STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **115385**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/21/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH - CRESTWOOD	**415 PENDLETON PLACE VALDOSTA, GA 31602**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0157

Level of harm - Immediate jeopardy

Residents Affected - Few

Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on clinical record review, facility investigation summary review, and staff interview, the facility failed to immediately consult with the physician related to the sudden onset of verbal threats and aggression of one (1) resident (Resident #1), who made multiple verbal threats of harm against another resident (Resident #2, the roommate of Resident #1), on the total survey sample of eleven (11) residents. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Interventions were developed to address Resident #1's behaviors. Resident #1 was documented as having no behaviors observed/reported from 10/01/2014 through 10/21/2014, and a 10/28/2014 Physician's Progress Note documented that Resident #1's mood, [MEDICAL CONDITION] Disorder, and [MEDICAL CONDITION] were stable. However, on 11/02/2014, Resident #1 was reported by facility staff to have made multiple verbal threats against Resident #2, including If you don't get her, I am going to get her, and I'm going to get that b---h. Even though Resident #1's verbal threats against Resident #2 were a change in behavior and a new behavior, the facility failed to consult with the physician to inform the physician of Resident #1's aggressive behavior and verbal threats. Then, on 11/11/2014, facility staff discovered Resident #2 not breathing, having no pulse, and with an electric cord around her neck. Resident #1 stated to facility staff that she had killed Resident #2, and Resident #1 was arrested and charged with felony murder and aggravated assault. This resulted in a situation in which the facility's noncompliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment or death to residents. The facility's Administrator and Corporate Consultant were informed of the immediate jeopardy on November 19, 2014 at 3:36 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on November 11, 2014, the date Resident #1 was documented as stating she had killed her roommate, Resident #2, after Resident #2 was found to have no respirations, no pulse, and with an electric cord around her neck, and nine (9) days after November 2, 2014, when the facility failed to enact interventions in response to Resident #1's voiced threats against Resident #2. The immediate jeopardy continued through November 20, 2014, and was removed on November 21, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on November 20, 2014. During an interview with the Administrator conducted on November 19, 2014 at 1:40 p.m., the Administrator acknowledged the November 2, 2014 incident during which Resident #1 was reported to have verbally threatened Resident #2, but also acknowledged that Resident #1's physician was not consulted regarding this change in behavior. An allegation of jeopardy removal was received on November 20, 2014. Based on the corrective plans which had been developed and implemented by the facility via a credible allegation of jeopardy removal on November 20, 2014, the immediacy of the deficient practice was determined to have been removed on November 21, 2014. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of staffs' monitoring of resident behaviors, resident screening and placement in the Behavior Management Program as indicated, resident Care Plan updating and implementation regarding resident behaviors, and physician notification of resident behavioral changes, in accordance with facility policies and procedures. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about facility policies and procedures governing resident monitoring and the reporting of resident behavioral changes to supervisors and the physician, to therefore ensure resident safety. Resident records were reviewed to ensure that resident assessments and Care Plans accurately reflected the current status of residents, including the development and implementation of interventions to address aggressive behaviors. Findings include:
Resident #1's Admission Minimum Data Set assessment of 09/10/2014 documented diagnoses, in Section I - Active Diagnoses, which included, but were not limited to, Hypertension, [MEDICAL CONDITION] Reflux Disease, Diabetes Mellitus, and [MEDICAL CONDITION] Disorder ([MEDICAL CONDITION]). A 09/03/2014, 4:10 p.m. Daily Skilled Nurses Notes (DSNN) entry for Resident #1 documented additional [DIAGNOSES REDACTED]. Resident #1's admission physician's orders [REDACTED]. A 09/06/2014, 5:30 a.m. DSNN entry documented that Resident #1 hit a nurse across the side of the face and refused to take any medications. DSNN entries of 09/14/2014 documented Resident #1 continued to refuse medications, and a 09/16/2014, 11:30 a.m. DSNN entry documented Resident #1 swung at a nurse and grabbed at another staff. A 09/18/2014, 7:00 a.m. DSNN entry documented Resident #1 was refusing care and that when notified, the physician ordered [MEDICATION NAME] one (1) mg each morning for escalating behaviors. In a 09/29/2014 Physician's Progress Notes entry for Resident #1, the physician documented that Resident #1 was combative and not taking medications. However, DSNN/SDNN entries completed daily for Resident #1 from 10/01/2014 through 10/21/2014 documented that no behaviors had been noted/reported for Resident #1 during that period, and a 10/28/2014 Physician's Progress Notes entry documented Resident #1's mood, [MEDICAL CONDITION], and Dementia were stable.
However, an 11/02/2014, 11:00 a.m. Nurses Notes (NN) entry documented that Resident #1 made verbal threats against another resident (Resident #2, the roommate of Resident #1), and documented administration of a 0.5 ml IM dose of [MEDICATION NAME]. This was only five (5) days after the 10/28/2014 Physician's Progress Note referenced above indicated Resident #1's mood, [MEDICAL CONDITION], and Dementia were stable; but, further record review revealed no evidence to indicate that the physician was consulted regarding Resident #1's change in behavior on 11/02/14 when she verbally threatened Resident #2.
Then, an 11/11/2014, 7:00 a.m. NN entry for Resident #1 documented that Resident #2 had been found not breathing, having no pulse, and an electric cord around her neck. An 11/11/2014, 7:10 a.m. NN entry for Resident #1 documented that Emergency Medical Services and a police officer had responded. A facility investigation summary (IS) into the 11/11/2014 incident involving Resident #2 (as documented in the 11/11/2014, 7:00 a.m. NN referenced above) documented that prior to 11/11/2014, on 11/02/2014, staff observed Resident #1 holding a picture of family and alleging that a family member had been murdered. The facility IS documented that Resident #1's behavior seemed to change suddenly, and that Resident #1 put the family picture in the face of Resident #2, prompting staff to redirect both residents. This IS documented that at that time, Resident #1 stated to the certified nursing assistant (CNA) I am going to get you, then stated to staff member, If you don't get her, I am going to get her, and later on 11/02/2014, stated to the CNA I'm going to get that b---h, referring to Resident #2. During an 11/18/2014, 12:45 p.m. interview with the DON and Licensed Practical Nurse (LPN) DD, LPN DD stated she was the nurse who administered the dose of IM [MEDICATION NAME] to Resident #1 on 11/02/2014 (as documented in the 11/02/2014, 11:00 a.m. NN referenced above). LPN DD stated that the behavior involving Resident #1 getting upset about a picture and verbally threatening other residents on 11/02/2014 was a new behavior. However, even though LPN DD acknowledged during the 11/18/2014, 12:45 p.m. interview referenced above that Resident #1's 11/02/2014 behavior of verbally threatening Resident #2 was a new behavior, record review revealed no evidence of Resident #1's physician being consulted on or after 11/02/2014 regarding Resident #1's verbally threatening behavior toward another resident. During an 11/19/2014, 1:40 p.m. interview, the Administrator acknowledged that Resident #1's physician was not consulted regarding her change in behavior when she made multiple verbal threats against Resident #2 on 11/02/2014. In the facility's IS referenced above, the

