy regarding resident rights to include dignity and Protected Health Information. 4. To ensure compliance audits were conducted ongoing and this information was forwarded to QAPI (quality assurance and performance improvement) for review. 5. Compliance Date 8/31/18 No other occurrences were identified during the survey. Past noncompliance. COMPLAINT DEFICIENCY	F 583		
F 600 SS=E	COMPLAINT DEFICIENCY 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	F 600		10/14/19

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F 600	Continued From page 10 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure six of 54 sampled residents, (Residents #56, #1, #39, #63, #83, and #187), were free from abuse. Resident #56 was punched in the stomach by Resident #1 on 9/22/19. Resident #187 punched Resident #1 in the left arm and rammed Resident #1 into the wall with his wheelchair on 10/16/18. On 3/12/19, Resident #32 "back handed" Resident #63 in the face. On 10/23/19, CNA (certified nursing assistant) #4 slapped Resident #83's arm and bent the resident's right hand/wrist. Resident #23 smacked Resident #83 on the back of the head on 4/19/19 and on 5/17/19. Resident #187's wheelchair bumped into Resident #23 and Resident #23 turned around and hit Resident #187 on the head. The findings include: 1. The facility staff failed to ensure Resident #56 was free from abuse. On 9/22/19, Resident #1 punched Resident #56 in the stomach. Resident #56 was admitted to the facility on 04/04/2018. His diagnoses included sleep apnea (periodic cessation of breathing during sleep),	F 600	1. The facility has established a corrective action plan for residents #56, #1, #39, #63, #83, and #187 as sited on the most recent annual survey to ensure that those residents were free from abuse. The staff #4 which was involved with resident #83 was suspended on 10/23/18 and after a complete investigation the staff member was terminated on 10/26/18. 2. The other residents who reside at the facility have the potential to be affected by this same deficient practice. 3. The facility staff were re-educated on the abuse policy to include monitoring resident behavior and having interventions in place to ensure that the residents are free from abuse. This re-education is to be completed by 10/14/19. 4. To ensure compliance, audits will be conducted by Administrative staff (or designee) every week for 4 weeks, then monthly for 3 months to monitor resident behaviors and review care plans for interventions to ensure that the residents are free from abuse and the staff are aware of the abuse policy. This	

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arthritis, and depression. Resident #56's most recent MDS (minimum data set) Assessment was a Quarterly Assessment with an ARD (assessment reference date) of 07/13/2019. The Brief Interview for Mental Status scored Resident #56 at a 14, indicating minimal impairment. Resident #56 was coded as requiring standby assistance of 1 person for ambulation, and requiring setup assistance of 1 person for eating and personal hygiene.

Resident #1 was admitted to the facility on 03/01/2016. His diagnoses included diabetes, hypertension (high blood pressure), and depression. Resident #1's most recent MDS Assessment was a Quarterly Assessment with an ARD of 08/28/2019. The BIMS scored Resident #1 at a 12, indicating mild impairment. Resident #1 was coded as requiring only setup assistance with all Activities of Daily Life (ADLs).

Resident #56's record was reviewed as part of a FRI regarding an incident of resident-to-resident abuse between Resident #56 and Resident #1 that occurred on 09/22/2019. A review of the FRI sent to the Office of Licensure and Certification on 09/22/2019 revealed the following:

Incident Date: 09/22/2019
Residents involved: [Resident #1], [Resident #56]
Injuries: the box marked "no" was checked.
Incident type: the box marked "Life/safety affected" is checked.
Describe the incident, including location, and action taken: "Both [Resident #1] & [Resident #56] were raising their voices due to another resident yelling in the day room. The men began to yell at one another which soon became physical. Several punches were thrown and both

information will be forwarded to QAPI for review.

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F 600	Continued From page 12	F 600		

men were struck during the altercation. Both men were separated, redirected [with] guided imagery, & provided a calm environment."
Employee action initiated or taken: "Both residents were provided a calm environment. They were redirected with guided imagery and separated immediately."

A form entitled "Statement by Witness" was included in the FRI. The document reads:
Facility Name: [FACILITY]
Witness Name: [CNA #21]
Job Title: CNA
Incident pertains to whom: [Resident #1]/ [Resident #56]
Please describe what happened in detail (including date, time, place, and any witnesses):
"I [CNA #21] was in the social area talking with my coworkers [COWORKERS NAMES] about intake on a resident when [COWORKER] noticed [RESIDENT #1] and [RESIDENT #56] was[sic] face to face with each other. So he jumped up to get in the middle of the two as he was on the way over I noticed [RESIDENT #1] hit [RESIDENT #56] in the stomach. Once [COWORKER] got over in the middle of them they parted and we went to go get the charge nurse."
Signature of Witness: [Signed by CNA #21]
Date Completed: 09/22/2019

A review of Resident #56 and Resident #1's Comprehensive Care Plans revealed that the care plans for each resident were reviewed and updated following the event, with interventions to monitor for aggressive behaviors and changes in mood for both residents.
On 9/18/19 at 2:51 p.m., CNA (certified nursing assistant) #17 was interviewed. When asked if a resident hitting another resident would be

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considered abuse, CNA #17 stated, "Yes ma'am. I think so. You can't just hit somebody." When asked what she would do if she saw one resident hit another resident with her walker, she stated, "I would separate them, make sure they are okay. Then I would get the nurse."

On 9/18/19 at 2:55 p.m., CNA #18 was interviewed. When asked if a resident hitting another resident would be considered abuse, CNA #18 stated, "Yes it would." When asked what she would do if she saw one resident hit another resident with her walker CNA #18 stated, "I would make sure they are separated. Maybe I would take one of the residents back to their room. I would get someone to help me. And I would get the nurse."

On 9/18/19 at 3:16 p.m., LPN (licensed practical nurse) #4, a unit manager, was interviewed. She stated that in the case of a resident-to-resident altercation, the residents should be immediately separated and assessed. She stated that if neither resident requires immediate first aid, the RRs (resident representatives) and the physician should be notified. She stated nurse notes should be written. When asked if care plans should be updated, she stated: "Yes, the care plans for both residents would need to show it."

On 9/19/19 at 11:15 a.m., CNA #9 was interviewed regarding any observed resident-to-resident contact. CNA #9 stated, "First I would make sure they are okay, and I would try to find out what is going on. I separate them right away, and then figure out if there is something one of them might need right away." When asked if she would report this, CNA #9 she stated, "Yes, here at [name of facility] especially, you should

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report it as soon as possible; immediately if you can. After you make sure they are okay." When asked whom she would tell, CNA #9 stated, "Here, you go up the chain. The charge nurse, if you can. Or really anybody who is a nurse or a supervisor."

A review of the facility policy, "Abuse Prevention," revealed, in part, the following: "The facility is committed to maintaining a safe and abuse-free environment for all residents and committed to a comprehensive investigation of any allegation of activities or situations that may constitute abuse...All alleged violations involving mistreatment , neglect, abuse, including injuries of unknown source, misappropriation of resident property, corporal punishment, and involuntary seclusion will be reported immediately in accordance with State and Federal law...Physical abuse is hitting, slapping, pinching, kicking, shoving, pushing, non-therapeutic pulling or twisting any part of a resident's body, burning, sticking a resident with an object, or striking a resident with a part of the body or with an object."

Administrative Staff Member (ASM) #1, the Executive Director, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 09/19/2019. No further information was provided.

No further information was provided prior to exit.

2. The facility staff failed to ensure Resident #1 was free from abuse. Resident #187 punched Resident #1 in the left arm and rammed Resident #1 into the wall with his wheelchair on 10/16/18.

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Resident #1 was admitted to the facility on 03/01/2016. His diagnoses included diabetes, hypertension (high blood pressure), and depression. Resident #1's most recent MDS Assessment was a Quarterly Assessment with an ARD of 08/28/2019. The BIMS scored Resident #1 at a 12, indicating mild impairment. Resident #1 was coded as requiring only setup assistance with all Activities of Daily Life (ADLs).

Resident #187 was deceased at the time of survey, and was reviewed as a closed record. Resident #187 was admitted to the facility on 08/26/2015. His diagnoses included diabetes, depression, and insomnia. Resident #187's most recent MDS Assessment was a Significant Change Assessment with an ARD of 02/18/2019. The BIMS scored Resident #187 at a three, indicating profound impairment. Resident #187 was coded as requiring extensive assistance of one person for ambulation and dressing, and requiring setup assistance for dining.

A Review of Resident #1's record was conducted as a part of an investigation of a Facility Reported Incident (FRI) of resident-to-resident abuse that occurred on 10/16/2018. The FRI form reads:
Incident Date: 10/16/2018
Residents Involved: [RESIDENT #187] [RESIDENT #1]
Injuries: "No" is checked.
Incident Type: "Resident to Resident Contact" is handwritten below the template options.
Describe the incident, including location, and action taken: "[RESIDENT #1] was walking back from the main dining room with his food and [RESIDENT #187] was sitting in front of the med cart, he started screaming at [RESIDENT #1] for no reason then went up to him & pushed him into

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the wall after punching him in the left arm." Employee Action initiated or taken: "[LPN #4] got in between residents to prevent residents from fighting or touching each other. [RESIDENT #1] went to his room. [RESIDENT #187] SM (South Main, a unit in the facility) sat [sic] at corner of west main beside food cart."

On 09/19/2019 at 11:11a.m., an interview was conducted with LPN #4 regarding the incident. LPN #4 stated that Resident #1 was on his way back from the dining room with his tray of food, when Resident #187 suddenly wheeled his wheelchair into Resident #1 "ramming [RESIDENT #1] into the wall". LPN #4 stated that she immediately separated the residents, and Resident #1 returned to his room. LPN #4 stated that once the residents were separated and calmed, she initiated an incident report, informed the residents' RPs (responsible parties), informed the Physician, and informed the on-call nurse. LPN #4 stated there was no further issue that shift. LPN #4 stated that she also initiated the FRI paperwork, as she was the evening supervisor and it was her responsibility to notify the Office of Licensure and Certification.

A review of the Residents' care plans revealed that both were reviewed and updated following the incident. Resident #1's care plan was revised to include monitoring for changes in behavior or mood, and Resident #187's was updated to include monitoring for aggressive behavior towards others. Review of the clinical record revealed staff monitored Resident #1 and Resident #187 and failed to reveal any behavior changes were noted after this incident.

Administrative Staff Member (ASM) #1, the

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Executive Director, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 09/19/2019. No further information was provided.

3. The facility staff failed to ensure Resident #39 and Resident #63 were free from abuse. On 8/5/18, Resident #63 struck Resident #39; Resident #39 then struck Resident #63 with no injury noted on either resident.

The "Facility Reported Incident" dated, 8/5/18, documented in part, "Incident date: 8/5/18. Resident's involved (Resident #39) and (Resident #63). Injuries: (A check mark was documented next to)"No." Describe Incident: Resident to resident altercation between (Resident #39) and (Resident #63). Resident #39 was hit by Resident #63 at 5:25 PM. No injuries. Residents were separated.

The "Final Report" dated, 8/5/18, documented in part, "This is the Final Report regarding the initial FRI of allegation of abuse/mistreatment regarding (Resident #39) and (Resident #63) reported August 5, 2018...Investigation Summary: Resident to resident altercation between (Resident #39) and (Resident #63) was reported. (Resident #39) and (Resident #63) were seated next to each other, turned and started shouting and hitting each other. Staff report that they did witness the incident and immediately separated the residents. Upon further interview with (Resident #39) by RN (registered nurse), Resident #39 stated that Resident #63 hit him first and he hit back. Resident #39 and Resident #63's care plans were reviewed and revised. Both residents have not had a change in mood or behavior. The residents will continue to be

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monitored for changes in mood or behaviors and staff will follow up with the physician as needed. Conclusion: Based on the investigation, the facility does substantiate a resident to resident altercation occurred between the residents per the residents' statements. Resident #39 was seen by NP (nurse practitioner) on 8/8/18 medication regimen was reviewed and anxiolytic (medication to treat anxiety), was increased.

Resident #39 was admitted to the facility on 3/26/13 with diagnoses that included but were not limited to: vascular dementia (progressive state of mental decline caused by vascular disease) (1), cerebrovascular accident (hemorrhage or blockage of the blood vessels of the brain leading to lack of oxygen) (2), and hemiplegia (paralysis affecting one side of the body) (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/2/19, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions.

Resident #63 was admitted to the facility on 12/17/07. Resident #63's diagnoses included but were not limited to dementia, muscle weakness and major depressive disorder. Resident #63's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 7/24/19, coded the resident's cognition as moderately impaired. Section G coded Resident #63 as requiring supervision with one-person physical assistance with locomotion on the unit.

A nurse's note in Resident #39's clinical record dated, 8/5/18 at 5:52 PM, documented in part,

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"Resident [Resident #39] was seen being hit and hitting another resident [Resident #63] this evening. Altercation ended and resident continued to be angry and started yelling. Resident has now calmed down. Range of motion within normal limits. Behavior checks sheet completed."

A social worker's note in Resident #39's clinical record dated, 8/6/18 at 9:25 AM, documented in part, "Resident [Resident #39] remembers incident, states the other resident kept asking when it was time to eat and wouldn't shut up so I yelled at him. Then he hit me, so I hit him. Resident understands it is wrong to hit. Resident is easily annoyed, short tempered if things don't go, as he perceives they should and can be worked up. He states he isn't injured or hurt and psychosocial appears at baseline."

The care plan dated 8/5/18, documented in part, Problem: "Resident #39 was hit by another male resident, got into verbal and physical altercation. Separated at time and monitored with no issues since. The Goal: dated 8/5/18, documented, "Resident will respond positively to visits by staff and mood/psychosocial well-being will not decline through next review 10/16/18." The Approaches: dated 8/6/18, documented, "Social work interviewed resident about incident, he recollects incident and states 'I am over it'."

An interview was conducted on 9/17/19 at 4:37 PM with Resident #39. When asked if there were any interactions with other residents, Resident #39 stated, "Yes, sometimes." When asked to describe what happened, Resident #39 stated, "I can't stand it when people tell me to be quiet. I can speak." When asked what happens when

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there is an interaction, Resident #39 stated, "The staff separate us or take us to our rooms."

The social worker's note in Resident #63's clinical record dated, 8/6/18 at 9:25 AM, documented in part, "Resident [Resident #63] does not remember incident. His psychosocial appears at baseline."

The care plan dated 8/5/18, documented in part, Problem: "Resident #63 was in verbal/physical altercation another male resident, both separated at time with no injury. The Goal: dated 8/5/18, documented, "Resident will not have any increase in behavior symptoms through next review date of 10/6/18." The Approaches: dated 8/6/18, documented, "Social work interviewed resident about incident, he has no recollection of the incident, psychosocial status at baseline."

An interview was conducted on 9/18/19 at 10:07 AM with RN (registered nurse) #1, the unit manager. When asked if she remembered the August 2018 situation with Resident #39 and Resident #63, RN #1 stated, "Yes." When asked to describe the incident, RN #1 stated, I was informed of this the next day. Resident #39 and Resident #63 were in the social area the evening before and were yelling at each other, then started hitting each other." When asked how Resident #63 and Resident #39 acted towards one another after the incident? RN #1 stated, "They were alright with each other, we monitor their behavior after incidents." The CNA's that witnessed the incident were unavailable for interview (one on family medical leave, one called in sick).

