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	495388	A. BUILDING _____ B. WING _____	C 06/07/2023

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GAINESVILLE HEALTH AND REHAB CENTER	7501 HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 6/6/2023 through 6/7/2023. One complaint was investigated during the survey. Complaint number VA00058993 was substantiated with an unrelated deficiency cited at F600 as a past non-compliance. The census in this 120 certified bed facility was 109 at the time of the survey. The survey sample consisted of nine current resident reviews.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to ensure one of nine residents in the survey sample was free from abuse, Resident #1. This was cited as past non-compliance.	F 600	Past noncompliance: no plan of correction required.	

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

Electronically Signed

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The findings include:

For Resident #1 (R1), the facility staff failed to ensure they were free from abuse by a staff member on 5/30/2023.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/28/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.

On 6/7/2023 at 10:30 a.m., an interview was conducted with R1. R1 stated that the previous week they were in the hallway just past the activities door listening to music with another resident who resides on that side of the facility. R1 stated that they always hang out in that area with their girlfriend to listen to music together and talk. R1 stated that CNA (certified nursing assistant) #4 became irritated with them for no apparent reason. R1 stated that CNA #4 started arguing with their girlfriend about them being in the hallway near the unit. R1 stated that they tried to calm the situation but then they became angry and started yelling also. R1 stated that the CNA was yelling at them that they were not allowed there and had to go back to their unit. R1 stated that CNA #4 started pulling his wheelchair backwards so he grabbed the handrail on the wall. R1 stated that CNA #4 kept yanking the wheelchair and taking their hand off the railing. R1 stated that he fell from his wheelchair on their knee and their buttocks. R1 stated that the unit manager had come and assisted him to get back in the wheelchair and he had not been injured. R1 stated that he did not know what upset the

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CNA so much because they were in the same area that they always hung out in with their friend. R1 stated that the incident made him feel unsafe and it was the first time anything like that had ever happened. R1 stated that they felt safe at the facility now because the facility had handled the situation.

The progress notes for R1 documented in part,
- "05/30/2023 23:52 (11:52 p.m.) Fall note. Data : At 1945 (7:45 p.m.), the resident fell off from wheelchair. Action : After the fall, resident was assessed for alertness and consciousness. Resident remains to be alert and verbally responsive. Body audit was done no new skin tears, bruises, lump on head were assessed. Assessed for injury all extremities were flexed, and resident c/o (complains of) R (right) knee soreness. Offered to apply ice pack but resident refused. Tylenol 325 mg (milligram), 2 tabs (tablets) were administered prn (as needed) for R knee soreness. ADON (assistant director of nursing) was informed of the incident. [Name of physician] was informed of the incident. Family, [Name of family member] was called but did not answer, a message was recorded for call back. Response : We will continue to monitor the resident closely."
- "05/31/2023 11:51 (11:51 a.m.) Psychosocial Visit note. Residents psychosocial concerns discussed (isolation, loneliness, fear, sadness, anxiety) : fear and anxiety. Residents outward appearance (sad, happy, crying, withdrawn, guarded) : happy but guarded. Interventions in place (staff visits, FaceTime visits, window visits, activities of interest) : phone calls with his mom, would like to take with psych services [Name of psychologist], weekly check-ins with social services. Follow up needed (psych referral, SW

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visits, family FaceTime visits) : psych referral, weekly meeting with SW (social worker)."
- "06/01/2023 08:42 (8:42 a.m.) Psych note. Note Text : Psychologist met with patient this AM; Discussed his interpretation of recent events involving an employee; Today he reports he feels "very safe" to be at this facility. His mood is calm. Also discussed recent escalation in aggressive verbal and at times physical behaviors. Patient states he feels his anger is due to "not being included by my family in more family things"; Encouraged talking to staff when frustrated; identified appropriate staff he can reach out to for support when needed."
- "06/05/2023 14:01 (2:01 p.m.) Psychosocial Visit note. Residents psychosocial concerns discussed (isolation, loneliness, fear, sadness, anxiety) : fear and anxiety over prior event. Residents outward appearance (sad, happy, crying, withdrawn, guarded) : Happy - expresses no fear of the event. Interventions in place (staff visits, FaceTime visits, window visits, activities of interest) : weekly visits with SW, Met with Psych services they helped a lot. Follow up needed (psych referral, SW visits, family FaceTime visits) : continued SW visits."

The comprehensive care plan for R1 documented in part, "(Name of R1) is at risk for or has a history of exhibiting aggressive behaviors that may impact self or others. Contributing factors include: Cognitive impairment, Depression. Date Initiated: 02/11/2022. Revision on: 05/16/2022."

Review of the facility synopsis of events final investigation dated 6/6/2023 documented in part, "...This letter serves as the final report of an allegation of patient abuse reported to your office on 05/30/2023...(Name of R1) alleged abuse by

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CNA (Name of CNA #4). (Name of R1) reported that CNA (Name of CNA #4) pushed or pulled him forcibly resulting in a fall...Based upon the Center's investigation the physical abuse allegation is substantiated due to the CNA attempting to physically remove resident against his will and removing his hand off the handrail to take him back to the Fairview Unit. CNA was terminated related to this allegation and a report will be filed with the Virginia DHP [department of health professions] as required by law..."