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) facility documented that on 11/11/2014, upon responding to the room of Resident #2, a nurse found Resident #2 on the floor with an electric cord unplugged and on or near the resident's neck, and having no respirations and no pulse. This facility IS report further documented that, based on sources close to the police department, Resident #2's autopsy report concluded that Resident #2's trachea was crushed. This IS documented Resident #1 told a nurse consultant she killed Resident #2, and documented that on 11/13/2014, Resident #1 was arrested and charged with felony murder and aggravated assault. Based on the above, Resident #1 was admitted on [DATE] having [DIAGNOSES REDACTED]. Resident #1 was documented to have exhibited behavioral problems including slapping staff and pulling staffs' hair, but was not initially documented to have a history of threatening other residents. Nursing notes entries for October of 2014 documented Resident #1's behaviors had lessened, and on 10/28/2014, the physician noted Resident #1's [MEDICAL CONDITION] Disorder, [MEDICAL CONDITION], Dementia and mood were stable. However, despite Resident #1 then exhibiting a significant change in behavior by making multiple verbal threats against Resident #2 on 11/02/2014, the facility failed to consult with the physician regarding this significant change in behavior for Resident #1. Then, on 11/11/2014, Resident #2 was found in her room with an electric cord around her neck, not breathing and having no pulse. Resident #1 stated to facility staff she had killed Resident #2, and was arrested and was charged with felony murder and aggravated assault. Cross refer to F323 for more information regarding Resident #1 and Resident #2. The facility presented a credible allegation of jeopardy removal (CAJR) on 11/20/2014, and it was determined that the immediate jeopardy was removed on 11/21/2014, at which time the facility had implemented the following interventions: 1. On 11/11/2014, upon the discovery of the incident of that date, Resident #1 was immediately placed on one-to-one staff observation until she was later transferred out of the facility. 2. On 11/13/2014, the facility's Interdisciplinary Team (consisting of the Administrator, DON, ADON, Admissions Personnel, LPN Supervisor, and Social Services Director) completed Behavioral Symptom Screening Forms on every facility resident. This process of resident behavior screening had been initiated on 11/12/2014. All residents screened during this process and identified as having had physical or verbal behaviors in the previous month were placed on the Behavior Monitoring Program, to ensure the monitoring of these residents and to ensure that no further behavioral interventions were necessary. All residents will have a behavior screen done upon facility admission, quarterly, upon significant change in status, and with any new behavior. 3. On 11/13/2014, the facility's Interdisciplinary Team completed a review, initially begun on 11/12/2014, of the Care Plans of all residents having any physical or verbal behaviors in the previous month. These Care Plans were revised as needed, based on these reviews. Resident Care Plans will be reviewed quarterly, annually, with a significant change in condition, and with any new behavior. 4. On 11/14/2014, the facility's Medical Director reviewed Resident #1's medical record, making no recommendations. 5. On 11/19/2014, the facility implemented a procedure by which the Interdisciplinary Team would screen and review all new resident admissions. This screening process would apply to all new resident admissions, and no resident would be admitted until a detailed review of the resident's mental condition and the potential for aggressive or physical behaviors can be assessed. This resident screening and review will be documented on the Admission Audit Tool, which documents: the date; the resident's name; the History and Physical; PASRR Level II; Nurse' Notes/MR notation; any Consultation Information; and a signature of the reviewer. 6. On 11/20/2014, the facility implemented a new procedure by which the Administrator would conduct a monthly audit of a minimum of 10 percent of the Resident Behavioral Symptom Screening forms and resident Care Plans for residents in behavioral management, to ensure the accuracy and completion of these documents. The Administrator will conduct a monthly audit of a minimum of 10 percent of the Behavior Management Documentation Form for residents in behavioral management, to ensure the accuracy and completion of this Form. This Form (a previously existing form) allows for the weekly documentation of residents in the Behavior Management Program, the tracking of the effectiveness of existing behavioral interventions, and the documentation of any newly developed interventions. In addition, the Administrator will conduct a monthly audit of a minimum of 10 percent of the Behavior Management Log Forms (a previously existing form) for all residents in a Behavior Management Program, to ensure accuracy and completion of this Form. This Form serves to document any observed behaviors, including agitated or combative behaviors, per day and per shift. These monthly form audits referenced above will be documented by the Administrator dating and signing the review of each of the referenced forms. 7. On 11/20/2014, the facility implemented a procedure by which a designated CNA was to document, using the Behavior Monitoring Form, continuous rounds in the Memory Support Unit on the hallways and resident areas to monitor for any aggressive resident behavior. This Behavior Monitoring Form allows for the documentation of resident behaviors, interventions, the reporting of the behavior(s) to the Charge Nurse and the identity of the staff member reporting the behavior, and a signature of the nurse of verification. If, during these continuous rounds conducted on the Memory Support Unit, behaviors were observed, this staff member was to intervene as necessary to de-escalate the behavior, and also to report the resident behavior to the Charge Nurse. This monitoring was actually initiated on 11/11/2014, when the staff member was immediately assigned to the Memory Support Unit to begin the continuous rounds. 8. On 11/20/2014, the facility's Interdisciplinary Team continued the process of reviewing resident Preadmission Screening and Resident Review (PASRR) Level II Assessments. This review revealed three (3) residents having PASRR Level II assessments with a recommendation for a psychiatric consultation. One (1) of these residents was seen by a psychiatrist on a regular basis. Appointments were made on 11/20/2014 for the remaining two (2) residents, identified with recommendations for a psychiatric consultation, to have a consultation with a psychiatrist. On 11/20/2014, the facility implemented a procedure by which the Administrator or Social Service Director will make a copy of each resident's PASRR, and initial and date that copy, which will then be kept in the resident's medical record. 9. On 11/20/2014, the facility's Interdisciplinary Team continued to provide staff in-service training related to a number of areas. In-service training was provided to staff to educate them in ways to prevent abuse, including behaviors what to report, and to whom to report observations of resident abuse. This included both physical and verbal resident behaviors. This in-service training also addressed how to identify abuse by observation of residents having suspicious bruising, showing signs of being afraid, or patterns of behaviors. Staff were informed that any resident suspected of any alleged abuse would be protected from any further abuse by the removal of the alleged perpetrator from the facility, as deemed appropriate. Staff were advised of reporting any alleged abuse immediately to their supervisor, leading up to the Administrator, who would then report the allegation of abuse to the appropriate State and corporate agencies. In-service training was also provided regarding employment screening, via criminal background checks, reference checks, and licensure/certification verification. As of 11/20/2014, eighty-nine (89) of one-hundred-and-two (102) staff had received this in-service training. This number included thirty-three (33) of thirty-seven (37) CNA staff; thirteen (13) of fourteen (14) LPN staff; nine (9) of eleven (11) housekeepers; four (4) of five (5) laundry workers; seventeen (17) of twenty (20) dietary workers; seven (7) of eight (8) Registered Nurses; seven (7) of seven (7) department heads (not including the DON, ADON, LPN Supervisor, Senior Care Partner, and MDS Nurse) that did not include nurses, including the Activities Director, Social Worker, Maintenance Director, Financial Counselor, Medical Records, Admissions Coordinator, and Housekeeping Supervisor. The remaining four (4) CNA staff, one (1) LPN staff, two (2) housekeepers, one (1) laundry worker, three (3) dietary workers, and one (1) Registered Nurse who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. Additionally, going forward, all employees will receive training upon hire during the orientation process, and quarterly, related to resident abuse, resident neglect, and the procedures by which to deal with residents having verbal or physical behaviors. 10. On 11/20/2014, the Interdisciplinary Team continued to conduct additional staff in-service training, originally initiated on 11/14/2014, specifically intended for licensed nursing staff and CNA staff regarding the resident behavior management policies and the documentation of resident behaviors. As of 11/20/2014, six (6) of eight (8) Registered Nurses, thirteen (13) of fourteen (14) LPN staff, and thirty-one (31) of thirty-seven (37) CNA staff had received this in-service training. The remaining two (2) Registered Nurses, one (1) LPN, and six (6) CNA staff who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. 11. On 11/20/2014, staff in-service training was conducted regarding the notification of the physician of a change in condition and of new resident behaviors. As of 11/20/2014, eleven (11) of fourteen (14) LPN staff and seven (7) of eight (8) Registered Nurses had received this training. The remaining three (3) LPN staff and one (1) Registered Nurse who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. 12. On 11/20/2014, the facility implemented a new procedure by which the results of Administrator and/or Social Service Director audits of the Admission Audit Tool, Behavior Monitoring Form, Behavior Management Documentation Form, Behavior Symptom Screening Form, Management Log Form, and Care Plan and PASRR Assessment reviews would be presented to the QA Sub-Committee each week for four (4)