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An interview was conducted on 09/18/2019 at 3:54p.m., with LPN (licensed practical nurse) #9. When asked how she would respond to an allegation of abuse or witnessing abuse, LPN #9 stated, "I would first protect the resident. Then I would notify their manager, who would pass it up the chain to be investigated." LPN #9 stated, "The nurses are expected to go directly to the DON (director of nursing)."

On 9/19/19 at 2:55 PM, ASM (Administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the assistant director of nursing was made aware of the above concern.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 111.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 264.
(4) An "embolus" is a blood clot or a piece of plaque that acts like a clot. The word "emboli" means there is more than one clot or piece of plaque. When the clot travels from the site where it formed to another location in the body, it is called an embolism.This information was obtained from the website: https://medlineplus.gov/ency/article/001102.htm
4. The facility staff failed to ensure Resident #63 was free from abuse. On 3/12/19, Resident #32 "back handed" Resident #63 in the face.

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Resident #63 was admitted to the facility on 12/17/07. Resident #63's diagnoses included but were not limited to dementia, muscle weakness and major depressive disorder. Resident #63's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 7/24/19, coded the resident's cognition as moderately impaired. Section G coded Resident #63 as requiring supervision with one-person physical assistance with locomotion on the unit.

Resident #32 was admitted to the facility on 6/20/18. Resident #32's diagnoses included but were not limited to high blood pressure, pain in right shoulder and chronic obstructive pulmonary (lung) disease. Resident #32's most recent MDS, a significant change in status assessment with an ARD of 6/19/19, coded the resident's cognition as severely impaired. Section G coded Resident #32 as requiring extensive assistance of two or more staff with bed mobility, transfers and dressing.

A FRI (facility reported incident) submitted from the facility to the VDH (Virginia Department of Health) OLC (Office of Licensure and Certification) on 3/12/19 documented, "Report date: 03/12/19. Incident date: 03/12/19. Residents involved: (Resident #32) (Resident #63).
Describe incident, including location, and action taken: (Resident #32) was sitting in her wheelchair in the social area. Resident back handed (Sic.) other resident in the face.
Employee action initiated or taken:
Resident (sic) were separated..."

A witness statement signed by LPN (licensed

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practical nurse) #4 on 3/12/19 documented, "(Resident #32) back handed (Resident #63) in the social area. (Resident #63) is very agitated this shift pacing back and forth in his wheelchair from social area to his room. Yelling at staff & threatening to hit them."

A witness statement signed by CNA (certified nursing assistant) #1 on 3/12/19 documented "(Resident #63) Threaten residents of hitting them and jumped at them getting in their faces."

A witness statement signed by CNA #16 on 3/12/19 documented, "I (name) was working 3-11 (3:00 p.m. to 11:00 p.m. shift) on (name of unit) 3/12/19. Around 4:50 pm (Resident #32) was sitting speaking with another resident. When I turned to look at her I saw (Resident #63) passing her at that time and (Resident #32) took the back of her left hand and hit (Resident #63) in the side of the face several times then hit him in the shoulder several times. (Resident #63) did not react to (Resident #32) but (Resident #63) did react to staff when trying to redriect (sic) him away from (Resident #32)."

A final report submitted from the facility to the VDH OLC on 3/15/19 documented the following; "This letter is to inform you our investigation involving: (Resident #63) (room number) with a BIMS (brief interview for mental status) of 9 (on a scale from 0 to 15, indicating the resident's cognition was moderately impaired) with a diagnosis (sic) dementia, peripheral vascular disease, Vitamin D deficiency and (Resident #32) (room number) with BIMS of 5 (on a scale from 0 to 15, indicating the resident's cognition was severely impaired) with a diagnosis (sic) chronic obstruction pulmonary disease, muscle

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weakness, cognitive communication deficit, hypertension (high blood pressure).
On March, 13, 2019 (Resident #32) made sudden contact with (Resident #63) after he bumped her wheelchair. (Resident #63) and (Resident #32) were separated and assessed. (Resident #63) received a skin assessment from a licensed nurse that revealed no open areas, no redness. (Resident #63) received a pain assessment from a licensed nurse and had no complaints of pain. (Resident #32) received a skin assessment form (sic) a licensed nurse that revealed no open area, no redness. (Resident #63's) Responsible party and a primary care physician were notified on 3/13/19 with no new orders. (Resident #32) received a pain assessment from a licensed nurse and had no complaints of pain. (Resident #32's) Responsible party and primary care physician were notified on 3/13/19 with changes in his (sic) anxiety medication.
Office of licensure and certification, adult protective service and local ombudsman were notified on 3/13/19.
(Resident #32) and (Resident #63) have had no further occurrences since 3/13/19.
We did not find evidence of abuse or neglect during this investigation..."

Resident #32's comprehensive care revised on 3/12/19 documented, "Resident slapped another male resident as he invaded her space and she became frustrated. No injuries..."

Resident #63's comprehensive care plan revised on 3/12/19 documented, "(Resident #63) was hit by another female resident on 3/12/19 as he was exhibiting behaviors of agitation, persistent wheeling his wheelchair into her and she became frustrated and hit him out of frustration and to

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make him stop..."

Resident #63's clinical record revealed a social services note dated 3/13/19 that documented, "S/w (Social worker) visited w/ (with) resident due to nsg. (Nursing) reports of a resident-resident altercation yesterday where he was slapped in the face by a female resident, as well as his behaviors of being agitated/wheeling wheelchair in/out of resident's space and in general being agitation (sic). Nsg. reports incident was witnessed and both resident's immediately separated w/out injuries..."

On 9/19/19 at 11:45 a.m., an interview was conducted with LPN #5 (a nurse who was present when Resident #32 struck Resident #63). LPN #5 was asked to explain the incident between Resident #32 and Resident #63 in March 2019. LPN #5 stated, "He I think jumped at her a little bit the way that he sometimes does when he gets agitated. He sort of jumps forward acting like he's angry. He didn't know she was there and she got angry that he was acting up so she cursed at him in a loud tone. He jumped forward and she slapped him in the face." LPN #5 was asked what was in place to help protect residents from hitting each other. LPN #5 stated there was nothing happening to lead staff to believe the incident was going to happen. LPN #5 stated Resident #32 is, "Up and down with moods but not usually physically aggressive."

On 9/19/19 at approximately 3:00 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

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5. The facility staff failed to ensure Resident #83 was free from abuse. On 10/23/19, CNA (certified nursing assistant) #4 slapped Resident #83's arm and bent the resident's right hand/wrist.

Resident #83 was admitted to the facility on 4/29/14. Resident #83's diagnoses included but were not limited to dementia, convulsions and anemia. Resident #83's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/14/19, coded the resident's cognitive skills for daily decision-making as moderately impaired. Section G coded the resident as requiring extensive assistance of two or more staff with ADLs (activities of daily living) such as dressing, toilet use and personal hygiene. Resident #83's comprehensive care plan dated 2/20/19 documented the resident presented with behaviors such as kicking, yelling and hitting.

A FRI (facility reported incident) submitted from the facility to the VDH (Virginia Department of Health) OLC (Office of Licensure and Certification) on 10/23/18 documented,
Report date: 10/23/18. Incident date: 10/23/18 10:20 pm.
Residents involved: (Resident #83).
Describe incident, including location and action taken:
Another CNA assisting (CNA #4) to change (Resident #83) she slapped her on the right arm and bent her Rt (right) hand/wrist in awkward position which looked painful.
Name of employee(s) involved and their positions: (CNA #4) CNA
Employee action initiated or taken: Badge was taken and she was escorted to the door."

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A witness statement signed by CNA #14 on 10/23/18 documented, "(CNA #4) and I were in the top hall spa bathroom with (Resident #83) and trying to change her brief. (Resident #83) was not standing up and was squeezing my fingers with her left hand while I stood on (Resident #83's) left side. (CNA #4) was standing on (Resident #83's) right side and slapped (Resident #83's) arm tightly to make her stop (illegible word) her arm. I then saw that (CNA #4) grabbed (Resident #83's) hand (right hand) and bend the wrist in an awkward way to try to get (Resident #83) to stop..."

A nurse's note dated 10/24/18 at 12:12 a.m. documented, "CNA was assisting another CNA in the front hall west main shower room to get resident changed. CNA slapped resident on her right arm and bent her right wrist/hand in an awkward position that looked painful @ 10:20 pm. Signee examined resident's right arm/wrist/hand, no bruiseing (sic) noted. Resident has good range of motion to right wrist/hand. VS (Vital Signs) - T (Temperature) 97.3. P (Pulse) 78- R (Respirations) 22- BP (Blood Pressure) 114/64. O2 (Oxygen) sats (saturation level) 98% on RA (Room Air). FRI [facility reported incident] was completed by signee. On call Nurse was notified as well as MD (Medical Doctor). Oncomming (sic) nurse notified by signee."

A witness statement signed by CNA #4 on 10/24/18 documented, "On 10/23/18 I was caring for (Resident #83). At one point in time, she was walking out from her chair and I had asked her to sit down. Later on in the night (CNA #15) and I gave her a whirlpool bath, it was sometime after dinner. Around 10:30 pm (CNA #14), was

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standing in the hallway with (Resident #83) and had been for a while. I asked her what was going on and she said '(name of another employee) and I tried to change her she is a mess.' We took her into the shower room. After getting gloves on and wash clothes (sic) ready we tried to pull (Resident #83's) pants down, she grabbed the front of her pants after they were past her knees, I asked (CNA #14) 'Are you okay to hold her while I pull the shower chair up?' She said 'Yes.' (Resident #83) sat down on the shower chair. (CNA #14) held her hands while I wash (sic) BM (bowel movement) off of (Resident #83's) back, butt, legs and her front. (CNA #14) was yelling 'Ouch (Resident #83)' the whole time. I noticed BM on (Resident #83's) hand from where she had grabbed her pants, and I washed her hand. (CNA #14) said she would be okay. I came back with clean pants. Again (CNA #14) held (Resident #83's) hands while I put her pants on, then shoes. (Resident #83) wasn't able to be coaxed to stand up so (CNA #14) started to tip her wheelchair forward, by picking up the back of (Resident #83's) wheelchair. I got (Resident #83's) pants up, and she sat back in her wheelchair. At some point in time (Resident #83) was on the shower chair and (CNA #14) was tipping it forward to get (Resident #83) to stand up, she was pulling the back of the shower chair up to push (Resident #83) off of it. I don't recall when this happened in the sequence of events. At no point in time did (CNA #14) say anything to me, or stop me. At no point in time did I hit or twist (Resident #83's) hand or arm."

Resident #83's comprehensive care plan was reviewed and revised on 10/24/18 to address this incident.

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A final report submitted from the facility to the VDH OLC on 10/26/18 documented,
"This letter serves as a follow-up to our initial F.R.I that was submitted on 10/23/18 on Resident: (Resident #83) (room number) with a Bims (Brief interview for mental status) of 99 (indicating staff were unable to complete the interview), Dx (Diagnoses): dementia in other disease, rheumatoid arthritis, Alzheimer's disease with D.O.B. (Date of Birth) 11/30/37.
Employee: (CNA #4).
On the Evening of 10/23/18 an allegation of abuse was made against (CNA #4). Nurse Aide reported to Evening Supervisor that (CNA #4) smacked (Resident #83's) right hand and twisted her right wrist while putting her hand in an awkward position that did not allow to move it.
(CNA #4) was suspended on 10/23/18 pending an investigation.
Department of Licensure and Certification, Adult Protective Services, Ombudsman and Town of (name of town) Police were notified.
(Resident #83) received a skin audit that showed no bruising, open areas or redness.
(Resident #83) received a pain assessment and had no signs and symptoms of verbal pain.
The Nurse Aide who reported the occurrence spoke with evening supervisor on 10/23/18 and gave a statement. The Nurse Aide was interviewed on 10/24/18 with the Director of Nursing, Human Resources and Unit Manager.
(CNA #4) was interviewed on 10/24/18 by the Director of Nursing, evening supervisor and Human Resources and gave a statement of the alleged occurrence on 10/23/18...
(CNA #4) was Terminated and reported to the Virginia Department of Health Professions on 10/26/18.
Based on Staff and Resident interview there is

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evidence of abuse and neglect in this matter..."

An employee separation form dated 10/26/18 documented, "(CNA #4) had an allegation of abuse- slapping a resident on the arm- which was founded. Reported as a FRI & turned in to Board of Nursing."

CNA #14 was no longer employed at the facility.

On 9/18/19 at 3:26 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (the evening supervisor when the above incident occurred). LPN #4 was asked to explain the incident related to Resident #83 in October 2018. LPN #4 stated CNA #14 asked if she could speak to her in private so she took her into an office. LPN #4 stated CNA #14 stated she saw the other CNA twist Resident #83's wrist. LPN #4 stated she asked CNA #14 to fill out a witness statement and she (LPN #4) spoke to the other CNA [CNA #4]. LPN #4 stated the other CNA said she did not twist Resident #83's wrist but that was an allegation of abuse so she (LPN #4) called the on-call nurse and suspended the other CNA, pending investigation. LPN #4 stated she then escorted the CNA to the time clock and the front door then completed the FRI paperwork.

On 9/19/19 at approximately 3:00 p.m., ASM #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.
No further information was presented prior to exit.
6 a. The facility staff failed to ensure that Resident #83 was free from abuse. Resident #23 smacked Resident #83 on the back of the head by on 4/19/19.

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The Facility Reported Incident dated 04/19/2019 documented, "Resident [Name of Resident #83] was sitting in her wheelchair on [Name of unit in facility] at nurses station and she started to back up her wheelchair and [Name of Resident #23] was behind her, resident [Name of Resident #23] tapped resident [Name of Resident #83] on the back of her head."

Resident #83 was admitted to the facility on 4/29/2014. Resident #83's diagnoses included but were not limited to dementia with behavioral disturbances (1) and rheumatoid arthritis (2). Resident #83's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/14/2019, documented Resident #83 as moderately impaired for making daily decisions.

The comprehensive care plan for Resident #83 documented, "Need for interaction, support, and encouragement in efforts to maintain psychosocial well-being d/t (due to) dx (diagnosis) dementia with behavioral disturbance ...Start Date 2/15/2019." Under "Intervention" it documented, "resident likes to roll about and might bump into others or get in their way-monitor ...Staff re-educated to attempt distractions when she is near other residents. Start Date 3/26/2019; resident tapped on the head by another resident when she bumped into her-no injury-no negative impact on resident- staff continues to monitor resident and divert as needed. Start Date 04/23/2019."

Review of Resident #83's record revealed a nursing progress note dated "4/19"Resident was sitting in the [Name of unit in facility] social area in her wheelchair @ (at) 6:30pm and she was

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backing up her wheelchair and another resident tapped her on the back of her head. No injuries noted upon assessment. Residents were separated at time of occurrence. MD (medical doctor), SS (social services), on call Nurse, Floor Nurse and ADON (assistant director of nursing) aware."

Resident #83 was observed on multiple occasions during the survey on each day, throughout the day from 9/17/19 to 9/19/19. During each observation, the resident was observed self-propelling in her wheelchair in the hallways of the facility. The resident proceeded to roll her wheelchair down the hallway when attempts were made to engage Resident #83 in conversation.

Resident #23 was admitted to the facility on 02/20/2014 with a readmission on 03/15/2016. Resident #23's diagnoses included but were not limited to, dementia with behavioral disturbances and anxiety (3). Resident #23's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 06/13/2019, coded Resident #23 as scoring a 4 (four) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 4- being severely impaired for making daily decisions.