On 6/7/2023 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that they were working late and were in their office with the door closed on 5/30/2023 when R1 fell out of the wheelchair. LPN #3 stated that R1 and the lady friend were sitting in the hallway just beyond the activities doorway near their office door. LPN #3 stated that everything was quiet and then they heard someone saying loudly through the door to R1 that they were not supposed to be there and needed to be back on their unit. LPN #3 stated that they came out due to the yelling and saw R1 in their wheelchair with CNA #4 pulling them backwards. LPN #3 stated that R1 was holding onto the hand rail on the wall to prevent CNA #4 from moving the wheelchair and he started slipping down in the wheelchair. LPN #3 stated that CNA #4 then removed R1's hand from the hand rail and put their arms underneath R1 and lifted them up when R1 started flailing their arm and cursing. LPN #3 stated that R1 went limp and went down on the floor on their behind at that time. LPN #3 stated that they advised CNA #4 to leave R1 on the floor to be assessed, then at that point the CNA left. LPN #3 stated that they had calmed R1 by telling him that it was not his fault

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and they would help them back in the chair. LPN #3 stated that once they got R1 back in the wheelchair they had called the evening supervisor to come over to assess R1 and they had found CNA #4 and asked them to go sit in the conference room. LPN #3 stated that R1 had called the police so two police officers had come in and taken statements from the residents, LPN #3 and CNA #4. LPN #3 stated that the police officers had asked R1 if they wanted to press charges against CNA #4 because it was assault, but R1 did not want to do this. LPN #3 stated that they explained the investigation process in the facility to the police and that CNA #4 would be suspended until the investigation was completed and the police relayed this to R1 who was satisfied with this process and did not want to press charges against the CNA. LPN #3 had notified the administrator of the incident when the police had arrived as soon as possible because it all happened so quickly. LPN #3 stated that they took R1 and the girlfriend back to their rooms and made sure they both felt safe. CNA #4 left the building after writing their statement and speaking with the police. LPN #3 stated that they had completed a body audit for R1. LPN #3 stated that there was peace and quiet on the unit and R1 was not doing anything wrong so they did not know why CNA #4 had approached them and that CNA #4 had no reason to come over and start yelling at the resident; and if anything should have used a calm approach to ask them to go back over to their unit. LPN #3 stated that R1 would never have fallen if CNA #4 had left him alone, and they never heard R1 say anything prior to CNA #4 yelling at the resident through their closed door.

On 6/7/2023 at 11:00 a.m., an interview was

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conducted with ASM (administrative staff member) #2, director of nursing. ASM #2 stated that they had investigated the fall for R1 on 5/30/2023. ASM #2 stated that it happened in the evening and they were all gone for the day. ASM #2 stated that they were informed of the incident the next morning. ASM #2 stated that they had concluded that R1 and their girlfriend were in the hallway when CNA #4 approached them and told them they needed to go back to their unit. ASM #2 stated that R1 did not want to go back to their unit and CNA #4 was holding the wheelchair at the back trying to pull him to take him back to the unit. ASM #2 stated that R1 held on to the hand rail resisting the move, CNA #4 removed R1's hand from the rail and pulled the wheelchair backwards which led to R1 sliding to the floor. ASM #2 stated that the unit manager came out when they heard the noise and witnessed the CNA removing R1's hand from the rail and pulling the wheelchair. ASM #2 stated that some parts of the witness statements were inconsistent but all of the witnesses said they R1 held on to the hand rail and felt that if R1 was holding onto the hand rail they did not want to go and CNA #4 should have left him alone. ASM #2 stated that CNA #4 said he did not take R1's hand off the rail but the other witnesses said he did. ASM #2 stated that their main concern was that CNA #4 physically pushed R1's hand off the rail and pulled him backwards causing the fall and they had substantiated the allegation of abuse based on those findings. ASM #2 stated that nothing was happening to precipitate that incident, that the residents were just in hallway listening to their music.

On 6/7/2023 at 11:35 a.m., a review was made of CNA #4's Virginia State Police background check

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completed upon hire and evidence of abuse and neglect training completed upon hire and current training. There were no concerns identified.

The facility policy, "Abuse Prevention" with a revision date of 10/7/2022 documented in part, "Residents should be free from abuse, neglect, corporal punishment, involuntary seclusion and misappropriation of personal property. The Center is committed to maintaining a safe environment for all residents and will appropriately investigate allegations..."

On 6/7/2023 at 11:49 a.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern. ASM #1 stated that they had put a plan of correction in place and would provide evidence.

On 6/7/2023 at 12:02 p.m., ASM #1 provided a binder containing a five point plan of correction regarding the incident on 5/30/2023 between R1 and CNA #4. ASM #1 stated that the date of compliance for the plan of correction was 6/6/2023. Review of the plan of correction documented interventions in place to ensure R1 was monitored and safe, identification of other affected residents, systemic changes put in place and monitoring plans. The plan of correction binder included an identification of all residents being at risk with body audits completed on all residents with a BIMS level of 9 or less and interviews completed for all residents with a BIMS level of 10 or greater. Review of the body audits documented all completed between 5/31-6/1/2023 and all resident interviews completed on 6/1/2023. The binder included evidence of education to all current staff on abuse and managing challenging behaviors and

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different approaches/intervention strategies completed on 6/1/2023. Sign in sheets for each department were reviewed for completion. The binder documented plan for monitoring to interview 12 alert and oriented residents (10% of current residents) for signs of abuse and review 12 body audits a week (10% of current residents) to ensure no further signs or symptoms of abuse are occurring weekly x 4 weeks and monthly x 2 months. Psychosocial visit completed by social services and will be completed weekly times 4 to ensure residents psychosocial well is being monitored. The audit findings will be reviewed and/or revised in the QAPI with any variances addressed. The binder documented ad hoc QAPI meetings held on 5/31/23 and 6/1/23. Verification of the facility plan of correction was completed by observations, staff interviews and review of the completed documents listed above. No other concerns regarding abuse were identified during the survey.

No further information was obtained prior to exit.

This was cited at past non-compliance.