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) weeks, then monthly by the Administrator or Director of Health Services. This process will allow the QA Sub-Committee to monitor staff compliance with the facility's policies and procedures regarding residents having verbal and/or physically aggressive behaviors which could have the potential to lead to resident abuse. Audit results will also be presented to the facility's QA Committee quarterly for the Committee's review and oversight of facility staff conformance with facility policies and procedures related to the management of resident behaviors, the screening of resident behaviors, physician notification, and resident monitoring. During this abbreviated survey, the State Survey Agency reviewed the corrective actions implemented by the facility, as reflected in the CAJR referenced above, with findings as follow: - On 11/21/2014, a review of facility investigative documents, including the facility IS, confirmed that Resident #1 was immediately placed on one-to-one observation on 11/11/2014 immediately after the incident involving Resident #1 and Resident #2, as indicated in Step #1 of the CAJR referenced above. - On 11/21/2014, a sampled review of resident records completed on that date, but which had been ongoing throughout the abbreviated survey, revealed that the Interdisciplinary Team had conducted behavioral screenings on residents for the purpose of ensuring appropriate resident placement in the Behavioral Monitoring Program, as indicated in Step #2 of the CAJR referenced above. - On 11/21/2014, a sampled review of multiple resident records, but which had been ongoing throughout the abbreviated survey, was completed and verified that resident Care Plans had been reviewed and updated by the Interdisciplinary Team, as related to physically/verbally aggressive behaviors. This was in accordance with Step #3 of the CAJR referenced above. - On 11/21/2014, review of facility investigative documents confirmed that the Medical Director had reviewed Resident #1's medical record and submitted a written summary of this information to the facility on [DATE]. This was in accordance with Step #4 of the CAJR referenced above. (Of note, on 11/20/2014 at 11:12 a.m., a telephone call had been placed to Resident #1's physician, but the physician declined interview.) - On 11/21/2014, interview with the Administrator at 11:20 a.m. confirmed that the Interdisciplinary Team will screen and review all new resident admissions, with no resident being admitted until a review of the resident's medical condition and potential for aggressive behaviors can be assessed. This review will be documented using the Admission Audit Tool. This Team will include the Administrator, DON, ADON, Admissions Personnel, an LPN Supervisor, and the Social Services Director. This was in accordance with Step #5 of the CAJR referenced above. - On 11/21/2014, facility document review and interview with the Administrator confirmed that the Administrator will be conducting monthly audits of the Resident Behavioral Symptom Screening forms, the Behavior Management Documentation Forms, the Behavior Management Log Forms, and resident Care Plans for resident requiring behavioral management services. This was in accordance with Step #6 of the CAJR referenced above. - On 11/21/2014, a 9:55 a.m. observation on the Secured Unit confirmed the presence of an assigned staff member to conduct ongoing and continuous rounds for the purpose of observing for any resident aggressive behaviors. These rounds were documented on the Behavior Monitoring Form. In addition, it was confirmed by interview with the Administrator that this process of ongoing, continuous rounds will be a permanent intervention. This was in accordance with Step #7 of the CAJR referenced above. - On 11/21/2014, a sampled review of resident records, which had been ongoing throughout the abbreviated survey, was completed and verified that the Interdisciplinary Team had reviewed all resident PASRR Level II Assessments, with the appropriate follow-up for residents needing additional psychiatric services. This action was also confirmed during an 11/21/2014, 10:45 interview with a Corporate Nursing Consultant. This was in accordance with Step #8 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted staff in-service training for staff, including (but not limited to) licensed nursing staff, CNA staff, Social Services staff, MDS staff, Medical Records staff, the Maintenance Director, and the Admissions Coordinator, regarding resident abuse and the Behavior Management Policy. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #9 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted additional staff in-service training, specific for licensed nursing staff and CNA staff, regarding resident behavior management policies and the documentation of resident behaviors. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #10 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted additional staff in-service training, specific for licensed nursing staff, regarding the notification of the physician for changes in condition and new resident behaviors. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #11 of the CAJR referenced above. - On 11/21/2014, an 11:20 a.m. interview with the Administrator confirmed that the results of all audits, as referenced in the CAJR intended to provide ongoing management level oversight of the assessment, planning of care, and provision of care to residents having behavioral problems, will be reviewed by the QA Committee to provide ongoing QA Committee oversight of this care. This was in accordance with Step #12 of the CAJR referenced above. Based on these corrective actions which had been developed and implemented by the facility as outlined in the CAJR referenced above, it was determined that the immediacy of the deficient practice had been removed on 11/21/2014; however, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. On 11/19/2014, the facility implemented a procedure by which the Interdisciplinary Team will screen and review all new resident admissions, and no resident will be admitted until a detailed review of the resident's mental condition and the potential for aggressive or physical behaviors can be assessed. This resident screening and review will be documented on the Admission Audit Tool. This was, however, a new procedure, having been implemented on 11/19/2014, only two (2) days prior to the 11/21/2014 exit date of this abbreviated survey; therefore, the Interdisciplinary Team's ongoing compliance with this newly-implemented procedure could not be fully evaluated at the time of survey exit, and will need further review on a future date. On 11/20/2014, the facility implemented a new procedure by which designated staff was to document, using the Behavior Monitoring Form, continuous rounds in the Memory Support Unit on the hallways and resident areas to monitor for any aggressive resident behavior. The use of this Behavior Monitoring Form was, however, only implemented as of 11/20/2014, one (1) day prior to the 11/21/2014 date of survey exit, thereby preventing the evaluation of facility staffs' ongoing compliance with the use of this Form and concomitant monitoring of aggressive resident behaviors. Such compliance will require further review on a future date. In addition, on 11/20/2014, the facility's Interdisciplinary Team continued to provide staff in-service training which included abuse prevention and reporting, and the identification of abuse by observation of residents having suspicious bruising, showing signs of being afraid, or patterns of behaviors. As of 11/20/2014, thirty-three (33) of thirty-seven (37) CNA staff, thirteen (13) of fourteen (14) LPN staff, nine (9) of eleven (11) housekeepers, four (4) of five (5) laundry workers, seventeen (17) of twenty (20) dietary workers, and seven (7) of eight (8) Registered Nurses had received this in-service training. The remaining four (4) CNA staff, one (1) LPN staff, two (2) housekeepers, one (1) laundry worker, three (3) dietary workers, and one (1) Registered Nurse who had not been available due to being off duty or on leave will receive this in-service training upon their return to work. On 11/20/2014, the Interdisciplinary Team continued to conduct additional staff in-service training for licensed nursing staff and CNA staff regarding the resident behavior management policies and the documentation of resident behaviors. As of 11/20/2014, six (6) of eight (8) Registered Nurses, thirteen (13) of fourteen (14) LPN staff, and thirty-one (31) of thirty-seven (37) CNA staff had received this in-service training. The remaining two (2) Registered Nurses, one (1) LPN, and six (6) CNA staff will need to receive this in-service training upon their return to work. Also, on 11/20/2014, staff in-service training was conducted regarding the notification of the physician of a change in condition and of new resident behaviors for eleven (11) of fourteen (14) LPN staff and seven (7) of eight (8) Registered Nurses, but the remaining three (3) LPN staff and one (1) Registered Nurse will receive this in-service training upon their return to work. Therefore, due to multiple licensed and certified staff members yet remaining to receive in-service training at the time of survey exit, their completion of this required training could not be assessed at the time of survey exit, and will need to be evaluated at a future time. Therefore, due to the need for future evaluation and assessment of the facility's ongoing compliance with newly-implemented procedures regarding the assessment, supervision, and monitoring of residents having aggressive behaviors, to include pending staff in-service training regarding these issues, the noncompliance continues, with the scope and severity of the deficiency reduced to the D level.