The comprehensive care plan for Resident #23 documented, "Need to monitor mood and psychosocial well-being due to dx: dementia w/anxiety and medication intervention ...periods of verbal/physical aggression/refusal of care. Start Date 12/3/2018." Under "Care Plan Goal" it documented, "Resident will continue with usual social routine ...mood will remain stable between 0-3 over the next quarter. Start Date: 12/3/2018."

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Under "Intervention" it documented, "resident tapped another resident on the head when she bumped into her-no injury-no negative impact on resident-staff continues to monitor resident and divert as needed. Start Date 4/23/2019"

Review of Resident #23's record revealed a nursing progress note dated "4/19/2019 11:57 PM", it documented "At 1830 (6:30 pm), resident had walked over to [Name of unit in facility]. Another resident was in her wheelchair backing up toward this resident. This resident became agitated and wanted her to stop. This resident tapped the other resident on the back of the head. The two residents were separated and a CNA (certified nursing assistant) assisted this resident back to [Name of unit in facility]. No injuries noted to either resident. No complaints of pain. ROM (range of motion) intact ...Supervisor and MD Aware. RP (responsible party) [Name of responsible party] aware."

On 9/19/19 at 8:40 a.m., an interview was conducted with Resident #23 regarding the incident of Resident #23 hitting Resident #83 on the back of the head on 4/19/19. When asked about the incident Resident #23 stated, "No, I have been good." and proceeded to describe the contents of her closet in her room. The resident did not recall the incident on 4/19/19.

Resident #23 was observed on multiple occasions during the survey on each day, throughout the day from 9/17/19 through 9/19/19. During the observation, the resident was observed using her rolling walker in the hallway of the facility, in her room or in the social area. Resident #23 was not displaying any aggressive behaviors during these observations.

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F 600	Continued From page 34 On 9/19/19 at 11:05 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager regarding Resident #23 hitting Resident #83 on the back of the head on 4/19/19. LPN #4 stated that both residents were in the social area when Resident #23 walked over to Resident #83 and wanted her to move. LPN #4 stated that Resident #83 was sitting in the walkway. LPN #4 stated that Resident #23 smacked Resident #83 on the back of the head. LPN #4 stated that Resident #83 did not respond when Resident #23 smacked her. LPN #4 stated that the residents were separated immediately and that staff took Resident #23 back over to her unit. LPN #4 stated that an incident report was completed, the doctor and the responsible party were notified as well as the on call nurse, and it was reported to the state. LPN #4 stated that any abuse is reported to the supervisor who notifies the director of nursing or assistant director of nursing who then notify the executive director. LPN #4 stated that facility staff notify appropriate agencies within two hours. When asked what type of training staff receive regarding abuse LPN #4 stated that staff receive in-services on abuse and neglect. LPN #4 stated that if there are any suspicions or occurrences they train the staff again. LPN #4 stated that all staff are advised to report any suspicions of abuse. When asked if an incident is resident to resident is it considered abuse LPN #4 stated, "I say yes, it is still considered abuse. One resident physically putting hands on another is abuse and should be reported." 6 b. The facility staff failed to ensure that Resident #83 was free from abuse. Resident #23 hit Resident #83on the back of the head by on	F 600		

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5/17/19.

The Facility Reported Incident dated 05/17/2019 documented, "[Name of Resident #83] bumped into [Name of Resident #23] while propelling her w/c (wheelchair)- [Name of Resident #23] hit [Name of Resident #83] in the back of the head."

The comprehensive care plan for Resident #83 documented, "Need for interaction, support, and encouragement in efforts to maintain psychosocial well-being d/t (due to) dx (diagnosis) dementia with behavioral disturbance ...Start Date 2/15/2019." Under "Intervention" it documented, "resident likes to roll about and might bump into others or get in their way-monitor ...Staff re-educated to attempt distractions when she is near other residents. Start Date 3/26/2019; resident to resident with no injury- staff will attempt to keep them separated-meeting with rp (responsible party) on 5-28. Start Date 5/23/2019."

Review of Resident #83's record revealed a nursing progress note dated "5/17/2019 11:48 PM", it documented "Resident wandering off unit per baseline behavior in self-propelled w/c (wheelchair). Resident was looking down at ground while self propelling w/c and ran into a chair another resident [Resident #23] was sitting in. The other resident [Resident #23] stated, "Hey, stop it now", and stood up. Before staff could reach the residents, other resident [Resident #23] hit resident [Resident #83] on the top of the head. Skin and pain level assessed ...On call unit manager aware."

Resident #83 was observed multiple times during the survey on each day, throughout the day from

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9/17/19 through 9/19/19. During each observation, the resident was observed self propelling in her wheelchair in the hallways of the facility. When attempts to engage in conversation with Resident #83 were made, the resident proceeded to roll her wheelchair down the hallway.

The comprehensive care plan for Resident #23 documented, "potential for resident to resident altercations based on hx (history), dx (diagnosis)/disease process, and hallucinations. Start Date 5/30/2019." Under "Care Plan Goal" it documented, "will have no resident to resident altercations over the next quarter. Start date 5/30/2019." Under "Intervention" it documented, "assist with calming/distracting resident in effort to keep her and others safe. Start Date: 5/30/2019."

Review of Resident #23's record revealed a nursing progress note dated "5/18/2019 12:08 AM", it documented "5-17-19 at 2000 (8:00 p.m.), resident was sitting in a chair in the social area. Another resident [Resident #83] from [name of unit of facility] was self propelling in her wheelchair and bumped into the chair this resident [Resident #23] was sitting in. This resident [Resident #23] yelled at her, "Hey, stop it now!" CNA (certified nursing assistant) was walking toward them to separate them but before she could reach them, this resident [Resident #23] smacked the other resident on the back of the head. The two residents were separated and assessed for injuries. Neither resident noted to have any injuries. No complaints voiced ... Resident continues on 15 minute checks at this time. Resident also refused all QHS (bedtime) medications this evening."

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On 9/19/19 at 8:40 a.m., an interview was conducted with Resident #23 regarding the incident of Resident #23 hitting Resident #83 on the back of the head on 5/17/19. When asked about the incident Resident #23 stated, "No, I have been good." and proceeded to describe the contents of her closet in her room. The resident did not recall the incident on 5/17/19.

Resident #23 was observed on multiple occasions during the survey on each day, throughout the day from 9/17/19 through 9/19/19. During the observations, the resident was using her rolling walker in the hallway of the facility, in her room or in the social area. Resident #23 was not displaying any aggressive behaviors during these observations.

On 9/19/19 at 10:45 a.m., a message was left requesting to speak with the CNA (certified nursing assistant) #19 who witnessed the incident of Resident #23 hitting Resident #83 on the back of the head on 5/17/19. The facility reported incident contained a document "Statement by Witness" from CNA #19. The document stated, "On May 17th at 8:00 pm [Name of Resident #83] was on [Name of unit in facility] hanging out with other residents and staff. She bumped into the chair [Resident #23] was sitting and she [name of Resident #23] said to [Name of Resident #83], "Hey, stop it now." I, [Name of CNA #19] was walking over to move [Name of Resident #83] away from bumping the chair, but before I could, [Name of Resident #23] slapped her on top of her head. Both [Name of unit in facility] and [Name of unit in facility] nurses notified, [Name of Resident #83] was taken back to [Name of unit in facility].

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On 9/19/19 at 2:45 p.m. a telephone interview was conducted with LPN (licensed practical nurse) #10 regarding resident to resident abuse. When asked the process for staff in instances of resident-to-resident abuse, LPN #10 stated that the residents are separated immediately and assessed. LPN #10 stated that staff try to intervene if residents get upset to try to keep them calm and happy. LPN #10 stated that staff often try to distract residents when they get upset. LPN #10 stated that they keep a close eye on residents who have wandering behaviors or residents who have aggressive behaviors. LPN #10 stated that there is a care folder for CNA's (certified nursing assistants) to use as a guide in caring for residents. LPN #10 stated that it has information on the resident's care, their preferences. How they communicate and their (the residents) habits. LPN #10 stated that new staff are trained which residents that are prone to aggressive behaviors.

On 09/20/19 at approximately 3:00 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. Dementia with behavioral disturbances
A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

2. Rheumatoid arthritis

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A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.

3. Anxiety
Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.
7. The facility staff failed ensure Resident #187 was free from the abuse of Resident # 23. On 11/30/18, Resident #187 was in a wheelchair, wheeling backwards and bumped into Resident #23. Resident #23 turned around and hit Resident #187 on the head.

The "Facility Reported Incident (FRI) dated, 11/30/18 documented in part, "Incident Date 11/30/18. (Resident #23 was walking with her walker down the hall; (Resident #187) was in his wheelchair wheeling behind her. (Resident #187 bumped into (Resident #23), (Resident #23) swung and hit him on the left side of his forehead. No injuries."

The "Final Report" dated, 12/4/18 documented in part, "This letter serves as a follow-up to our initial F.R.I that was submitted on November 30, 2018 with (Resident #23) (room number) with a diagnoses of Parkinson's disease, dementia with behavioral disturbances, history of failing, ataxia, insomnia, muscles weakness. DOB (date of birth) (00/00/00) with a BIMS (brief interview for mental status) score of 5 (indicating the resident was severely impaired to make daily cognitive decisions) and,(Resident #187) (room number), DOB (00/00/00) with diagnoses of major

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depression, mild cognitive impairment, hypertension, restless leg syndrome with a BIMS of 9 (indicating he was moderately impaired to make daily cognitive decisions). On the evening of November 30,, 2018, (Resident #187) was rolling in his wheelchair and accidentally bumped (Resident #23)she became upset and in reaction made contact with (Resident #187)'s right side of his forehead. (Resident #23) and (Resident #187) were separated immediately. Office of licensure and certification, Adult protective services and ombudsman were notified on 11/30/18. (Resident #187) received a skin assessment by a licensed (nurse) for injury and no injury noted. (Resident #187) received a pain assessment by a licensed nurse and had no complaints of pain related to his occurrence. (Resident #23)'s primary care physician and responsible party were notified of this occurrence, no new orders were received. (Resident #187)'s primary care physician and responsible party were notified of this occurrence, with no new orders. (Resident #23) received a skin assessment by a licensed (nurse) for injury and not injury was noted. (Resident #23) received a pain assessment by a licensed nurse and had no complaints of pain related to this occurrence. (Resident #23) has had no change in mood or behavior related to the occurrence, when interviewed by social services. (Resident #187) has had no change in mood or behavior related to the occurrence, when interviewed by social services. Staff education to continue to assist residents in being aware of their environment. (Resident #187) and (Resident #23) have had no further occurrences. We did not find evidence of abuse and neglect in this matter, if you have any further questions please feel free to contact me."

Resident #187 was admitted to the facility on

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8/26/15 with diagnoses that included but were not limited to: diabetes, depression, high blood pressure, and COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1).

The MDS (minimum data set) assessment, around the time of the incident, a Medicare five day assessment, with an assessment reference date of 12/01/18, coded the resident as usually understood and usually understanding others. Resident #187 was not coded as having any behaviors. The resident was coded as being independent on moving on the unit.

The "Resident Incident Report" dated, 11/30/18 at 4:00 p.m., documented in part, "Resident [Resident #187] was sitting in hallway in wheelchair and rolled wheelchair backwards into another resident [Resident #23] who was standing behind him with her walker. The resident with the walker became angry and smacked this resident on the right side of his forehead with her hand. The charge nurse quickly intervened and separated the two residents. This resident has no signs of injury and no complaints voiced. No injuries noted.

The comprehensive care plan dated 1/11/18, documented in part, "Problem/need: 11/30/19 - Resident hit on head by another resident after bumping into resident while rolling backwards in hallway." The "Approaches documented, "encourage resident to not roll backwards down the hall in wheelchair."

Resident #23 was admitted to the facility on

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2/20/14 with diagnoses that included but were not limited to: anxiety disorder, high blood pressure, difficulty walking and dementia. The MDS (minimum data set) assessment, nearest to the time of the incident, a quarterly assessment, with an assessment reference date of 11/30/18 coded the resident as scoring a "05" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions.

The "Resident Incident Report" dated, 11/30/18, documented in part, "Resident was walking in the hallway with her walker and was walking behind another resident when that resident rolled his wheelchair backwards bumping to this resident's walker. This resident became upset and smacked the other resident on the left side of his forehead with her right palm. The charge nurse intervened immediately and separated the residents. No injuries noted. No complaints of pain."

The comprehensive care plan dated, 12/3/18 documented in part, "(Resident #23) will redirect from verbally/physically aggressive behaviors with assistance of staff over the next quarter." The "Approaches" documented in part, "Resident was physically aggressive with another resident on 11-30-18 but has no recollection of this. Educate staff to assist resident to be aware of environment."

Several attempts were made to contact the nurse, who was the witness to this incident, were unsuccessful.

An interview was conducted on with CNA (certified nursing assistant) # 2 on 9/18/19 at 2:00

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F 600	Continued From page 43 p.m. regarding the process staff follows if they see resident to resident abuse, CNA # 2 stated you report it to the charge nurse or unit manager or DON (director of nursing)." CNA # 2 stated it has to be reported as soon as possible or immediately. An interview was conducted with OSM (other staff member) # 4, the medical supply staff member, on 9/18/19 at 2:32 p.m. When asked about the process staff follows if resident-to-resident abuse is observed, OSM # 4 stated she would check the resident first, and then report it immediately to the supervisor. When asked if it could wait, OSM # 4 stated, no. An interview was conducted with LPN # 9 on 9/18/19 at 3:54 p.m. When asked how she would respond to an allegation of abuse or witnessing abuse, staff member stated she would first protect the resident. Then she would notify her manager, who would pass it up the chain to be investigated. If a staff member stated there was a concern with the unit manager not acting on the report, the nurses are expected to go directly to the DON. Administrative staff member (ASM) #1, the executive director, was made aware of the above concern on 9/19/19 at 1:58 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 600		
F 607	Develop/Implement Abuse/Neglect Policies	F 607		10/14/19

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F 607 SS=E	Continued From page 44 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 observation, resident interview, staff interview, facility document review, clinical record review, it was determined that the facility staff failed to implement the abuse policy for reporting allegations of abuse immediately to the state agency for four of 54 residents in the survey sample, Residents #39, #63, #83, and #51. The findings include: 1. On 8/5/18 at 5:25 p.m. Resident #63 struck Resident #39; Resident #39 then struck Resident #63. The staff failed to implement the abuse policy to report allegations of abuse for Resident #39 and #63, immediately to the state agency. The facility did not report the incident until 8/6/18 00:48 AM The "Facility Reported Incident" [for Resident #39] dated, 8/5/18, documented in part, "Incident date: 8/5/18. Resident's involved (Resident #39) and (Resident #63). Injuries: (A check mark was	F 607	1. The facility has established a corrective action plan to include following the facility policy regarding allegations of abuse for residents #39, #63, #83, and #51. 2. The other residents who reside at the facility have the potential to be affected by this deficient practice. 3. The facility staff were re-educated on implementing the abuse policy for reporting allegations of abuse immediately to the State Agency. This re-education is to be completed by 10/14/19. 4. To ensure compliance, audits will be conducted by Administrative staff (or designee) every week for 4 weeks then monthly for 3 months, these audits will be conducted to ensure staff are implementing the abuse policy of reporting allegations of abuse immediately	

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F 607	Continued From page 45 documented next to)"No." Describe Incident: Resident to resident altercation between (Resident #39) and (Resident #63). Resident #39 was hit by Resident #63 at 5:25 PM. No injuries. Residents were separated. The facility's "Suspected/Actual Resident Abuse, Neglect or Mistreatment Notification Checklist" form noted the regulatory agency was informed by fax at 11:00 PM on 8/5/18. The fax transmission, verification report documented the time of transmission as 8/6/18 00:48 AM. The "Facility Reported Incident" [for Resident #63] dated, 8/5/18, documented in part, "Incident date: 8/5/18. Resident's involved (Resident #63) and (Resident #39). Injuries: (A check mark was documented next to)"No." Describe Incident: Resident to resident altercation between (Resident #63) and (Resident #39). Resident #63 was hit by Resident #39 at 5:25 PM. No injuries. Residents were separated. The facility's "Suspected/Actual Resident Abuse, Neglect or Mistreatment Notification Checklist" form noted the regulatory agency was informed by fax at 11:00 PM on 8/5/18. The fax transmission, verification report documents the time of transmission as 8/6/18 00:48 AM. The "Final Report" for Resident #39 dated, 8/5/18, documented in part, "This is the Final Report regarding the initial FRI of allegation of abuse/mistreatment regarding (Resident #39) and (Resident #63) reported August 5, 2018...Investigation Summary: Resident to resident altercation between (Resident #39) and (Resident #63) was reported. (Resident #39) and (Resident #63) were seated next to each other,	F 607	to the State Agency. This information will be forwarded to QAPI for review.	