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigation summary review, and staff interview, the facility failed to provide monitoring, as specified by the Care Plan, related to verbal threats and aggression exhibited by one (1) resident (Resident

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) #1), whose Care Plan specified monitoring for socially inappropriate/disruptive behavior, and who made multiple verbal threats of harm against another resident (Resident #2). The facility also failed to assess Resident #1 for the need for a psychiatric evaluation/obtain a psychiatric consultation as specified by the Care Plan, and failed to notify Resident #1's physician of medication regimen noncompliance, also as specified by the Care Plan. The total survey sample was eleven (11) residents. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Care Plan for Resident #1 identified the resident's use of [MEDICAL CONDITION] medication, and specified notification of the physician regarding non-compliance with the medication regimen. However, even though during October of 2014 Resident #1 refused her [MEDICATION NAME] 1 milligram (mg) dose on eight (8) days and her [MEDICATION NAME] 2 mg dose on five (5) days, there was no evidence to indicate that the physician was notified of the resident's medication regimen noncompliance, as specified by the Care Plan. Additionally, a Care Plan Problem/Need for Resident #1 identified that she displayed socially inappropriate/disruptive behavior, and a Care Plan Approach specified that staff monitor the resident in relation to her behavior. On 11/02/2014, Resident #1 exhibited a new behavior by making multiple verbal threats against Resident #2, including If you don't get her, I am going to get her, and I'm going to get that b---h. However, even though verbal threats against residents was a new behavior for Resident #1, the facility failed to implement, after this new behavior of verbal threats against another resident, any specific method to ensure close monitoring of Resident #1, as specified by the Care Plan. Also, despite Resident #1's Care Plan specifying she would be provided with a psychiatric consultation if needed, there was no evidence to indicate that, after this 11/02/2014 incident, Resident #1 was provided with, or was assessed for the need for, a psychiatric consultation. Subsequently, on 11/11/2014, Resident #2 (Resident #1's roommate) was found not breathing, having no pulse, and having an electric cord around her neck. Resident #1 stated to facility staff that she had killed Resident #2, and Resident #1 was arrested and charged with felony murder and aggravated assault. This resulted in a situation in which the facility's noncompliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment or death to residents. The facility's Administrator and Corporate Consultant were informed of the immediate jeopardy on November 19, 2014 at 3:36 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on November 11, 2014, the date Resident #1 was documented as stating she had killed her roommate, Resident #2, after Resident #2 was found to have no respirations, no pulse, and with an electric cord around her neck, and nine (9) days after November 2, 2014, when the facility failed to enact interventions in response to Resident #1's voiced threats against Resident #2. The immediate jeopardy continued through November 20, 2014, and was removed on November 21, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on November 20, 2014. During an interview conducted on 11/19/2014 at 1:40 p.m., the Administrator acknowledged the lack of evidence of physician notification regarding Resident #1's verbal threats against Resident #1. In an 11/19/2014, 2:30 p.m. interview, the Administrator acknowledged that no new interventions for monitoring had been put into place after Resident #1 verbally threatened Resident #2 on 11/02/2014. An allegation of jeopardy removal was received on November 20, 2014. Based on the corrective plans which had been developed and implemented by the facility via a credible allegation of jeopardy removal on November 20, 2014, the immediacy of the deficient practice was determined to have been removed on November 21, 2014. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of staffs' monitoring of resident behaviors, resident screening and placement in the Behavior Management Program as indicated, resident Care Plan updating and implementation regarding resident behaviors, and physician notification of resident behavioral changes, in accordance with facility policies and procedures. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about facility policies and procedures governing resident monitoring and the reporting of resident behavioral changes to supervisors and the physician, to therefore ensure resident safety. Resident records were reviewed to ensure that resident assessments and Care Plans accurately reflected the current status of residents, including the development and implementation of interventions to address aggressive behaviors. Findings include: Resident #1's 09/10/2014 Admission Minimum Data Set assessment documented an admission date of [DATE], and Section E - Behavior documented Resident #1 had shown physical behavioral symptoms one-to-three days during the look-back period. Section I - Active [DIAGNOSES REDACTED]. A 09/03/2014, 4:10 p.m. Daily Skilled Nurses Notes (DSNN) entry for Resident #1 documented additional [DIAGNOSES REDACTED]. Review of Resident #1's Care Plan revealed a Problem/Need dated 09/18/2014 which indicated that Resident #1 displayed socially inappropriate/disruptive behavior related to her [DIAGNOSES REDACTED]. Approaches included on this Care Plan to address Resident #1's socially inappropriate/disruptive behaviors included monitoring the resident. Resident #1's Care Plan documented another Problem/Need dated 09/18/2014 which indicated the resident required [MEDICAL CONDITION] medication related to cognitive impairment, and Approaches to address this Problem/Need included obtaining a psychiatric consultation as needed. An additional Care Plan Problem/Need dated 09/18/2014 indicated that Resident #1 had the potential for side effects and/or adverse reactions related to [MEDICAL CONDITION] medication use, and Approaches included notifying the physician of signs/symptoms of adverse medication reactions and/or of non-compliance with the medication regimen. Resident #1's 09/03/2014 admission physician's orders [REDACTED]. A subsequent 09/18/2014, 7:00 a.m. DSNN entry documented the physician ordered that Resident #1 also receive [MEDICATION NAME] one (1) mg each morning for escalating behaviors. Review of Resident #1's September 2014 Medication Record (MR) and Nurse's Medication Notes revealed nursing staff documented the resident refused all medications (including the [MEDICATION NAME] 2 mg dose) at 8:00 p.m. on 09/20/2014, and refused all medications (including the [MEDICATION NAME] 1 mg dose) at 8:00 a.m. on 09/19/2014, 09/20/2014, and 09/23/2014. A 09/29/14 Physician's Progress Notes entry for Resident #1 documented the physician's awareness that Resident #1 was not taking medications. Resident #1's October 2014 MR documented Resident #1 refused the daily 8:00 a.m. [MEDICATION NAME] 1 mg dose on eight (8) of thirty-one (31) days, and refused the nightly 8:00 p.m. [MEDICATION NAME] 2 mg dose on five (5) of thirty-one (31) days. However, despite Resident #1's Care Plan specifying that the physician would be notified of non-compliance with the medication regimen, record review revealed no evidence to indicate that Resident #1's physician was notified of Resident #1 continuing to refuse medications, including [MEDICATION NAME], on these thirteen (13) occasions during October of 2014. Further review of Resident #1's record revealed a Nurse's Notes (NN) entry of 11/02/2014 at 11:00 a.m. which documented that Resident #1 made verbal threats against another resident (Resident #2, who resided in room [ROOM NUMBER]B as the roommate of Resident #1). This 11/02/2014 NN entry documented that an intramuscular dose of [MEDICATION NAME] was administered to Resident #1 and that staff were monitoring Resident #1. Review of Resident #1's record revealed no evidence of her having made threats toward other residents before the 11/02/2014, 11:00 a.m. NN entry referenced above. During an on 11/18/2014, 12:45 p.m. interview, Licensed Practical Nurse (LPN) DD stated that on 11/02/2014, Resident #1 had held a family picture in the face of Resident #2 and verbally threatened her, which LPN DD acknowledged was a new behavior for Resident #1. Further record review for Resident #1, however, revealed that even though Resident #1 had exhibited threatening behavior toward Resident #2 on 11/02/2014, and even though this was a new behavior for Resident #1 (per the 11/18/2014, 12:45 p.m. interview with LPN DD referenced above), there was no evidence to indicate that the facility put into place interventions, specific to a method and/or frequency, to ensure close staff monitoring of Resident #1 in relation to this newly-exhibited threatening behavior toward other residents. This was despite the Care Plan of Resident #1 specifying the Approach, as referenced above, that staff would provide monitoring of the resident in relation to her disruptive behaviors. Additional record review for Resident #1 revealed that, despite Resident #1's verbally threatening behavior toward Resident #2 on 11/02/2014, and despite Resident #1's current Care Plan noting the resident's need for [MEDICAL CONDITION] medications and specifying a psychiatric consultation as needed, there was no evidence to indicate that Resident #1 was assessed for the need for a psychiatric evaluation after this 11/02/2014 incident involving the new behavior of verbally threatening another resident. Then, an 11/11/2014, 7:00 a.m. NN entry for Resident #1 documented that the nurse heard staff yelling (from the resident's room) and responded to find Resident #2 (Resident #1's roommate) not breathing, with no pulse and with an electric bed cord around Resident #2's neck. In an investigation summary (IS) completed by the facility related to the 11/11/2014 incident involving Resident #2 (as documented in the 11/11/2014, 7:00 a.m. NN entry for Resident #1 referenced above), the facility documented that on 11/11/2014 at 7:00 a.m., the nurse noted Resident #2 having no respirations or pulse and on the floor of her room with the bed's electric cord unplugged and on or near her neck. This IS further documented that on 11/02/2014 (nine days prior to 11/11/2014 when Resident #2 was found not breathing and with no pulse), Resident #1 was observed to hold a family picture in the face of Resident #2, and as a certified nursing assistant (CNA) was redirecting Resident #1, Resident #1 stated I am going to get you, then said to the staff member If you don't get her, I am going to get her, and later stated to the CNA I'm going to get that b---h (referring to Resident #2). However, as indicated above, even though Resident #1 made multiple verbal threats against

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **115385**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/21/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH - CRESTWOOD	**415 PENDLETON PLACE VALDOSTA, GA 31602**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) Resident #2 on 11/02/2014 (per Resident #1's 11/02/2014, 11:00 a.m. NN entry and the facility's IS, both referenced above), record review revealed no evidence to indicate that the facility initiated any additional method or process by which to ensure close monitoring of Resident #1 (as specified by Resident #1's Care Plan) on or after 11/02/2014, to ensure Resident #2's safety. During an 11/19/2014, 2:30 p.m. interview, the Administrator acknowledged that after Resident #1 made verbal threats against Resident #2 on 11/02/2014, no new interventions were developed related to Resident #1's verbal threats against Resident #2. Then, as documented in the 11/11/2014, 7:00 a.m. NN entry for Resident #1 referenced above, on 11/11/2014, Resident #2 was found not breathing and with no pulse. Further review of the facility IS report referenced above revealed that, based on verbal reports from sources close to the police department, an autopsy report for Resident #2 concluded that Resident #2's trachea was crushed. This IS further documented that Resident #1 told a nurse consultant she had killed Resident #2, and the IS documented Resident #1 was arrested and charged with felony murder and aggravated assault. Based on the above, Resident #1 had [DIAGNOSES REDACTED]. Resident #1's Care Plan identified that the resident had displayed socially inappropriate/disruptive behavior, with an Approach related to this behavior including the monitoring of the resident. Resident #1's Care Plan also identified the resident's receipt of [MEDICAL CONDITION] medication, with an Approach specifying a psychiatric consultation as needed, and also identified Resident #1's potential for side effects/adverse reactions related to [MEDICAL CONDITION] medication use, with an Approach specifying notification of the physician of non-compliance with the medication regimen. However, the facility failed to notify Resident #1's physician, as specified by the Care Plan, of the resident's refusal of drug therapy, including [MEDICATION NAME], on thirteen (13) occasions in October of 2014. Then, when Resident #1 exhibited a new behavior on 11/02/2014 by making verbal threats against Resident #2, the facility failed to develop interventions to ensure the close monitoring of Resident #1, as specified by the Care Plan, and failed to evaluate Resident #1 to determine the need for a psychiatric evaluation, also as specified by the Care Plan. Subsequently, on 11/11/2014, Resident #2 was found on the floor with an electric cord around her neck, not breathing and having no pulse. Resident #1 was documented as stating to facility staff that she had killed Resident #2, was arrested, and was charged with felony murder and aggravated assault. Cross refer to F323 for more information regarding Resident #1 and Resident #2, and F406 for more information regarding Resident #1. The facility presented a credible allegation of jeopardy removal (CAJR) on 11/20/2014, and it was determined that the immediate jeopardy was removed on 11/21/2014, at which time the facility had implemented the following interventions: 1. On 11/11/2014, upon the discovery of the incident of that date, Resident #1 was immediately placed on one-to-one staff observation until she was later transferred out of the facility. 2. On 11/13/2014, the facility's Interdisciplinary Team (consisting of the Administrator, DON, ADON, Admissions Personnel, LPN Supervisor, and Social Services Director) completed Behavioral Symptom Screening Forms on every facility resident. This process of resident behavior screening had been initiated on 11/12/2014. All residents screened during this process and identified as having had physical or verbal behaviors in the previous month were placed on the Behavior Monitoring Program, to ensure the monitoring of these residents and to ensure that no further behavioral interventions were necessary. All residents will have a behavior screen done upon facility admission, quarterly, upon significant change in status, and with any new behavior. 3. On 11/13/2014, the facility's Interdisciplinary Team completed a review, initially begun on 11/12/2014, of the Care Plans of all residents having any physical or verbal behaviors in the previous month. These Care Plans were revised as needed, based on these reviews. Resident Care Plans will be reviewed quarterly, annually, with a significant change in condition, and with any new behavior. 4. On 11/14/2014, the facility's Medical Director reviewed Resident #1's medical record, making no recommendations. 5. On 11/19/2014, the facility implemented a procedure by which the Interdisciplinary Team would screen and review all new resident admissions. This screening process would apply to all new resident admissions, and no resident would be admitted until a detailed review of the resident's mental condition and the potential for aggressive or physical behaviors can be assessed. This resident screening and review will be documented on the Admission Audit Tool, which documents: the date; the resident's name; the History and Physical; PASRR Level II; Nurse' Notes/MR notation; any Consultation Information; and a signature of the reviewer. 6. On 11/20/2014, the facility implemented a new procedure by which the Administrator would conduct a monthly audit of a minimum of 10 percent of the Resident Behavioral Symptom Screening forms and resident Care Plans for residents in behavioral management, to ensure the accuracy and completion of these documents. The Administrator will conduct a monthly audit of a minimum of 10 percent of the Behavior Management Documentation Form for residents in behavioral management, to ensure the accuracy and completion of this Form. This Form (a previously existing form) allows for the weekly documentation of residents in the Behavior Management Program, the tracking of the effectiveness of existing behavioral interventions, and the documentation of any newly developed interventions. In addition, the Administrator will conduct a monthly audit of a minimum of 10 percent of the Behavior Management Log Forms (a previously existing form) for all residents in a Behavior Management Program, to ensure accuracy and completion of this Form. This Form serves to document any observed behaviors, including agitated or combative behaviors, per day and per shift. These monthly form audits referenced above will be documented by the Administrator dating and signing the review of each of the referenced forms. 7. On 11/20/2014, the facility implemented a procedure by which a designated CNA was to document, using the Behavior Monitoring Form, continuous rounds in the Memory Support Unit on the hallways and resident areas to monitor for any aggressive resident behavior. This Behavior Monitoring Form allows for the documentation of resident behaviors, interventions, the reporting of the behavior(s) to the Charge Nurse and the identity of the staff member reporting the behavior, and a signature of the nurse of verification. If, during these continuous rounds conducted on the Memory Support Unit, behaviors were observed, this staff member was to intervene as necessary to de-escalate the behavior, and also to report the resident behavior to the Charge Nurse. This monitoring was actually initiated on 11/11/2014, when the staff member was immediately assigned to the Memory Support Unit to begin the continuous rounds. 8. On 11/20/2014, the facility's Interdisciplinary Team continued the process of reviewing resident Preadmission Screening and Resident Review (PASRR) Level II Assessments. This review revealed three (3) residents having PASRR Level II assessments with a recommendation for a psychiatric consultation. One (1) of these residents was seen by a psychiatrist on a regular basis. Appointments were made on 11/20/2014 for the remaining two (2) residents, identified with recommendations for a psychiatric consultation, to have a consultation with a psychiatrist. On 11/20/2014, the facility implemented a procedure by which the Administrator or Social Service Director will make a copy of each resident's PASRR, and initial and date that copy, which will then be kept in the resident's medical record. 