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turned started shouting and hitting each other. Staff report that they did witness the incident and immediately separated the residents. Upon further interview with (Resident #39) by RN (registered nurse), Resident #39 stated that Resident #63 hit him first and he hit back. Resident #39 and Resident #63's care plans were reviewed and revised. Both residents have not had a change in mood or behavior. The residents will continue to be monitored for changes in mood or behaviors and staff will follow up with the physician as needed. Conclusion: Based on the investigation, the facility does substantiate a resident to resident altercation occurred between the residents per the residents' statements. Resident #39 was seen by NP (nurse practitioner) on 8/8/18 medication regimen was reviewed and anxiolytic (medication to treat anxiety), was increased.

The "Final Report" for Resident #63 dated, 8/5/18, documented in part, "This is the Final Report regarding the initial FRI of allegation of abuse/mistreatment regarding (Resident #63) and (Resident #39) reported August 5, 2018...Investigation Summary: Resident to resident altercation between (Resident #63) and (Resident #39) was reported. (Resident #63) and (Resident #39) were seated next to each other, turned started shouting and hitting each other. Staff report that they did witness the incident and immediately separated the residents. Upon further interview with (Resident #39) by RN (registered nurse), Resident #39 stated that Resident #63 hit him first and he hit back. Resident #39 and Resident #63's care plans were reviewed and revised. Both residents have not had a change in mood or behavior. The residents will continue to be monitored for changes in mood

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or behaviors and staff will follow up with the physician as needed. Conclusion: Based on the investigation, the facility does substantiate a resident to resident altercation occurred between the residents per the residents' statements.

Resident #39 was admitted to the facility on 3/26/13 with diagnoses that included but were not limited to: vascular dementia (1), cerebrovascular accident (2), and hemiplegia. (3)
The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/2/19, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions.

Resident #63 was admitted to the facility on 12/17/07 with diagnoses that included but were not limited to: dementia, depression, and acute embolism (blockage of a blood vessel) (4). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/23/19, coded the resident as scoring a "11" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions.

A nurse's note in Resident #39's clinical record dated, 8/5/18 at 5:52 PM, documented in part, "Resident [Resident #39] was seen being hit and hitting another resident [Resident #63] this evening. Altercation ended and resident continued to be angry and started yelling. Resident has now calmed down. Range of motion within normal limits. Behavior checks sheet completed."

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A social worker's note in Resident #39's clinical record dated, 8/6/18 at 9:25 AM, documented in part, "Resident [Resident #39] remembers incident, states the other resident kept asking when it was time to eat and wouldn't shut up so I yelled at him. Then he hit me, so I hit him. Resident understands it is wrong to hit. Resident is easily annoyed, short tempered if things don't go, as he perceives they should and can be worked up. He states he isn't injured or hurt and psychosocial appears at baseline."

The care plan dated 8/5/18, documented in part, Problem: "Resident #39 was hit by another male resident, got into verbal and physical altercation. Separated at time and monitored with no issues since. The Goal: dated 8/5/18, documented, "Resident will respond positively to visits by staff and mood/psychosocial well-being will not decline through next review 10/16/18." The Approaches: dated 8/6/18, documented, "Social work interviewed resident about incident, he recollects incident and states 'I am over it'."

An interview was conducted on 9/17/19 at 4:37 PM with Resident #39. When asked if there were any interactions with other residents, Resident #39 stated, "Yes, sometimes." When asked to describe what happened, Resident #39 stated, "I can't stand it when people tell me to be quiet. I can speak." When asked what happens when there is an interaction, Resident #39 stated, "The staff separate us or take us to our rooms."

The social worker's note in Resident #63's clinical record dated, 8/6/18 at 9:25 AM, documented in part, "Resident [Resident #63] does not remember incident. His psychosocial appears at

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baseline."

The care plan dated 8/5/18, documented in part, Problem: "Resident #63 was in verbal/physical altercation another male resident, both separated at time with no injury. The Goal: dated 8/5/18, documented, "Resident will not have any increase in behavior symptoms through next review date of 10/6/18." The Approaches: dated 8/6/18, documented, "Social work interviewed resident about incident, he has no recollection of the incident, psychosocial status at baseline."

The facility policy, "Abuse Prevention" documented in part, "The facility shall report all alleged violations and all substantiated incidents. Reporting must be filed within "2 hours after the allegation is made."

An interview was conducted on 9/18/19 at 3:15 PM with ASM (administrative staff member) #2 (the director of nursing). When asked what abuse is, ASM #2 stated "Any physical or verbal actions that may cause harm." When asked the time frame for reporting allegations of abuse, ASM #2 stated, "It must be reported within two hours after allegation of abuse is made that result in serious bodily injury." The facility's policy "Abuse Prevention" policy including the reporting section was reviewed with ASM #2. Under reporting the policy documents in part: "Reporting must be filed within two 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 twenty-four hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." ASM #2 stated, "I don't believe that wording is correct, it is only for serious injury." ASM #2 was referred to

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the regulations. ASM #2 was informed the facility reported incident above did not meet this time frame. ASM #2 stated, "I will have to check the regulations and get back to you."

On 9/19/19 at 2:55 PM, ASM (Administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the assistant director of nursing was made aware of the above concern.

No further information was provided prior to exit.

References:
(1) Dementia: Progressive state of mental decline caused by vascular disease. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154.
(2) Cerebrovascular accident (hemorrhage or blockage of the blood vessels of the brain leading to lack of oxygen). Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 111.
(3) Hemiplegia paralysis affecting one side of the body. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 264.
(4) An "embolus" is a blood clot or a piece of plaque that acts like a clot. The word "emboli" means there is more than one clot or piece of plaque. When the clot travels from the site where it formed to another location in the body, it is called an embolism. This information was obtained from the website: https://medlineplus.gov/ency/article/001102.htm
2. The facility staff failed to implement the abuse policy to report immediately an incident/allegation of abuse for Resident #83 after being hit on the back of the head by Resident #23 on 5/17/19.

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Facility staff reported the alleged abuse to ASM (administrative staff member) #2, the Director of Nursing (administrative staff member [ASM] #3) on 5/17/19 at 8:00 p.m., but did not report the allegation to the State Agency until 5/18/19.

The Facility Reported Incident dated 05/17/2019 documented, "[Name of Resident #83] bumped into [Name of Resident #23] while propelling her w/c (wheelchair)- [Name of Resident #23] hit [Name of Resident #83] in the back of the head."

The document "Suspected/Actual Resident Abuse, Neglect or Mistreatment Notification Checklist" documented, "Resident Name: [Name of Resident #83], Date of Incident: 5/17/19, Individual Notified, Administrative or Nursing Supervisor on duty: [Name of ASM (administrative staff member) #2], the director of nursing, Date 5/17/19, Time 8pm, By Whom [Name of RN (registered nurse) #5]." Further review of the document revealed, "Department of Health O.L.C. (office of licensure and certification) ...Fax initial State Letter (keep confirmation in file), Individual Notified, Faxed, Date 5/18/19, Time 11:17, By Whom [Name of ASM #3], the assistant director of nursing.

Review of the fax confirmation revealed a start time of "05-18, 11:17" The fax cover sheet documented send to "Virginia Department of Health, Date 5/18/19" from ASM #3. The document failed to reveal reporting within two hours after the incident was reported to ASM #2 on 5/17/19 at 8:00 p.m.

Resident #83 was admitted to the facility on 4/29/2014. Resident #83's diagnoses included

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but were not limited to dementia with behavioral disturbances (1) and rheumatoid arthritis (2). Resident #83's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/14/2019, documented Resident #83 as moderately impaired for making daily decisions.

Resident #23 was admitted to the facility on 02/20/2014 with a readmission on 03/15/2016. Resident #23's diagnoses included but were not limited to, dementia with behavioral disturbances and anxiety (3). Resident #23's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 06/13/2019, coded Resident #23 as scoring a 4 (four) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 4- being severely impaired for making daily decisions.

Review of Resident #23's record revealed a nursing progress note dated "5/18/2019 12:08 AM", it documented "5-17-19 at 2000 (8:00 p.m.), resident was sitting in a chair in the social area. Another resident from [name of unit of facility] was self-propelling in her wheelchair and bumped into the chair this resident was sitting in. This resident yelled at her, "Hey, stop it now!" CNA (certified nursing assistant) was walking toward them to separate them but before she could reach them, this resident smacked the other resident on the back of the head. The two residents were separated and assessed for injuries. Neither resident noted to have any injuries. No complaints voiced ... Resident continues on 15 minute checks at this time. Resident also refused all QHS (bedtime) medications this evening."

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On 9/19/19 at 11:05 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. When asked the process for reporting incidents of resident-to-resident abuse, LPN #4 stated that any abuse is reported to the supervisor who notifies the director of nursing or assistant director of nursing who then notify the executive director. LPN #4 stated that facility staff notify appropriate agencies within two hours. When asked if an incident is resident to resident if it is considered abuse LPN #4 stated, "I say yes, it is still considered abuse. One resident physically putting hands on another is abuse and should be reported."

The facility policy "Abuse Prevention. Revised: July 2019" documented, "7. Reporting/Response. A. ...Reporting must be filed within '2 (two) 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'."

On 9/19/19 at 2:40 p.m., an interview was conducted with ASM #2, the director of nursing. When asked to review the facility reported incident documents including the notification checklist and the fax confirmation regarding the incident on 5/17/19 of Resident #83 being hit on the back of the head by Resident #23, ASM #2 stated that the required reporting was not completed within two hours. ASM #2 agreed that according to the documentation, she was notified of the incident on 5/17/19 at 8:00 p.m. and the fax was sent to the state agency on 5/18/19 at 11:17 a.m. ASM #2 stated, "Reporting should be within

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two hours."

On 09/20/19 at approximately 3:00 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. Dementia with behavioral disturbances
A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

2. Rheumatoid arthritis
A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.
3. The facility staff failed to implement the abuse policy to report immediately an allegation of verbal abuse by CNA (certified nursing assistant) #23 towards Resident #51. CNA (certified nursing assistant) # 24 did not report the allegation until 9/24/19, at which time the facility submitted a report.

The Facility Reported Incident (FRI) dated, 9/24/18 documented in part, "Report date: 9/24/18. Incident date: 9/22/18. Staff member stated that on Saturday 9/22/18, staff member (CNA - certified nursing assistant #23) stated to (Resident #51) over top of her in bed and stated, 'You need to shut the [Expletive] up."

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The "Final Report" dated, 9/26/18, documented, "This letter serves as a follow-up to our initial FRI that was submitted on 9/24/18 involving: Resident (Resident #51) (Room number) with a Bims (Sic.) of 4 and a diagnoses of dementia without behavioral disturbance, adjustment disorder and hypertension (high blood pressure). Employee: (CNA #23 with license number). The Office of licensure and certification, Ombudsman, Adult Protective and Town of Orange Police Departments Services were notified on 9/24/18. On September 24, 2018, (CNA #24) stated that on Saturday September 22, 2018 (CNA #23) whispered to (Resident #51) 'Why don't you just the F--- up.' (CNA #24 stated that she should have reported on Saturday, she thought she did when she was the nurse's station. (CNA #24) was reeducated on reporting allegations of abuse and neglect. (CNA #23) was suspended pending an investigation. (Resident #51)'s responsible party and MD (medical doctor) were both notified. (Resident #51) had a skin audit by a licensed nurse that revealed no open areas, no redness and no bruising. (Resident #51) received a pain assessment from a licensed nurse with no complaints of pain. The Town of Orange Police Department reported to the facility and stated it was not a criminal case. (Resident #51) had had no change in mood or behavior since the alleged occurrence. (CNA #24) stated that there was never any contact with this occurrence. (CNA #24) stated that (Resident #51) was upset and cursing at staff as she often does when being put to bed or performing ADL (activities of daily living) task and that (CNA #23) leaned over the bed, not directly over (Resident #51) and whispered to her. (CNA #24) apologized again and stated she should have followed through on reporting this

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occurrence. (CNA #23) was interviewed and denied every making comments to (Resident #51) or any resident. (CNA #23) was called on 9/26/18 that she could return to work on 9/27/18 after receiving education on dealing with behavior and customer service. Staff and Resident interviews showed no negative outcome related to this matter. Staff was reeducated on reporting abuse and neglect. We did not find evidence of abuse and neglect in this matter."

The witness statement by CNA #24 dated, 9/24/18 documented in part, "While I, (CNA #24) was assisted (CNA #23) after we assisted (Resident #51) into the bed after using the Sarah lift (Resident #51) was still highly agitated and (CNA #23) told (Resident #51) to 'shut the [expletive] up.' Then she left the room stating I have to leave before I loose (sic) my job...I reported it to a nurse can't remember exactly who but when I stated it to them they just laughed and said ok. I am ashamed of myself for not reporting it to another administration. I should report quickly. I am ashamed and there is no excuse for my behavior, this is first incident in my 11 yrs (years) of nursing...I was wrong and I'm very ashamed of myself for my faults in the whole situation."

CNA #23 was no longer employed at the facility and CNA #24 was not available for interview.

Resident #51 was admitted to the facility on 9/1/16 with diagnoses that included but were not limited to: dementia, high blood pressure, and atrial fibrillation. (1)

The MDS (minimum data set) assessment, closest to the incident above, was a Significant

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change assessment, with an assessment reference date of 7/17/18, coded the resident as scoring a "04" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. In Section E - Behaviors, the resident was coded as having improved in her behaviors compared to her previous assessment. Resident #51 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating.

There were no nurse's notes or incident reports for this incident.

An interview was conducted on with CNA (certified nursing assistant) # 2 on 9/18/19 at 2:00 p.m., regarding reporting witnessed resident abuse such as staff being rough with a resident, cursing at a resident or hitting a resident. CNA # 2 stated you report it to the charge nurse or unit manager or DON (director of nursing)." When asked how soon she reports this, CNA # 2 stated as soon as possible or immediately.