9. On 11/20/2014, the facility's Interdisciplinary Team continued to provide staff in-service training related to a number of areas. In-service training was provided to staff to educate them in ways to prevent abuse, including behaviors what to report, and to whom to report observations of resident abuse. This included both physical and verbal resident behaviors. This in-service training also addressed how to identify abuse by observation of residents having suspicious bruising, showing signs of being afraid, or patterns of behaviors. Staff were informed that any resident suspected of any alleged abuse would be protected from any further abuse by the removal of the alleged perpetrator from the facility, as deemed appropriate. Staff were advised of reporting any alleged abuse immediately to their supervisor, leading up to the Administrator, who would then report the allegation of abuse to the appropriate State and corporate agencies. In-service training was also provided regarding employment screening, via criminal background checks, reference checks, and licensure/certification verification. As of 11/20/2014, eighty-nine (89) of one-hundred-and-two (102) staff had received this in-service training. This number included thirty-three (33) of thirty-seven (37) CNA staff; thirteen (13) of fourteen (14) LPN staff; nine (9) of eleven (11) housekeepers; four (4) of five (5) laundry workers; seventeen (17) of twenty (20) dietary workers; seven (7) of eight (8) Registered Nurses; seven (7) of seven (7) department heads (not including the DON, ADON, LPN Supervisor, Senior Care Partner, and MDS Nurse) that did not include nurses, including the Activities Director, Social Worker, Maintenance Director, Financial Counselor, Medical Records, Admissions Coordinator, and Housekeeping Supervisor. The remaining four (4) CNA staff, one (1) LPN staff, two (2) housekeepers, one (1) laundry worker, three (3) dietary workers, and one (1) Registered Nurse who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. Additionally, going forward, all employees will receive training upon hire during the orientation process, and quarterly, related to resident abuse, resident neglect, and the procedures by which to deal with residents having verbal or physical behaviors. 10. On 11/20/2014, the Interdisciplinary Team continued to conduct additional staff in-service training, originally initiated on 11/14/2014, specifically intended for licensed nursing staff and CNA staff regarding the resident behavior management policies and the documentation of resident behaviors. As of 11/20/2014, six (6) of eight (8) Registered Nurses, thirteen (13) of fourteen (14) LPN staff, and thirty-one (31) of thirty-seven (37) CNA staff had received this in-service training. The remaining two (2) Registered Nurses, one (1) LPN, and six (6) CNA staff

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NAME OF PROVIDER OF SUPPLIER **PRUITTHEALTH - CRESTWOOD**		STREET ADDRESS, CITY, STATE, ZIP **415 PENDLETON PLACE VALDOSTA, GA 31602**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. 11. On 11/20/2014, staff in-service training was conducted regarding the notification of the physician of a change in condition and of new resident behaviors. As of 11/20/2014, eleven (11) of fourteen (14) LPN staff and seven (7) of eight (8) Registered Nurses had received this training. The remaining three (3) LPN staff and one (1) Registered Nurse who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. 12. On 11/20/2014, the facility implemented a new procedure by which the results of Administrator and/or Social Service Director audits of the Admission Audit Tool, Behavior Monitoring Form, Behavior Management Documentation Form, Behavior Symptom Screening Form, Management Log Form, and Care Plan and PASRR Assessment reviews would be presented to the QA Sub-Committee each week for four (4) weeks, then monthly by the Administrator or Director of Health Services. This process will allow the QA Sub-Committee to monitor staff compliance with the facility's policies and procedures regarding residents having verbal and/or physically aggressive behaviors which could have the potential to lead to resident abuse. Audit results will also be presented to the facility's QA Committee quarterly for the Committee's review and oversight of facility staff conformance with facility policies and procedures related to the management of resident behaviors, the screening of resident behaviors, physician notification, and resident monitoring. During this abbreviated survey, the State Survey Agency reviewed the corrective actions implemented by the facility, as reflected in the CAJR referenced above, with findings as follow: - On 11/21/2014, a review of facility investigative documents, including the facility IS, confirmed that Resident #1 was immediately placed on one-to-one observation on 11/11/2014 immediately after the incident involving Resident #1 and Resident #2, as indicated in Step #1 of the CAJR referenced above. - On 11/21/2014, a sampled review of resident records completed on that date, but which had been ongoing throughout the abbreviated survey, revealed that the Interdisciplinary Team had conducted behavioral screenings on residents for the purpose of ensuring appropriate resident placement in the Behavioral Monitoring Program, as indicated in Step #2 of the CAJR referenced above. - On 11/21/2014, a sampled review of multiple resident records, but which had been ongoing throughout the abbreviated survey, was completed and verified that resident Care Plans had been reviewed and updated by the Interdisciplinary Team, as related to physically/verbally aggressive behaviors. This was in accordance with Step #3 of the CAJR referenced above. - On 11/21/2014, review of facility investigative documents confirmed that the Medical Director had reviewed Resident #1's medical record and submitted a written summary of this information to the facility on [DATE]. This was in accordance with Step #4 of the CAJR referenced above. (Of note, on 11/20/2014 at 11:12 a.m., a telephone call had been placed to Resident #1's physician, but the physician declined interview.) - On 11/21/2014, interview with the Administrator at 11:20 a.m. confirmed that the Interdisciplinary Team will screen and review all new resident admissions, with no resident being admitted until a review of the resident's medical condition and potential for aggressive behaviors can be assessed. This review will be documented using the Admission Audit Tool. This Team will include the Administrator, DON, ADON, Admissions Personnel, an LPN Supervisor, and the Social Services Director. This was in accordance with Step #5 of the CAJR referenced above. - On 11/21/2014, facility document review and interview with the Administrator confirmed that the Administrator will be conducting monthly audits of the Resident Behavioral Symptom Screening forms, the Behavior Management Documentation Forms, the Behavior Management Log Forms, and resident Care Plans for resident requiring behavioral management services. This was in accordance with Step #6 of the CAJR referenced above. - On 11/21/2014, a 9:55 a.m. observation on the Secured Unit confirmed the presence of an assigned staff member to conduct ongoing and continuous rounds for the purpose of observing for any resident aggressive behaviors. These rounds were documented on the Behavior Monitoring Form. In addition, it was confirmed by interview with the Administrator that this process of ongoing, continuous rounds will be a permanent intervention. This was in accordance with Step #7 of the CAJR referenced above. - On 11/21/2014, a sampled review of resident records, which had been ongoing throughout the abbreviated survey, was completed and verified that the Interdisciplinary Team had reviewed all resident PASRR Level II Assessments, with the appropriate follow-up for residents needing additional psychiatric services. This action was also confirmed during an 11/21/2014, 10:45 interview with a Corporate Nursing Consultant. This was in accordance with Step #8 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted staff in-service training for staff, including (but not limited to) licensed nursing staff, CNA staff, Social Services staff, MDS staff, Medical Records staff, the Maintenance Director, and the Admissions Coordinator, regarding resident abuse and the Behavior Management Policy. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #9 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted additional staff in-service training, specific for licensed nursing staff and CNA staff, regarding resident behavior management policies and the documentation of resident behaviors. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #10 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted additional staff in-service training, specific for licensed nursing staff, regarding the notification of the physician for changes in condition and new resident behaviors. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #11 of the CAJR referenced above. - On 11/21/2014, an 11:20 a.m. interview with the Administrator confirmed that the results of all audits, as referenced in the CAJR intended to provide ongoing management level oversight of the assessment, planning of care, and provision of care to residents having behavioral problems, will be reviewed by the QA Committee to provide ongoing QA Committee oversight of this care. This was in accordance with Step #12 of the CAJR referenced above. Based on these corrective actions which had been developed and implemented by the facility as outlined in the CAJR referenced above, it was determined that the immediacy of the deficient practice had been removed on 11/21/2014; however, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. On 11/19/2014, the facility implemented a procedure by which the Interdisciplinary Team will screen and review all new resident admissions, and no resident will be admitted until a detailed review of the resident's mental condition and the potential for aggressive or physical behaviors can be assessed. This resident screening and review will be documented on the Admission Audit Tool. This was, however, a new procedure, having been implemented on 11/19/2014, only two (2) days prior to the 11/21/2014 exit date of this abbreviated survey; therefore, the Interdisciplinary Team's ongoing compliance with this newly-implemented procedure could not be fully evaluated at the time of survey exit, and will need further review on a future date. On 11/20/2014, the facility implemented a new procedure by which designated staff was to document, using the Behavior Monitoring Form, continuous rounds in the Memory Support Unit on the hallways and resident areas to monitor for any aggressive resident behavior. The use of this Behavior Monitoring Form was, however, only implemented as of 11/20/2014, one (1) day prior to the 11/21/2014 date of survey exit, thereby preventing the evaluation of facility staffs' ongoing compliance with the use of this Form and concomitant monitoring of aggressive resident behaviors. Such compliance will require further review on a future date. In addition, on 11/20/2014, the facility's Interdisciplinary Team continued to provide staff in-service training which included abuse prevention and reporting, and the identi
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigation summary review, facility Entity Reported Incident Intake review, facility Behavior Management Program Policy review, facility Behavior Management Documentation Form review, staff written statement review, and staff interview, the facility failed to provide supervision in response to verbal threats and aggression exhibited by one (1) resident (Resident #1), who made multiple verbal threats of harm against another resident (Resident #2), to thus ensure the safety of Resident #2. The total survey sample was eleven (11) residents. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. After facility admission, Resident #1 exhibited aggressive behaviors toward staff, including hitting staff and pulling staffs' hair. Interventions were developed to address Resident #1's behavior, and the resident was placed on a Behavior Management Program on 09/09/2014. Documented evidence then indicated that Resident #1 had no behaviors observed/reported daily from 10/01/2014 through 10/21/2014, at which time she was discontinued from the Behavior Management Program. The physician documented in a Physician's Progress Note of

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NAME OF PROVIDER OF SUPPLIER **PRUITTHEALTH - CRESTWOOD**	STREET ADDRESS, CITY, STATE, ZIP **415 PENDLETON PLACE** **VALDOSTA, GA 31602**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) 10/28/2014 that Resident #1's mood, Bipolar Disorder, and Schizophrenia were stable. The facility, however, failed to notify Resident #1's physician of the resident's ongoing refusal of drug therapy, including her Risperidone antipsychotic drug therapy, during October of 2014. On 11/02/2014, Resident #1 experienced a change in behavior and was reported by facility staff to have made multiple verbal threats against Resident #2, including If you don't get her, I am going to get her, and I'm going to get that b---h. However, even though these verbal threats against Resident #2 represented a change in behavior for Resident #1, the facility failed to put measures into place to ensure close monitoring of Resident #1, failed to place Resident #1 in the Behavior Management Program as specified by facility Policy, and failed to notify Resident #1's physician of the aggressive behavior and verbal threats. Then, on 11/11/2014, facility staff discovered Resident #2 not breathing and having no pulse, and with an electric bed cord around her neck. Resident #1 was documented as stating to facility staff that she had killed Resident #2, and Resident #1 was later arrested and charged with felony murder and aggravated assault. This resulted in a situation in which the facility's noncompliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment or death to residents. The facility's Administrator and Corporate Consultant were informed of the immediate jeopardy on November 19, 2014 at 3:36 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on November 11, 2014, the date Resident #1 was documented as stating she had killed her roommate, Resident #2, after Resident #2 was found to have no respirations, no pulse, and with an electric cord around her neck, and nine (9) days after November 2, 2014, when the facility failed to enact interventions in response to Resident #1's verbal threats against Resident #2. The immediate jeopardy continued through November 20, 2014, and was removed on November 21, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on November 20, 2014. During an interview with the Administrator conducted on 11/19/2014 at 2:30 p.m., the Administrator acknowledged the 11/02/2014 incidents during which Resident #1 made verbal threats against Resident #2, further stating that as a result of Resident #1's 11/02/2014 verbal threats toward Resident #2, staff administered (the antianxiety drug) Ativan intramuscularly to Resident #1, and also redirected the two residents. The Administrator acknowledged, however, that the administration of Ativan to Resident #1 and the redirection of these residents were interventions in place prior to the 11/02/2014 incidents involving Resident #1 making verbal threats against Resident #2, and further acknowledged that no new measures had been developed in response to Resident #1's aggressive behavior involving verbal threats on 11/02/2014. An allegation of jeopardy removal was received on November 20, 2014. Based on the corrective plans which had been developed and implemented by the facility via a credible allegation of jeopardy removal on November 20, 2014, the immediacy of the deficient practice was determined to have been removed on November 21, 2014. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of staffs' monitoring of resident behaviors, resident screening and placement in the Behavior Management Program as indicated, resident Care Plan updating and implementation regarding resident behaviors, and physician notification of resident behavioral changes, in accordance with facility policies and procedures. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about facility policies and procedures governing resident monitoring and the reporting of resident behavioral changes to supervisors and the physician, to therefore ensure resident safety. Resident records were reviewed to ensure that resident assessments and Care Plans accurately reflected the current status of residents, including the development and implementation of interventions to address aggressive behaviors. Findings include: Facility Entity Reported Incident Intake (ERII) Number GA 575 dated 11/12/2014 documented the facility's report to the State Survey Agency of an incident involving two (2) facility residents (Resident #1 and Resident #2). This ERII documented that on 11/11/2014, facility staff noted Resident #2 on the floor and unconscious, with a cord around her neck. The ERII further documented that Resident #1 stated she had an altercation with Resident #2, her roommate, and that she had killed Resident #2. In an investigation summary (IS) submitted by the facility to the State Survey Agency on 11/17/2014 as a follow-up report to the ERII, the facility documented that on 11/13/2014, Resident #1 was arrested and charged with felony murder and aggravated assault. Record review for Resident #1 (one of the residents reported by the facility to have been involved in the incident of 11/11/2014, as documented in facility ERII Number GA 575 referenced above) revealed an Admission Minimum Data Set (MDS) assessment having an Assessment Reference Date of 09/10/2014 which documented the resident's admission Entry Date of 09/03/2014. Section I - Active [DIAGNOSES REDACTED].#1 had [DIAGNOSES REDACTED]. Section C - Cognitive Patterns documented that Resident #1 had a Brief Interview for Mental Status (BIMS) Summary Score of 8, indicating that the resident had moderate cognitive impairment, and Section E - Behavior documented she had exhibited physical behavioral symptoms toward others on one (1) to three (3) days during the look-back period. A Daily Skilled Nurses Notes (DSNN) entry of 09/03/2014 timed at 4:10 p.m. for Resident #1 documented the resident's arrival at the nursing facility from an Intensive Treatment Board center. This DSNN entry documented that Resident #1 had [DIAGNOSES REDACTED]. This DSNN entry further documented that upon admission, Resident #1 was placed in resident room 260A. The admission physician's orders [REDACTED].