The facility policy, "Abuse Prevention," documents in part: "The facility is committed to maintaining a safe and abuse-free environment for all residents and committed to a comprehensive investigation of any allegation of activities or situations that may constitute abuse...All alleged violations involving mistreatment , neglect, abuse, including injuries of unknown source, misappropriation of resident property, corporal punishment, and involuntary seclusion will be reported immediately in accordance with State and Federal law."

Administrative staff member (ASM) #1, the

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F 607	Continued From page 58 executive director, was made aware of the above concern on 9/19/19 at 1:58 p.m. No further information was provided prior to exit.	F 607		
F 609 SS=E	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: Surveyor: Grammar, Martha	F 609	1. The facility cannot go back and correct	10/14/19

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F 609	Continued From page 59 Based on observation, resident interview, staff interview, facility document review, clinical record review, it was determined that the facility staff failed to immediately report allegations of abuse to the State Agency for four of 54 residents in the survey sample, (Residents #39, #63, #83, and #51). On 8/5/18, at 5:25 p.m., Resident #63 struck Resident #39; Resident #39 then struck Resident #63; the allegations of abuse for Resident #39 and #63, were not reported to the state agency until 8/6/18 00:48 AM (12:48 a.m.). On 5/17/19 at 8:00 p.m. staff notified the Director of Nursing that Resident #23 hit Resident #83 on the back of the head, the allegation was not reported to the State Agency until 5/18/19. On 9/22/19 the facility staff failed to immediately report an allegation of verbal abuse by CNA (certified nursing assistant) #23 towards Resident #51 to the administrator. CNA (certified nursing assistant) # 24 did not report the allegation until 9/24/19, at which time the facility submitted a report. The findings include: 1. Resident #63 struck Resident #39; Resident #39 then struck Resident #63 with no injury noted on either resident on 8/5/18, at 5:25 p.m. The allegations of abuse for Resident #39 and #63, were not reported to the state agency until 8/6/18 00:48 AM The facility policy, "Abuse Prevention" documented in part, "The facility shall report all alleged violations and all substantiated incidents. Reporting must be filed within "2 hours after the allegation is made."	F 609	the timing of the reports sent to the State Agency for residents #39, #63, #83, and #51. 2. The other residents who reside at the facility have the potential to be affected by this deficient practice. 3. The facility staff were re-educated on CMS abuse guidelines regarding reporting allegations of abuse in a timely manner. This re-education will be completed by 10/14/19. 4. To ensure compliance, audits will be conducted by Administrative staff (or designee) every week for 4 week then monthly for 3 months. Staff interviews will be conducted to ensure the staff are aware of the CMS guidelines on reporting abuse. This information will be forwarded to QAPI for review.	

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The "Facility Reported Incident" [for Resident #39] dated, 8/5/18, documented in part, "Incident date: 8/5/18. Resident's involved (Resident #39) and (Resident #63). Injuries: (A check mark was documented next to)"No." Describe Incident: Resident to resident altercation between (Resident #39) and (Resident #63). Resident #39 was hit by Resident #63 at 5:25 PM. No injuries. Residents were separated.

The facility's "Suspected/Actual Resident Abuse, Neglect or Mistreatment Notification Checklist" form noted the regulatory agency was informed by fax at 11:00 PM on 8/5/18. The fax transmission, verification report documented the time of transmission as 8/6/18 00:48 AM.

The "Facility Reported Incident" [for Resident #63] dated, 8/5/18, documented in part, "Incident date: 8/5/18. Resident's involved (Resident #63) and (Resident #39). Injuries: (A check mark was documented next to)"No." Describe Incident: Resident to resident altercation between (Resident #63) and (Resident #39). Resident #63 was hit by Resident #39 at 5:25 PM. No injuries. Residents were separated.

The facility's "Suspected/Actual Resident Abuse, Neglect or Mistreatment Notification Checklist" form noted the regulatory agency was informed by fax at 11:00 PM on 8/5/18. The fax transmission, verification report documents the time of transmission as 8/6/18 00:48 AM.

The "Final Report" for Resident #39 dated, 8/5/18, documented in part, "This is the Final Report regarding the initial FRI of allegation of

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abuse/mistreatment regarding (Resident #39) and (Resident #63) reported August 5, 2018...Investigation Summary: Resident to resident altercation between (Resident #39) and (Resident #63) was reported. (Resident #39) and (Resident #63) were seated next to each other, turned started shouting and hitting each other. Staff report that they did witness the incident and immediately separated the residents. Upon further interview with (Resident #39) by RN (registered nurse), Resident #39 stated that Resident #63 hit him first and he hit back. Resident #39 and Resident #63's care plans were reviewed and revised. Both residents have not had a change in mood or behavior. The residents will continue to be monitored for changes in mood or behaviors and staff will follow up with the physician as needed. Conclusion: Based on the investigation, the facility does substantiate a resident to resident altercation occurred between the residents per the residents' statements. Resident #39 was seen by NP (nurse practitioner) on 8/8/18 medication regimen was reviewed and anxiolytic (medication to treat anxiety), was increased.

The "Final Report" for Resident #63 dated, 8/5/18, documented in part, "This is the Final Report regarding the initial FRI of allegation of abuse/mistreatment regarding (Resident #63) and (Resident #39) reported August 5, 2018...Investigation Summary: Resident to resident altercation between (Resident #63) and (Resident #39) was reported. (Resident #63) and (Resident #39) were seated next to each other, turned started shouting and hitting each other. Staff report that they did witness the incident and immediately separated the residents. Upon

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further interview with (Resident #39) by RN (registered nurse), Resident #39 stated that Resident #63 hit him first and he hit back. Resident #39 and Resident #63's care plans were reviewed and revised. Both residents have not had a change in mood or behavior. The residents will continue to be monitored for changes in mood or behaviors and staff will follow up with the physician as needed. Conclusion: Based on the investigation, the facility does substantiate a resident to resident altercation occurred between the residents per the residents' statements.

Resident #39 was admitted to the facility on 3/26/13 with diagnoses that included but were not limited to: vascular dementia (1), cerebrovascular accident (2), and hemiplegia. (3)
The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/2/19, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions.

Resident #63 was admitted to the facility on 12/17/07 with diagnoses that included but were not limited to: dementia, depression, and acute embolism (blockage of a blood vessel) (4). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/23/19, coded the resident as scoring a "11" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions.

A nurse's note in Resident #39's clinical record

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dated, 8/5/18 at 5:52 PM, documented in part, "Resident [Resident #39] was seen being hit and hitting another resident [Resident #63] this evening. Altercation ended and resident continued to be angry and started yelling. Resident has now calmed down. Range of motion within normal limits. Behavior checks sheet completed."

A social worker's note in Resident #39's clinical record dated, 8/6/18 at 9:25 AM, documented in part, "Resident [Resident #39] remembers incident, states the other resident kept asking when it was time to eat and wouldn't shut up so I yelled at him. Then he hit me, so I hit him. Resident understands it is wrong to hit. Resident is easily annoyed, short tempered if things don't go, as he perceives they should and can be worked up. He states he isn't injured or hurt and psychosocial appears at baseline."

The care plan dated 8/5/18, documented in part, Problem: "Resident #39 was hit by another male resident, got into verbal and physical altercation. Separated at time and monitored with no issues since. The Goal: dated 8/5/18, documented, "Resident will respond positively to visits by staff and mood/psychosocial well-being will not decline through next review 10/16/18." The Approaches: dated 8/6/18, documented, "Social work interviewed resident about incident, he recollects incident and states 'I am over it'."

An interview was conducted on 9/17/19 at 4:37 PM with Resident #39. When asked if there were any interactions with other residents, Resident #39 stated, "Yes, sometimes." When asked to describe what happened, Resident #39 stated, "I can't stand it when people tell me to be quiet. I

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can speak." When asked what happens when there is an interaction, Resident #39 stated, "The staff separate us or take us to our rooms."

The social worker's note in Resident #63's clinical record dated, 8/6/18 at 9:25 AM, documented in part, "Resident [Resident #63] does not remember incident. His psychosocial appears at baseline."

The care plan dated 8/5/18, documented in part, Problem: "Resident #63 was in verbal/physical altercation another male resident, both separated at time with no injury. The Goal: dated 8/5/18, documented, "Resident will not have any increase in behavior symptoms through next review date of 10/6/18." The Approaches: dated 8/6/18, documented, "Social work interviewed resident about incident, he has no recollection of the incident, psychosocial status at baseline."

An interview was conducted on 9/18/19 at 3:15 PM with ASM (administrative staff member) #2 (the director of nursing). When asked what abuse is, ASM #2 stated "Any physical or verbal actions that may cause harm." When asked the time frame for reporting allegations of abuse, ASM #2 stated, "It must be reported within two hours after allegation of abuse is made that result in serious bodily injury." The facility's policy "Abuse Prevention" policy including the reporting section was reviewed with ASM #2. Under reporting the policy documents in part: "Reporting must be filed within two 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 twenty-four hours if the events that cause the allegation do not involve abuse and do

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not result in serious bodily injury." ASM #2 stated, "I don't believe that wording is correct, it is only for serious injury." ASM #2 was referred to the regulations. ASM #2 was informed the facility reported incident above did not meet this time frame. ASM #2 stated, "I will have to check the regulations and get back to you."

On 9/19/19 at 2:55 PM, ASM (Administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the assistant director of nursing was made aware of the above concern.

No further information was provided prior to exit.

(1) Dementia: Progressive state of mental decline caused by vascular disease. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154.
(2) Cerebrovascular accident (hemorrhage or blockage of the blood vessels of the brain leading to lack of oxygen). Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 111.
(3) Hemiplegia paralysis affecting one side of the body. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 264.
(4) An "embolus" is a blood clot or a piece of plaque that acts like a clot. The word "emboli" means there is more than one clot or piece of plaque. When the clot travels from the site where it formed to another location in the body, it is called an embolism. This information was obtained from the website: https://medlineplus.gov/ency/article/001102.htm

2. The facility staff failed to report an incident of

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abuse for Resident #83 within two hours. Resident #23 hit Resident #83 on the back of the head on 5/17/19. Facility staff reported the alleged abuse to ASM (administrative staff member) #2, the Director of Nursing on 5/17/19 at 8:00 p.m., but did not report the allegation to the State Agency until 5/18/19.

The facility policy "Abuse Prevention. Revised: July 2019" documented, "7. Reporting/Response. A. ...Reporting must be filed within '2 (two) 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'."

The Facility Reported Incident dated 05/17/2019 documented, "[Name of Resident #83] bumped into [Name of Resident #23] while propelling her w/c (wheelchair)- [Name of Resident #23] hit [Name of Resident #83] in the back of the head."

The document "Suspected/Actual Resident Abuse, Neglect or Mistreatment Notification Checklist" documented, "Resident Name: [Name of Resident #83], Date of Incident: 5/17/19, Individual Notified, Administrative or Nursing Supervisor on duty: [Name of ASM (administrative staff member) #2], the director of nursing, Date 5/17/19, Time 8pm, By Whom [Name of RN (registered nurse) #5]." Further review of the document revealed, "Department of Health O.L.C. (office of licensure and certification) ...Fax initial State Letter (keep confirmation in file), Individual Notified, Faxed, Date 5/18/19, Time 11:17, By Whom [Name of ASM #3], the assistant director of nursing.

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Review of the fax confirmation revealed a start time of "05-18, 11:17" The fax cover sheet documented send to "Virginia Department of Health, Date 5/18/19" from ASM #3. The document failed to reveal reporting within two hours after the incident was reported to ASM #2 on 5/17/19 at 8:00 p.m.

Resident #83 was admitted to the facility on 4/29/2014. Resident #83's diagnoses included but were not limited to dementia with behavioral disturbances (1) and rheumatoid arthritis (2). Resident #83's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/14/2019, documented Resident #83 as moderately impaired for making daily decisions.

Resident #23 was admitted to the facility on 02/20/2014 with a readmission on 03/15/2016. Resident #23's diagnoses included but were not limited to, dementia with behavioral disturbances and anxiety (3). Resident #23's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 06/13/2019, coded Resident #23 as scoring a 4 (four) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 4- being severely impaired for making daily decisions.

Review of Resident #23's record revealed a nursing progress note dated "5/18/2019 12:08 AM", it documented "5-17-19 at 2000 (8:00 p.m.), resident was sitting in a chair in the social area. Another resident from [name of unit of facility] was self-propelling in her wheelchair and bumped into the chair this resident was sitting in. This

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resident yelled at her, "Hey, stop it now!" CNA (certified nursing assistant) was walking toward them to separate them but before she could reach them, this resident smacked the other resident on the back of the head. The two residents were separated and assessed for injuries. Neither resident noted to have any injuries. No complaints voiced ... Resident continues on 15 minute checks at this time. Resident also refused all QHS (bedtime) medications this evening."

On 9/19/19 at 11:05 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. When asked the process for reporting incidents of resident-to-resident abuse, LPN #4 stated that any abuse is reported to the supervisor who notifies the director of nursing or assistant director of nursing who then notify the executive director. LPN #4 stated that facility staff notify appropriate agencies within two hours. When asked if an incident is resident to resident if it is considered abuse LPN #4 stated, "I say yes, it is still considered abuse. One resident physically putting hands on another is abuse and should be reported."

On 9/19/19 at 2:40 p.m., an interview was conducted with ASM #2, the director of nursing. When asked to review the facility reported incident documents including the notification checklist and the fax confirmation regarding the incident on 5/17/19 of Resident #83 being hit on the back of the head by Resident #23, ASM #2 stated that the required reporting was not completed within two hours. ASM #2 agreed that according to the documentation, she was notified of the incident on 5/17/19 at 8:00 p.m. and the fax was sent to the state agency on 5/18/19 at 11:17

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a.m. ASM #2 stated, "Reporting should be within two hours."

On 09/20/19 at approximately 3:00 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. Dementia with behavioral disturbances
A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

2. Rheumatoid arthritis
A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.
3. On 9/22/19 the facility staff failed to immediately report an allegation of verbal abuse by CNA (certified nursing assistant) #23 towards Resident #51 to the administrator. CNA (certified nursing assistant) # 24 did not report the allegation until 9/24/19, at which time the facility submitted a report.

The Facility Reported Incident (FRI) dated, 9/24/18 documented in part, "Report date: 9/24/18. Incident date: 9/22/18. Staff member stated that on Saturday 9/22/18, staff member (CNA - certified nursing assistant #23) stated to (Resident #51) over top of her in bed and stated,

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'You need to shut the [Expletive] up."

The "Final Report" dated, 9/26/18, documented, "This letter serves as a follow-up to our initial FRI that was submitted on 9/24/18 involving: Resident (Resident #51) (Room number) with a Bims (Sic.) of 4 and a diagnoses of dementia without behavioral disturbance, adjustment disorder and hypertension (high blood pressure). Employee: (CNA #23 with license number). The Office of licensure and certification, Ombudsman, Adult Protective and Town of Orange Police Departments Services were notified on 9/24/18. On September 24, 2018, (CNA #24) stated that on Saturday September 22, 2018 (CNA #23) whispered to (Resident #51) 'Why don't you just the F--- up.' (CNA #24 stated that she should have reported on Saturday, she thought she did when she was the nurse's station. (CNA #24) was reeducated on reporting allegations of abuse and neglect. (CNA #23) was suspended pending an investigation. (Resident #51)'s responsible party and MD (medical doctor) were both notified. (Resident #51) had a skin audit by a licensed nurse that revealed no open areas, no redness and no bruising. (Resident #51) received a pain assessment from a licensed nurse with no complaints of pain. The Town of Orange Police Department reported to the facility and stated it was not a criminal case. (Resident #51) had had no change in mood or behavior since the alleged occurrence. (CNA #24) stated that there was never any contact with this occurrence. (CNA #24) stated that (Resident #51) was upset and cursing at staff as she often does when being put to bed or performing ADL (activities of daily living) task and that (CNA #23) leaned over the bed, not directly over (Resident #51) and whispered to her. (CNA #24) apologized again and stated she

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should have followed through on reporting this occurrence. (CNA #23) was interviewed and denied every making comments to (Resident #51) or any resident. (CNA #23) was called on 9/26/18 that she could return to work on 9/27/18 after receiving education on dealing with behavior and customer service. Staff and Resident interviews showed no negative outcome related to this matter. Staff was reeducated on reporting abuse and neglect. We did not find evidence of abuse and neglect in this matter."

The witness statement by CNA #24 dated, 9/24/18 documented in part, "While I, (CNA #24) was assisted (CNA #23) after we assisted (Resident #51) into the bed after using the Sarah lift (Resident #51) was still highly agitated and (CNA #23) told (Resident #51) to 'shut the [expletive] up.' Then she left the room stating I have to leave before I loose (sic) my job...I reported it to a nurse can't remember exactly who but when I stated it to them they just laughed and said ok. I am ashamed of myself for not reporting it to another administration. I should report quickly. I am ashamed and there is no excuse for my behavior, this is first incident in my 11 yrs (years) of nursing...I was wrong and I'm very ashamed of myself for my faults in the whole situation."

CNA #23 was no longer employed at the facility and CNA #24 was not available for interview.

Resident #51 was admitted to the facility on 9/1/16 with diagnoses that included but were not limited to: dementia, high blood pressure, and atrial fibrillation. (1)

The MDS (minimum data set) assessment,

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closest to the incident above, was a Significant change assessment, with an assessment reference date of 7/17/18, coded the resident as scoring a "04" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. In Section E - Behaviors, the resident was coded as having improved in her behaviors compared to her previous assessment. Resident #51 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating.

There were no nurse's notes or incident reports for this incident.

The comprehensive care plan dated, 2/24/17 and revised on 3/9/19, documented in part, "Problem/Need: Need to monitor mood, affect and psychosocial well-being d/t (due to) dx (diagnosis) dementia - mood score state at 00 as she shared no indicator of mood with worker during interview. Under comments, dated, 3/9/19, "No change in behavior related to allegation of verbal abuse."

An interview was conducted on with CNA (certified nursing assistant) # 2 on 9/18/19 at 2:00 p.m., regarding reporting witnessed resident abuse such as staff being rough with a resident, cursing at a resident or hitting a resident. CNA # 2 stated you report it to the charge nurse or unit manager or DON (director of nursing)." When asked how soon she reports this, CNA # 2 stated as soon as possible or immediately.

An interview was conducted with LPN # 9 on 9/18/19 at 3:54 p.m. When asked to describe signs of abuse, staff member stated changes in

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F 609	Continued From page 73 behavior and/or new injuries would be suspicious. When asked how she would respond to an allegation of abuse or witnessing abuse, staff member stated she would first protect the resident. Then she would notify her manager, who would pass it up the chain to be investigated. Staff member stated that if there was a concern with the unit manager not acting on the report, the nurses are expected to go directly to the DON. Administrative staff member (ASM) #1, the executive director, was made aware of the above concern on 9/19/19 at 1:58 p.m. No further information was provided prior to exit.	F 609		
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.	F 622		10/14/19

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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 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

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F 622	Continued From page 75 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 (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, it was determined that the facility staff failed to evidence the comprehensive care plan goals were provided to the hospital upon transfer for two of 54 residents in the survey sample, Residents #63 and #57. The findings include: 1. Resident #63 was transported to the hospital on 7/7/19, and was admitted. The facility failed to send the resident's comprehensive care plan	F 622	1. Residents #63 and #57 have returned back to the facility after a safe and effective transition even though the Resident's Care Plan Goals were not sent. 2. The other residents who transfer out of the facility have the potential to be affected by this defective practice. 3.The facility staff were re-educated regarding the Orange Folder process. This process includes a check-off list with	

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F 622	Continued From page 76 goals to the hospital upon transfer. Resident #63 was admitted to the facility on 12/17/07, and was most recently readmitted on 7/15/19, with diagnoses that include, but not limited to, dementia with behavioral disturbances and major depression. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/24/19, Resident #63 was coded as being moderately cognitively impaired for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status). A review of nurses' notes for Resident #63 revealed the following note, written 7/7/19 at 2:50 p.m.: "Resident noted very pale in color, anxious, grunting. Denies any pain or sob (shortness of breath) or nausea but has vomited food in urinal....Resident unable to maneuver w/c as normally does. RP (responsible party) notified and would like him do go to hospital if he will cooperate. Message left for on call physician and awaiting return call." Further review revealed another note, written 7/7/19 at 3:22 p.m.: "Rescue squad transported resident to hospital for evaluation and possible admission. On call nurse notified of resident departure." Further review of Resident #63's clinical record (including an acute care transfer checklist, a hospital transfer form) failed to reveal evidence that the resident #63's comprehensive care plan goals were provided to the hospital staff for this transfer. On 9/19/19 p.m. at 1:37 p.m., LPN (licensed practical nurse) #7 was interviewed regarding the process the facility staff follows regarding resident	F 622	all boxes checked off including a section to signify that the Comprehensive Care Plan Goals from our new electronic software "Work-Center" are included with the information sent with the transfer. This re-education will be completed by 10/14/19. 4. To ensure compliance, audits will be conducted by Administration (or designee) every week for 4 weeks then monthly for 3 months to ensure that the Orange Folder process includes the check-off sheet with all boxes checked off to include the Comprehensive Care Plan Goals from our new electronic software "Work-Center" are included with the information sent with the transfer. This information will be forwarded to QAPI for review.	

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documentation when a resident is transferred to the hospital. LPN #7 stated, "We notify the doctor, get the order, notify the family. Then we have an orange folder. It has a checklist. We do all the things on the list, and we give the folder to the rescue squad when they arrive."

On 9/19/19 at 1:56 p.m., ASM (administrative staff member) #2, the DON (director of nursing) was interviewed. She stated facility staff should use the checklist in the orange folder when transferring a resident to the hospital. When asked if the orange folder includes a prompt for the staff to send the comprehensive care plan goals with the resident, ASM #2 stated, "Yes, it does." She stated she could not find evidence that Resident #63's care plan goals had been sent to the hospital when he was transferred there on 7/7/19.

On 9/19/19 at 2:45 p.m., ASM #1, the executive director, and ASM #2 were notified of these concerns. The surveyor requested a policy on resident transfers.

On 9/19/19 at 3:56 p.m., ASM #2 stated the facility did not have a policy on hospital transfers. She stated the facility uses the checklist in the orange folders as their guide.

A review of the document, "Checklist for orange folder," revealed, in part, the following: "The following items will be placed in the orange folder that goes with a resident when they discharge to the hospital:...Copy of care plan."

No further information was provided prior to discharge.

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2. The facility staff failed to evidence the comprehensive care plan goals were provided to the receiving hospital upon Resident # 57 transfer on 8/17/19.

Resident #57 was admitted to the facility on 7/16/18 with diagnoses that included but were not limited to: high blood pressure, dementia and anemia (condition in which the hemoglobin content of the blood is below normal limits) (1).

The most recent MDS (minimum data set) assessment, an annual assessment, coded the resident as scoring a "05" on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions.

Review of the clinical record revealed a document titled, "Checklist for orange folder." The resident's name was documented on this list. There were check marks next to the following items:
*copy of face sheet
*copy of DNR (do not resuscitate) or any advanced directive
*In (initials of computer program), you will need to do a transfer summary form.
* Bed Hold form in folder.
There was no check mark next to "Copy of the baseline care plan."

An interview was conducted with RN (registered nurse) #5, on 9/18/19 at 3:59 p.m. When asked about the process for sending residents to the hospital, RN #5 stated, "We send the orange folder with the checklist. We go by the checklist." The checklist for Resident #57 for 8/17/19 was reviewed with RN #5. When asked what they are sending when it says baseline care plan goals,

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F 622	Continued From page 79 RN #5 stated she would have to check. RN #5 was interviewed again with the presence of the director of nursing, administrative staff member (ASM) #2; on 9/18/19 at 4:20 p.m., RN #5 stated if a resident has been here less than 21 days and is transferred to the hospital, we send the baseline care plan. If the resident is here greater than 21 days, we send the comprehensive care plan goals. When asked if the box is not checked can you evidence that the care plan goals were sent with Resident #57 upon transfer to the hospital on 8/17/19, ASM #2 stated, "I can't evidence that." ASM #1, the executive director was made aware of the above concern on 9/19/19 at 1:58 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33 .	F 622		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		10/18/19

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F 684	Continued From page 80 by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care per the comprehensive care plan and resident preference, resulting in injury for one of 54 residents in the survey sample, Resident #136. Resident #136 presented with left sided paralysis and limited range of motion in the left arm due to a stroke. The comprehensive care plan dated 6/16/17 documented the resident prefers to manipulate her arms for ADLs (activity of daily living). On 2/11/19, CNA (certified nursing assistant) #5 raised the resident's left arm during ADL (activities of daily living) care, resulting in a left arm dislocation, and harm. The resident was transferred to the hospital where the left arm was fractured while a physician attempted to reduce the dislocation. The findings include: Resident #136 was admitted to the facility on 6/16/17. Resident #136's diagnoses included but were not limited to history of stroke, paralysis of one side of the body and muscle weakness. Resident #136's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/18/19, coded the resident as being cognitively intact. Section G coded Resident #136 as requiring extensive assistance of one staff with dressing/personal hygiene and as having a functional limited range of motion of both upper extremities. Resident 136's comprehensive care plan dated 6/16/17 documented, "(RESIDENT #136) HAS	F 684	Past noncompliance: no plan of correction required.	

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FUNCTIONAL STATUS LIMITATION REQUIRING VARIOUS LEVELS OF ASSIST WITH ADL'S (ACTIVITIES OF DAILY LIVING) DUE TO WEAKNESS, HX (HISTORY) OF CVA (CEREBROVASCULAR ACCIDENT [STROKE]) WITH LEFT HEMIPARESIS (PARALYSIS). ..ASSIST HER AS NEEDED FOR EATING, TOILETING CARE NEEDS, BED MOBILITY DRESSING AND BATHING..." The care plan further documented, "PER RP (RESPONSIBLE PARTY) AND RESIDENT'S CHOICE: RESIDENT PREFERS TO MANIPULATE HER ARMS FOR ADL'S..."

A nurse's note dated 2/11/19 documented, "RESIDENT STATED CNA LIFTED HER LEFT ARM TOO HIGH DURING CARE. RESIDENT STATED IT HURT A LOT AT THE TIME (3:30 PM), AND STILL FEELS TENDER WHEN REPORTING TO THE NURSE AT 4:00 PM. RESIDENT AND RP (RESPONSIBLE PARTY) ARE REQUESTING AN XRAY FOR POSSIBLE DISLOCATION, PENDING APPROVAL FROM MD (MEDICAL DOCTOR). PRN (AS NEEDED) TYLENOL ADMINISTERED FOR HEADACHE, RESIDENT STATED IT WAS HELPFUL. EVENING NURSE SUPERVISOR AWARE."

A FRI (facility reported incident) submitted from the facility to the VDH (Virginia Department of Health) OLC (Office of Licensure and Certification) on 2/12/19 documented, "Incident date: 2/11/19. Residents involved: (Resident #136) Injuries: Yes. X-ray showed a dislocated right shoulder. Describe incident, including location, and action taken: On 2/11/19 (Resident #136) stated to another C.N.A. that the C.N.A. working with her was rough. (Resident #136) expressed on 2/12/19 to unit manager that C.N.A.

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working with her lifted her arm to (sic) high and heard a pop. (Resident #136) had new order per MD (medical doctor) for xray. Xray showed a dislocated right shoulder..." Note: an interview with ASM (administrative staff member) #2 (the director of nursing) on 9/19/19 at 2:24 p.m. confirmed the documentation of a dislocation of the right shoulder in the FRI was typed in error and the dislocation was of the left shoulder.

A witness statement signed by CNA #5 on 2/11/19 documented,
"On Monday 2-11-19 at approx (approximately) 3:00 I was asked by (name of another CNA) if I could give (Resident #136) a shower. I said I would. I went to (Resident #136) and let her know it was her shower day and I would do her shower if she was ready. I got all of her things together and took her to shower room & started her shower. 3/4 of the way through her shower I lifted her right [*Note it was the left arm see above] arm she stated, 'Ouch that hurts' to which I apologized and did not lift it that high again when I went to rinse the soap off. The water was beginning to get cold even at high heat setting for water so I quickly washed her leggs (sic) and rinsed her body off. I dryed (sic) her some in bathroom before wrapping a bed sheet around shower chair and we returned to (Resident #136's) room where I put lotion on her back, arms, legs, put powder under breast and got her dressed."

A witness statement signed by RN (registered nurse) #5 on 2/12/19 documented,
"On 2-11-19, at 4:00 pm, (Resident #136) reported to me that one of the aides has always been too 'rough with me.' She also stated that after her shower (3:30 pm), the aide pulled her

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arm up too far when trying to put her shirt on. The resident stated it hurt a lot at the time, and still feels tender at the time it was reported. Another aide finished helping resident to get dressed and provide care. The nurse administered PRN (as needed) tylenol 650 mg (milligrams) which was effective."

A witness statement signed by CNA #15 on 2/12/19 documented,
"I walked into the residents (sic) room after her shower and one of the other aids was getting her ready. I noticed the resident looked uncomfortable. I saw the aid holding her stroke arm (left) up. The resident said, 'I told you to do it from the back, that hurts." I told the aid I would finish helping the resident. When she left, the resident said, 'Don't ever leave me with her again. She's way too rough.' I asked her what she did. She replid (sic), 'She hurt my arm.' Nurse notified."

A nurse's note dated 2/12/19 documented,
"NO PAIN TO LEFT ARM VOICED. RESIDENT STATES ITS (SIC) JUST TENDER AND STILL WOULD LIKE TO HAVE XRAY..."

A physician's order dated 2/12/19 documented an order for a STAT (immediate) x-ray of the right shoulder (note: the order was clarified to be obtained on the left shoulder).

A left shoulder x-ray dated 2/12/19 documented a shoulder dislocation.

The hospital history and physical dated 2/12/19 documented, "(Resident #136) is a very pleasant 79 yo (year old) female, with a history of stroke and residual L (left) sided weakness and

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hypertension (high blood pressure), brought to the ED (emergency department) from her assisted living facility with complaint of L should (sic) pain and report of dislocation. Patient states that yesterday evening a health aide at her facility was hoping (sic) move her left arm secondary to residual weakness when she had acute onset of pain. Pain is in the left shoulder does not radiate. She has old weakness but denies any numbness over her arm or shoulder. She denies any falls or injuries. Patient states that an x-ray was obtained earlier today by her assisted living facility, which revealed a shoulder dislocation." The note further documented a reduction of the dislocation was attempted and resulted in a fractured humerus (upper arm bone).

A nurse's note dated 2/13/19 documented, "RESIDENT C/O (COMPLAINED OF) HAVING A BAD NIGHT THIS AM WITH C/O NOT GETTING MUCH SLEEP DUE TO ER (EMERGENCY ROOM) VISIT AND HER SCHEDULE GETTING MESSED UP. THIS WRITER CALLED INTO RESIDENTS (SIC) ROOM THIS AM TO ASSIST GETTING RESIDENTS (SIC) SHIRT OVER SLING. WHILE THIS WRITER WAS ASSISTING WITH MORNING CARE RESIDENT BECAME NAUSEATED AND C/O FEELING LIKE SHE WAS GOING TO PASS OUT. SKIN COLOR PALE. RESIDENT DID HAVE EMESIS (VOMIT) OF A SMALL AMOUNT OF YELLOWISH LIQUID X (TIMES) 2. RESIDENT WAS ABLE TO GET HERSELF TOGETHER SHORTLY AFTER EPISODE OF EMESIS AND CONTINUE WITH AM CARE. RESIDENT DENIES NEED FOR PAIN MEDS OR VITAL SIGNS THIS AM BUT DID TAKE PRN ZOFRAN (1) FOR NAUSEA. RESIDENT SEEMS VERY UPSET AND BELIEVES HER FEELING THIS WAY THIS AM

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F 684	Continued From page 85 IS DUE TO STRESS ABOUT HER ARM INJURY AND HAVING TO GO OUT TO THE ER, NOT GETTING ENOUGH SLEEP AND HER ROUTINE GETTING OFF TRACK. SLING IN PLACE TO LEFT ARM." A final report submitted to the VDH OLC from the facility on 2/15/19 documented, "This letter serves as a follow-up to our initial F.R.I. that was submitted on 2-12-18 (wrong year) involving: Resident: (name of Resident #136). unspecified convulsions, presence of right artificial should (sic) joint, other instability, right shoulder, pain in right shoulder, hemiplegia (paralysis affecting one side of the body), muscle weakness, muscle spasm, foot drop of left foot, coronary (heart) artery without out (sic) angina pectoris (chest pain), anemia, essential (sic), mild intermittent asthmas, chronic obstructive pulmonary (lung) disease, hypothyroidism (underactive thyroid gland), hyperlipidemia (high cholesterol), GERD (Gastroesophageal reflux disease [digestive disorder]), allergic rhinitis (symptoms affecting the nose), constipation, malaise (discomfort), dry eye syndrome, adjustment disorder with anxiety, hypo osmolality, hyponatremia (low sodium), difficulty in walking, edema, unspecified osteoarthritis, pain in leg, pain right fingers, tinea uniguuum (sic) (nail fungus), edema (swelling), and pain in the leg in room (number) with a BIMS (brief interview for mental status) of 15 (on a scale from 0 to 15, indicating the resident is cognitively intact). Employee: (Name of CNA #5) On February 11, 2019 at appx (approximately) 330pm (Resident #136) stated to a charge nurse that a C.N.A. working with her lifted her arm to (sic) high up and she felt something in her arm that felt like a pop.	F 684		

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The responsible party requested and (sic) X-ray and staff sought MD (medical doctor) confirmation. A new order to obtain an X-ray was given on 2/12/19. The results showed that her left shoulder had a dislocation. The MD requested that the resident be sent to ER. Resident returned with sling on arm and it was noted that while the ER was attempting to manually place arm back in place, (Resident #136) obtained a left a (sic) humerus fracture. (Resident #136) returned to the facility and had an orthopedic follow up on 2/15/19 that stated that resident is appropriate for non-operative treatment. She was placed in an elastic immobilizer which was much more comfortable for (Resident #136), (Resident #136) is to remain in the immobilizer 24/7 and return 2 weeks for repeat x-rays.
The Office of licensure and certification, Ombudsman, Adult Protective and Town of (name of town) Police Department Services were notified on 2-12-19.
(CNA #5) was sent home immediately pending an investigation.
(Resident #136's) responsible party and MD were both notified.
(Resident #136) had a skin audit by a licensed nurse that revealed no open areas, no redness and no bruising.
(Resident #136) received a pain assessment from a licensed nurse on 2/11/19 with complaints of pain at the time of arm feeling popped.
The Town of (name of town) Police Department reported to the facility and stated that this is not a criminal case. They did visit with (Resident #136) who stated that (CNA #5) lifted her arm too high to apply deodorant and is not afraid to be in the facility.
After review of (CNA #5"s) work record it was

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noted that she has worked with (Resident #136) in the past and has given her a shower and placed deodorant. (Resident #136) stated that this time while (CNA #5) was working with her, she appeared rushed and did not seem concerned about her as a person, only with getting her task done while rushing around. (Resident #136) has had no change in mood or behavior since the alleged occurrence.
We did find evidence of neglect with this allegation that (CNA #5) had cared for (Resident #136) in the past and had no issues. However, when caring for (Resident #136) this time and rushing per (Resident #136's) statement an injury occurred to her left shoulder.
(CNA #5) will be notified of termination by Director of Nursing and human resources on 2/18/19, she will remain on suspension until notification.
Social Services at (name of facility) met with (Resident #136) and her daughter on 2/15/19 and she stated she did feel safe to be in the facility and was not fearful..."

On 9/18/19 at 12:46 p.m., an interview was conducted with Resident #136. The resident was sitting in a wheelchair and the resident's left arm was lying limp in the resident's lap. Resident #136 stated she has limited range of motion in the left arm as a result of a stroke. Resident #136 stated she can slightly move the left arm forward and back and slightly raise the arm but is not able to lift the shoulder. Resident #136 was asked to describe the incident that occurred on 2/11/19. Resident #136 stated the CNA had given her a shower on 2/11/19 and was assisting her with getting dressed. Resident #136 stated, "I told her you cannot raise that arm so what does she do? She pulled it up and raised." Resident #136 was asked how high the CNA lifted her left

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arm. Resident #136 stated from what she could recall, the CNA raised her left arm high enough to where hand was parallel with her face. Resident #136 stated, "It felt funny as soon as she raised it." Resident #136 stated she complained to one of the nurses and the nurses had the x-ray unit come in and complete x-rays and then the nurse came in and told her that her arm was dislocated. Resident #136 stated she was sent to the hospital and confirmed her arm was broken while the physician was trying to reduce the dislocation. Resident #136 was asked how the incident made her feel. Resident #136 stated, "Having the aide not listen to what I told her. I'm a stroke patient to begin with and am very much aware with what is going on and she being a CNA and not paying attention to what I told her, I think it was pretty rotten. I did not know her and she did not know me. Excuse my language but it pissed me off." Resident #136 stated most CNAs are very careful with her arm but that CNA just jerked her arm up.

On 9/18/19 at 3:09 p.m., an interview was conducted with CNA #8 (a CNA who cares for Resident #136). CNA #8 was asked if Resident #136 has any physical limitations. CNA #8 stated the resident had a stroke and one arm is affected to the point where the resident can't lift the arm and her hand is in a fist. CNA #8 was asked how she knows how to care for Resident #136. CNA #8 stated the first day she cared for Resident #136, the resident explained to her that she had a history of stroke and explained how to transfer her and dress her due to the limitations with her arm. CNA #8 further stated Resident #136's care plan documents to not lift the resident from her shoulders or pull on her shoulders.

On 9/18/19 at 3:53 p.m., an interview was

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conducted with RN #5 (a nurse caring for Resident #136 on 2/11/19). RN #5 was asked to explain the incident regarding Resident #136 on 2/11/19. RN #5 stated, "The CNA was assisting her with care after her shower. The CNA lifted her arm too high and it caused some pain to the resident's arm. It was reported to me close to the beginning of the 3-11 shift around 4:00 p.m. and I went in to see her. She said that when it first happened that it was painful and when I talked to her the pain was not as bad. I talked to her and her daughter and they wanted to get an x-ray to see the status of her arm and shoulder. They didn't think it was an emergency; just when the x-ray people could come. I talked to the CNA to let her know to go with the resident's pace and to be careful with the affected side." RN #5 was asked if Resident #136's left arm should have been raised as high as the resident reported the CNA lifted it on 2/11/19. RN #5 stated, "I don't think it should be raised that high. It may be able to be raised that high if done slowly." RN #5 was asked if she would raise Resident #136's arm to that level and stated, "If I did it slowly and saw it wasn't causing any pain."

On 9/18/19 at 4:16 p.m., an attempt to contact CNA #15 was made. The CNA did not answer the phone.

On 9/18/19 at 5:28 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern and the concern for harm.

On 9/19/19 at 8:32 a.m., ASM #1, ASM #2 and ASM #3 (the assistant director of nursing) presented a plan of correction regarding Resident

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#136's incident on 2/11/19. The plan of correction documented,
"1. The facility has established a corrective actin (sic) plan for resident (name of Resident #136).
2. The resident (sic) of the facility who require transfer in the facility have the potential to be affected.
3. Facility Nursing Staff were in serviced on 2/14/19 3/14 7/11 9/5- additional listed.
4. To ensure compliance random care giver task (sic) were reviewed on (sic) by nursing and verified by (name of administrative assistant) for correct information.
Compliance date: 5/13/19. Past non compliance was discussed in QAPI 3/19/19 regarding resident with a FRI on 2/11/19; ALL FRI and ACCIDENTS AND INJURY ARE DISCUSSED DURING QAPI."

ASM #2 provided credible evidence to confirm all other residents who had the potential to be affected were identified and staff education was provided. The staff education documented a list of topics that were covered in a nursing staff meeting in February 2019. The topics included transfers and incidents/accidents. ASM #2 stated she verbalized to staff that they needed to follow residents' care plans and should not rush while providing care. ASM #2 stated she used the incident regarding Resident #136 as an example during the meeting. This was confirmed through interviews with facility staff.

Other residents were reviewed during the survey to ensure no similar incidents occurred after 2/11/19. No concerns were identified.

On 9/19/19 at 11:37 a.m., an interview was conducted with OSM (other staff member) #10

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(the rehab director). OSM #10 was asked if she could provide any rehab notes regarding Resident #136's left arm. OSM #10 stated Resident #136's left arm was injured from a stroke in 2008. OSM #10 stated the only documentation she had was an occupational therapy evaluation from 2016 that documented the resident's left upper extremity range of motion was impaired. OSM #10 stated the evaluation documented the resident had minimal active range of motion due to the stroke and the resident was able to use the arm as a stabilizer but had minimal functional use. OSM #10 was asked to describe the function of Resident #136's left arm. OSM #10 stated the arm is flaccid most of the time but gets tone with reflexes such as sneezing. OSM #10 stated the arm is not functional. OSM #10 was asked if someone should be lifting Resident #136's left arm in the manner that the resident reported a CNA did on 2/11/19. OSM #10 stated the resident was not being seen by the rehab department at the time. OSM #10 stated the CNA lifting Resident #136's arm was passive range of motion and she (OSM #10) did not have measurements of what passive range of motion the resident could withstand at the time so she could not answer the question.

On 9/19/19 at 2:24 p.m., ASM #2 was asked to provide the standard of practice used by the facility. ASM #2 stated the facility staff follows the facility policies.

On 9/19/19 at 3:18 p.m., RN #8 confirmed the facility did not have a policy regarding ADL care.

On 9/19/19 at 3; 22 p.m., ASM #2 confirmed the facility did not have a policy regarding resident preferences except for meal choices.

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F 684	Continued From page 92 The facility policy regarding comprehensive care plans documented, "2) The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs...9) The resident will receive the services and/or items included in the plan of care..." No further information was presented prior to exit. PAST NON-COMPLIANCE (1) Zofran is used to prevent nausea and vomiting. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601209.html	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide care in a manner to prevent an accident resulting in injury and harm for one of	F 689	Past noncompliance: no plan of correction required.	10/18/19

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54 residents in the survey sample, Resident #132. On 1/11/19, two CNAs (certified nursing assistants) failed to use a mechanical lift to transfer Resident #132 from a wheelchair to a shower chair. The CNAs attempted to transfer the resident manually. As a result, the resident fell and sustained a laceration under his arm. This laceration required the resident to be transported to the emergency room where he received 19 stitches, resulting in harm.

The findings include:

Resident #132 was admitted to the facility on 12/13/17, and most recently readmitted on 5/24/19, with diagnoses including, but not limited to Schizoaffective disorder (1), traumatic brain injury (2) vascular dementia (3) cognitive communication deficit (4), congestive heart failure (5) and failure to thrive. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/28/19, he was coded as having mild impairment for making daily decisions, having scored 14 out of 15 on the BIMS (brief interview for mental status). He was coded as having unclear speech, as usually being understood by others, and as usually understanding others for communication. He was coded as requiring extensive assistance of two-plus staff members for transferring from one surface to another, and as not having walked in his room or on the unit during the look back period.

On the most recent MDS prior to 1/11/19, a significant change assessment with an ARD of 10/19/18, Resident #132 was coded as having mild cognitive impairment for making daily decisions, having scored 13 out of 15 on the

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BIMS. He was coded as having unclear speech, as usually being understood by others, and as always understanding others for communication. He was coded as requiring the extensive assistance of one staff member for transferring from one surface to another, and as not having walked in his room or the unit during the look back period.

On 9/18/19 at 10:05 a.m., Resident #132 was observed self-propelling in his wheelchair in his room. He was wearing long sleeves; neither arm was visible. When asked about the incident in January when he received a cut under his arm, he stated, "Yes, that happened; I don't really want to talk about it." He then stated he was late for a meeting and needed to "go down hall." The resident left his room and headed toward the social area near the end of the hall.

A review of the initial FRI (facility reported incident) related to Resident #132 submitted to the SA (stated agency) on 1/11/19 revealed, in part, the following: "Report date: 01/11/19, Incident date: 01/11/19. Resident involved: [Resident #132]. Injuries: Yes. Incident type: Unusual occurrence. Describe incident, including location, and action taken: 2 CNA's (sic) were transferring [Resident #132] by manually lifting without gait belt. Transfer status is 2 person with hoyer (mechanical) lift. Resident's left axillary (underarm) was torn when lowering resident to floor in west main shower room. Area measures 2.0 X (by) 8.0 X 2.0 (centimeters). Resident was sent out to ER (emergency room) for placement of sutures. Name of employee(s) involved and their positions: [CNA #14] and [CNA #13]. Employee action initiated or taken: Staff Education and suspension of employees."

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A review of the follow-up to the initial FRI dated 1/16/19 revealed, in part, the following: "This letter serves as a follow-up to our initial FRI that was submitted on 1/11/19. Resident: [Resident #132] [Resident #132's room number]...Employee: [CNA #14], [CNA#13] On January 11, 2019, [CNA #13 and CNA #14] were transferring [Resident #132]. [Resident #132] was a Hoyer lift as of 1/4/19. [CNA #13] and [CNA #14] transferred [Resident #132] as a 2 person assist, as they were transferring him from the wheelchair to the shower chair, [Resident #132] became weak and started to fall. [CNA #14] and [CNA #13] grabbed by the arms to assist with fall causing a laceration (cut) in his axilla. [Resident #132] was sent to the Emergency room and received 19 sutures and returned to the facility. [CNA #14] and [CNA #13] were suspended immediately on 1/11/19 pending an investigation. The investigation showed that [CNA #14] and [CNA #13] did not follow transfer orders and were terminated on 1/15/19. Staff education remains ongoing regarding resident transfer status. Based on staff interviews and statements, [CNA #14] and [CNA #13] were terminated for not following policy and procedure."

A review of the document, "Resident Incident Report," dated 1/11/19 at 7:30 p.m., revealed, in part, the following: "Incident type: Fall/no head injury. Type of Injury: Skin Tear, Laceration - deep. Location: Shower room. Property involved: floor - tile/wood. Equipment: Shower chair - wheeled. Activity at time: From chair w/ (with) assist. Associate Involved: [CNA #13]. Incident reported by: [CNA #14]. Non-Witnessed. Narrative of incident and description of injuries: At approximately 7:30 p.m., resident was lowered to

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the floor during unsuccessful transfer in shower room on unit. Injuries include deep tissue skin tear to left posterior (back) axilla, measuring 2cm (centimeters) X 8cm X 2 cm deep. Moderate amount of blood noted to the area. Resident is assisted to the shower chair from the floor by multiple staff. Skin tear cleansed with NS (normal saline) and covered with dry dressing. [Name of attending physician] aware. RP (responsible party) aware. Shift super (supervisor) aware. Staff education was provided. Injuries include deep tissue skin tear to left posterior axilla measuring 2cm X 8cm X 2 cm deep. Moderate amount of blood noted to the area. Immediate Actions Taken: Skin assessment, ROM (range of motion) assessment, pain assessment, vital signs taken, assisted to the shower chair, wound cleansed and dressing applied...Temp (temperature) 97.4, Pulse 101, Resp (respirations) 24, BP (blood pressure) 143/83, Pain Scale 4...Medical risk factors possibly related to incident: Fall history, Inability to understand directions, confusion/Disorientation, Incontinency (inability to control bowel and bladder), Sensory limitations." The report was completed by a nurse who was unavailable for interview at the time of the survey.

A review of the clinical record revealed a nurses' note for Resident #132 dated 1/11/19 at 11:57 p.m. The note documented, in part, the following: "At approximately 7:30 p.m., resident was lowered to the floor during unsuccessful transfer in shower room on unit. Injuries include deep tissue skin tear to left posterior (back) axilla, measuring 2cm (centimeters) X 8cm X 2 cm deep. Moderate amount of blood noted to the area. Resident is assisted to the shower chair from the floor by multiple staff. Skin tear cleansed with NS (normal saline) and covered with dry

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dressing. [Name of attending physician] aware. RP (responsible party) aware. Shift super (supervisor) aware. DON (director of nursing) aware. Staff education was provided. VS (vital signs) Temp (temperature) 97.4, Pulse 101, Resp (respirations) 24, BP (blood pressure) 143/83, [Blood oxygen level] 86% 3 L (liters) nc (nasal cannula). N.O. (new order) Send out to E. D. (emergency department) for further evaluation d/t (due to) deep tissue skin tear...Medical transportation takes resident to E. D. at 9pm." The nurse who wrote this note was unavailable for interview at the time of the survey.

A review of Emergency Department Report for Resident #132 for 1/11/19 revealed, in part, the following: "Evaluation: Physical exam shows patient to be (sic) no acute distress...Patient denies any other complaints except for laceration to left underarm. Has full active range of motion to left upper extremity without difficulty...Laceration repaired with deep layer superficial layer (sic) sutures. Good approximation noted. Patient tolerated procedure well. Wound thoroughly irrigated (cleaned with water) with pressure syringe saline prior to closure...Informed to have sutures out in 10-14 days...Procedures: Laceration/Wound Repair: Wound length (cm) 9, Wound's depth, shape: deep, linear...Wound repaired with: sutures...Number of sutures: 16...Number Deep Layer Sutures: 3."

Further review of the clinical record revealed a nurses' note for Resident #132 dated 1/12/19 at 1:06 a.m. The note documented, in part: "Resident returned from ER with 19 sutures to left axilla. During assessment, noted multiple bruises over left arm. Resident also received tetanus shot

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at ER. Sutures need to be removed in 10-14 days. Resident in bed and denies any pain at this time." The nurse who wrote this note was unavailable for interview at the time of the survey.

A review of the witness statement submitted 1/11/19 by CNA #13 revealed, in part, the following: "At about 8ish, we went to get [Resident #132] from the recliner to get him cleaned up and ready for bed. When we got him up he stood, we removed his brief and it was beyond soiled. We then decided it would be best for his hygeine (sic) to rinse him of (sic) in the shower room. When we got him up to remove the wheelchair to put the shower chair underneith (sic) him he began to fall we encouraged him to stand (which he was doing great) but then he just kept falling, so we held on. But instead of letting him fall, we ease (sic) him to the floor. When we picked him up to get him up, I noticed blood on my glove and lifted his arm and noticed the tear. Then I went to get the nurse. As far as my knowledge it was said to me he was a 2 person assist. I began checking the CNA book but over the past few weeks, it has been changing. Also this is the first time [Resident #132] has been out of bed in over a week and a few days."

A review of the witness statement submitted 1/11/19 by CNA #14 revealed, in part, the following: "I was assisting another CNA in the...shower room to his shower chair. When he started to go down to the floor, we helped (sic) under his arms to assist him to the floor gently. I went then to the nurse for help and we saw the blood on the other aids (sic) gloves and informed the nurse of the skin tear on the left underarm of the resident. I was on the right hand side and the other aid (sic) had been on the left side.

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A review of Resident #132's ADL Assistance and Support record for 1/2/19 through 1/11/19 revealed that he was totally dependent on the physical assistance of at least two staff members for all transfers between surfaces.

A review of physician's orders for Resident #132 revealed the following order dated 1/4/19 and discontinued on 1/13/19: "Transfer status [mechanical] lift with 2 person assist."

A review of Resident #132's care plan dated 12/27/17 revealed, in part, the following: "Transfers: SARA (mechanical) lift with 2 people with green trim sling."

A review of the facility's CNA communication book revealed the following entry dated 1/2/19: [Resident #132: Transfer: Hoyer + 2p (people)."

A review of the facility policy, "Resident Transfers," revealed, in part, the following information: "Safety is the first priority for residents...Follow directives in physicians' orders and the comprehensive care plan to perform safe transfers for all residents."

A review of CNA #13's employee record revealed a termination notice dated 1/16/10. The notice documented, in part: "Resident was transferred with 2 people instead of Hoyer, resulting in resident falling (lowered to the floor) and obtaining a significant skin tear to axillary. Resident required 19 stitches and treatment @ (at) ER...Action to be taken: Employee termination." The form was signed by both CNA #13 and ASM (administrative staff member) #2, the DON (director of nursing).

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A review of CNA #14's employee record revealed a termination notice dated 1/16/10. The notice documented, in part: "Resident was transferred with 2 people instead of Hoyer, resulting in resident falling (lowered to the floor) and obtaining a significant skin tear to axillary. Resident required 19 stitches and treatment @ (at) ER...Action to be taken: Employee termination." The form was signed by both CNA #13 and ASM (administrative staff member) #2, the DON (director of nursing).

Neither CNA involved who participated in the 1/11/19 transfer of Resident #132 is currently employed by the facility.

On 9/18/19, CNA #17 was interviewed. She stated if she has a question about a resident's status, she checks with nurse or looks in the CNA book. She stated, "You can also check it in the tablet." She stated she has worked with Resident #132 "a couple of times."

On 9/18/19 at 2:55 p.m., CNA #18 was interviewed. Can #18 stated, "The residents can change from one day to the next, even over a shift. You should always double check on a transfer status if you have any questions." She stated she does not remember ever working with Resident #132.

On 9/18/19 at 3:16 p.m., LPN (licensed practical nurse) #4, a unit manager, was interviewed. She stated Resident #132 resides on the unit she manages. LPN #4 stated she was the evening supervisor on 1/11/19. She stated she was in the building, but not in the shower room when the transfer happened. LPN #4 stated, "I got called to

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the shower room and [Resident #132] was lying on the floor and bleeding. He was on the floor, on his bottom. I lifted up his left arm, under the axillae, and it was ripped. [CNA #13 and #14] said he had hit something on the shower chair behind him. But there was no way. We got the Hoyer lift to get him safely up and into a chair. He is so hard to get up once he falls. I assessed the area, held pressure. I had the floor nurse call 911 to get him sent out to get his stitches. I called to notify [ASM #3, the assistant director of nursing (DON)]. I wrote the employees up. I had called [ASM #3] because [CNA #13 and #14] did not follow the transfer status. That was a written three-day suspension pending investigation. They were sent home. I had to notify the RP and the doctor. I knew there was no way the cut came from the shower chair. There was no blood on the nearby heating vent. I knew the CNAs were not telling me the truth." When asked what a CNA book is, LPN #4 stated, "It's a book we keep on the unit. It has all the transfer statuses in it; each shift fills in one on each resident. It tells all about the resident - their likes and dislikes - things we can add to the care plan. The CNAs know they are in there." When asked if the expectation is that CNAs review the book, LPN #4 stated, "Yes. They should review this when they come on a shift. Transfer status is something that can change day to day. And if they are unsure or confused, they can always ask the nurse." LPN #4 stated, "I want to say we put out an inservice right away. We have a communication book that we put inservice material in for the nurses and CNAs to read and sign, saying they understand the material. Transfer specifics for [Resident #132] were specifically covered after this happened. Unit managers make sure the training gets done."

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On 9/18/19 at 3:38 p.m., ASM (administrative staff member) #3, the assistant DON, was interviewed about the events of 1/11/19. ASM #3 stated, "I was not here. [LPN #4] was here as the supervisor." ASM #3 stated she called back to the facility, and was informed of what happened. "There were a series of phone calls. I asked what his transfer status is. Let's make sure. Everything agreed. The care plan, the care guide/kiosk, the manual CNA book. It all matched. He had been a Hoyer lift for several days - like a week. He had not been back from the hospital long. When we realized that everything matched, there was no excuse. I told the evening supervisor to suspend [CNA #13 and #14] pending an investigation. We went over the write up by phone. The CNAs were sent home. We took their badges. The statements they wrote admitted what they did." When asked what a kiosk is, ASM #3 stated, "It's a caregiver guide, electronic. It used to be on the walls, now it is a tablet. It has information about the resident's transfer status."

On 9/18/19 at 5:27 p.m., ASM #1, the executive director, and ASM #2, the DON (director of nursing) were informed of these concerns. They were informed of the survey team's concern for harm to Resident #132 as a result of the improper transfer on 1/11/19.

On 9/19/19 at 8:30 a.m., ASM #1, the executive director, and ASM #2 presented a plan of correction regarding the incident on 1/11/19 involving Resident #132. ASM #2 stated, "On 1/4/19, the electronic record, the CNA book, the care plan, and the physician order all matched for Resident #132 in that all documented that the resident should be transferred by two people with a mechanical lift." She stated that as soon as she

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learned of the incident, the CNAs were suspended. She checked their training records, and determined that both CNAs had received training on, and successfully returned demonstration of, the use of a mechanical lift. She stated the facility did a complete plan of corrections, including a complete audit of the transfer status of all residents on 1/18/19. She stated multiple inservices were completed, and that she could provide documentation of all of the training that occurred since the event.

Review of the plan of correction revealed, in part, the following: "1. The facility has established a corrective actin (sic) plan for [Resident #132]. 2. The resident (sic) of the facility who require transfer in the facility have the potential to be affected. 3. Facility Nursing Staff were in serviced (sic) on 1/11/19, 1/17/19, 1/24/19, 2/7/19, 3/4/19, 7/11/19, and 9/5/19. 4. To ensure compliance, the Transfer status were reviewed on (sic) by nursing and verified by [name of administrative assistant] for correct transfer status. Compliance date: 5/13/19. Past non-compliance was discussed in QAPI 2/12/19 regarding resident with a FRI on 1/11/19; ALL FRI and ACCIDENTS AND INJURY ARE DISCUSSED DURING QAPI."

ASM #2 provided credible evidence to confirm all other residents who had the potential to be affected were identified and staff education was provided. ASM #2 stated that in the inservices alleged in #3 of the plan of correction, she personally taught the inservices, and the content centered around how to verify a resident's transfer status, as well as how to transfer a resident using a mechanical life. She reinforced at each inservice that staff should follow the CNA sheets, the electronic information on the tablets,

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and the physician's order for a resident's transfer staff. She stated she used the incident regarding Resident #132 as an example during the training's. This was confirmed through multiple interviews with facility staff. Other residents were reviewed during the survey to ensure no similar incidents occurred after 1/11/19. No concerns were identified. All document review and staff interviews verified that the facility had completed the education as outlined in the plan of correction.

No further information was provided prior to exit.

PAST NONCOMPLIANCE

(1) "Schizoaffective disorder is a mental condition that causes both a loss of contact with reality (psychosis) and mood problems (depression or mania)." This information is taken from the website https://medlineplus.gov/ency/article/000930.htm.

(2) "Traumatic brain injury (TBI) happens when a bump, blow, jolt, or other head injury causes damage to the brain." This information is taken from the website https://medlineplus.gov/traumaticbraininjury.html.

(3) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. Vascular dementia (VaD) is caused by a series of small strokes over a long period." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.

(4) "Acquired cognitive-communication deficits

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F 689	Continued From page 105 may occur after a stroke, tumor, brain injury, progressive degenerative brain disorder, or other neurological damage. These deficits result in difficulty with thinking and how someone uses language." This information is taken from the website https://sphsc.washington.edu/cognitive-communication-deficits. (5) "In elderly patients, failure to thrive describes a state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments. Manifestations of this condition include weight loss, decreased appetite, poor nutrition, and inactivity." This information was taken from the website https://www.ncbi.nlm.nih.gov/pubmed/15291092.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		10/14/19

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F 812	Continued From page 106 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to serve food in a sanitary manner in the kitchen. The male facility staff failed to cover their mustaches while preparing and/or serving food and the facility staff failed to store mops in a sanitary manner. The findings include: Observation was made of the kitchen on 9/17/19 at 10:05 a.m. with OSM (other staff member) # 2, the dietary manager. The mop closet was observed. A mop was sitting in a bucket, without water. When asked the storage of the mops, (OSM) #2 stated after we use them they are to be stored on a rack, not sitting in a bucket. Observation of the kitchen was conducted on 9/18/19 at 11:10 a.m. Two male employees with mustaches were observed working in the kitchen. OSM #12 was prepping food at the back table in the kitchen. OSM #13 was working on the tray line. Both employees had a beard guard on but neither staff member had their mustaches covered. When asked how beard guards should be worn, OSM #2 stated it should cover all facial hair. A policy was requested of OSM #2 on the storage of mops and the use of beard guards. A policy was provided by OSM #2 on 9/18/19 at	F 812	1. The facility has established a corrective action plan to ensure that the facility prepares and serves food in a sanitary manner. Staff members #12 and #13 who failed to cover their mustaches while preparing and/or serving food was directed to cover mustaches. The facility also removed the kitchen mop that was stored in the mop bucket and placed it in a sanitary manner. 2. The residents of the facility have the potential to be affected by this deficient practice. 3. The Dining Staff were re-educated regarding the covering of their mustache while preparing and/or serving food. The re-education also included the sanitary manner to store the kitchen mop. This re-education will be completed by 10/14/19. 4. To ensure compliance, audits will be conducted by Administrative Staff (or designee) daily for 4 weeks then weekly thereafter to ensure that the staff have covered their mustache to ensure that the facility prepares and/or serves food in a sanitary manner. The audits will also include the proper sanitary storage of the kitchen mop. This information will be forwarded to QAPI for review.	

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F 812	Continued From page 107 approximately 1:30 p.m. The policy, "Food Safety and Sanitation" documented in part, "Beard nets are required when facial hair is visible." No policy on mop storage was provided. Administrative staff member (ASM) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above concern on 9/18/19 at 5:30 p.m. No further information was provided prior to exit.	F 812		