#1 specified orders of 09/03/2014 for the resident to receive the antipsychotic medication Risperidone two (2) milligrams (mgs) by mouth at bedtime, the antianxiety medication Lorazepam (Ativan) one (1) mg by mouth every six (6) hours as needed for agitation, and Lorazepam Injection, 0.5 milliliter (1 mg) intramuscularly (IM) every six (6) hours as needed for agitation if unable to take oral Lorazepam. A DSNN entry of 09/06/2014 timed at 5:30 a.m. for Resident #1 documented that the nurse had gone into the resident's room to ask the resident to get up for breakfast, but the resident sat up in the the bed, hit the nurse across the left side of the face, and stated I am not doing anything and get out. This DSNN further documented that Resident #1 refused to take any of her medications. A DSNN entry of 09/07/2014 timed at 8:00 a.m. for Resident #1 documented that the nurse went to check the status of the resident and began to ask the resident questions, but the resident closed her eyes, pulled the cover over her, would not respond to the nurse, and refused her medications. A Behavior Management Documentation Form for Resident #1 indicated that on 09/09/2014, the resident was placed in the facility's Behavior Management Program. Review of the Behavior Management Program Policy revealed that all residents would be evaluated upon admission/readmission, and with new behaviors or a change in existing behaviors, for placement in the Behavior Management Program, and would have interventions, per the Care Plan and additional interventions if necessary, to eliminate or reduce behaviors. This Policy further indicated that residents placed in the Behavior Management Program would be evaluated by the Behavior Management Team at weekly Behavior Management Meetings for purposes which included brainstorming/assessing for potential causes and risks of behaviors, developing interventions as indicated, and reassessing and revising the behavior reduction interventions if indicated. The Policy further required that each resident in the Behavior Management Program would remain in the Program until behavior-free for 30 days or until deemed appropriate to discontinue by the Behavior Management Committee. The Behavior Management Documentation Form of 09/09/2014 referenced above for Resident #1 documented that the decision to place Resident #1 in the Behavior Management Program was based on the resident's physically aggressive behaviors. A Behavioral Symptom Screening Form for Resident #1, completed on 09/10/2014 upon the resident's inclusion in the Behavior Management Program, documented the resident's history of Manic Depression, Dementia with Behavioral Disturbances, and Schizophrenia - Residual Type, and also documented a history of the resident being physically aggressive towards staff, refusing medications, refusing to eat sporadically, and pocketing (cheeking) medications. The 09/09/2014 Behavior Management Documentation Form for Resident #1, as referenced above, documented that once enrolled in the Behavioral Management Program on that date, the Behavior Management Team reviewed the resident's behavior and behavioral interventions weekly, as outlined in the Behavior Management Policy, on the dates of 09/16/2014, 09/23/2014, 09/30/2014, 10/07/2014, and 10/14/2014. Further review of Resident #1's clinical record revealed DSNN entries of 09/14/2014 timed at 10:30 a.m. and 9:00 p.m. which documented the resident continued to refuse medications, and a DSNN entry of 09/16/2014 timed at 11:30 a.m. documented that Resident #1 had balled up her fist and swung at the nurse, then grabbed at another staff member. A 09/18/2014, 7:00 a.m. DSNN entry for Resident #1 documented the resident continued refusing care, and documented that when notified of her escalating behaviors, the physician ordered for the resident to receive Risperidone one (1) mg each morning (in addition to the nightly Risperidone two (2) mg dose already being administered at bedtime, as indicated above). A DSNN entry of 09/20/2014 timed at 7:14 a.m. for Resident #1 then documented the resident was still uncooperative and struck out and hit a certified nursing assistant (CNA). Resident #1's September 2014 Medication Record (MR) and Nurse's Medication Notes documented, per licensed nursing staff entries, that on 09/20/2014, Resident #1 had refused medications, including the daily Risperidone 2 mg dose ordered and scheduled at 8:00 p.m. This September MR further documented, per licensed nursing staff entries, that on 09/19/2014, 09/20/2014, and 09/23/2014, Resident #1 refused all of her medications, including the daily Risperidone 1 mg dose ordered and scheduled at 8:00 a.m. A DSNN entry of 09/28/2014 timed at 1:40 p.m. for Resident #1 documented that Resident #1 had received a 0.5 mg dose of intramuscular Ativan for increased agitation after having slapped staff and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **115385**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/21/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH - CRESTWOOD	**415 PENDLETON PLACE VALDOSTA, GA 31602**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) pulled staffs' hair out as they were attempting to assist the resident to dress and ambulate. A 09/29/2014 Physician's Progress Notes entry for Resident #1 signed by the attending physician documented the physician examined the resident on that date. In this 09/29/2014 Physician's Progress Notes entry, the physician documented that Resident #1 was combative and that the resident was not taking her medications, thus documenting the physician's awareness on that date of the resident's behavioral issues and refusal to take medications. Review of Resident #1's October 2014 nursing notes entries revealed DSNN entries of 10/03/2014 timed at 9:00 p.m. and 10/04/2014 timed at 8:00 a.m. which documented the resident again refused medications. Subsequent DSNN entries of 10/17/2014 timed at 9:00 p.m. and 10/18/2014 timed at 7:30 p.m., and a Skilled Daily Nurse's Note's (SDNN) entry of 10/19/2014 timed at 5:55 p.m. for Resident #1 documented the resident continued to refuse to take her oral medications on occasion. More specifically, review of Resident #1's October 2014 MR revealed licensed nursing staff documented the resident refused the Risperidone 1 mg dose, ordered and scheduled to be administered at 8:00 a.m. daily, on eight (8) of thirty-one (31) days during the month of October, those dates being 10/04/2014, 10/05/2014, 10/17/2014, 10/19/2014, 10/23/2013, 10/24/2014, 10/28/2014 and 10/29/2014. Resident #1's October 2014 MR also documented that the resident refused the evening Risperidone 2 mg dose, ordered and scheduled to be administered at bedtime at 8:00 p.m., on five (5) of thirty-one (31) days of the month, those days being 10/03/2014, 10/17/2014, 10/18/2014, 10/19/2014, and 10/21/2014. However, even though Resident #1 continued to refused medications on multiple occasions during the month of October 2014, as documented in the resident's October MR and DSNN/SDNN entries referenced above, review of Resident #1's clinical record revealed no evidence to indicate that Resident #1's physician was notified of her continuing to refuse her ordered medication therapy, including the Risperidone medication therapy prescribed in response to her escalating behaviors, during the month of October 2014. The last documented evidence of Resident #1's attending physician being aware of the resident's refusal of medications was the 09/29/2014 Physician's Progress Notes entry referenced above in which the physician documented awareness of the resident's medication refusal. Even though Resident #1's DSNN/SDNN and October MR entries from 10/03/2014 through 10/21/2014 referenced above documented that Resident #1 refused medications on multiple occasions during October of 2014, daily DSNN/SDNN entries for Resident #1 dated 10/01/2014 at 2:30 a.m. and 8:00 p.m., 10/02/14 at 7:00 a.m., 10/03/2014 at 2:50 a.m. and 7:00 a.m., 10/04/14 at 3:00 a.m. and 8:00 p.m., 10/05/14 at 2:00 a.m. and 8:00 p.m., 10/06/2014 at 7:00 a.m. and 8:00 p.m., 10/07/2014 at 7:00 a.m. and 6:30 p.m., 10/08/2014 at 7:00 a.m. and 7:00 p.m., 10/09/2014 at 2:35 a.m. and 7:00 a.m., 10/10/2014 at 7:00 a.m. and 7:00 p.m., 10/11/2014 at 9:00 a.m. and 5:00 p.m., 10/12/2014 at 2:14 a.m. and 8:00 p.m., 10/13/2014 at 2:16 a.m. and 6:00 p.m., 10/14/14 at 2:05 a.m. and 7:00 a.m., 10/15/2014 at 7:00 a.m. and 9:00 p.m., 10/16/2014 at 2:40 a.m., 10/17/14 at 7:00 a.m., 10/18/14 at 8:00 a.m., 10/19/2014 at 2:30 a.m., 10/20/14 at 2:30 a.m. and 7:00 p.m., and 10/21/2014 at 7:00 a.m. documented that no behaviors had been noted/reported for Resident #1 during this period of time. A SDNN of 10/21/2014 at 5:30 p.m. documented that Resident #1 was calm, with no behaviors at that time, and that the resident had tolerated her medications without fussing. A final entry on Resident #1's Behavior Management Documentation Form dated 10/21/2014 then documented that Resident #1 was discontinued from the Behavior Management Program on that date. A subsequent SDNN entry of 10/24/2014 timed at 2:00 a.m. for Resident #1 documented the resident continued to refuse medications, but a later 10/24/2014, 7:00 a.m. SDNN documented that Resident #1 had no noted behaviors at that time. Continued review of facility records revealed a clinical record for Resident #2 (who, in addition to Resident #1, was reported by the facility to have been involved in the incident of 11/11/2014, as documented in facility ERII Number GA 575 referenced above). Review of Resident #2's clinical record revealed a SDNN of 10/24/2014 at 11:10 a.m. documenting this resident had arrived at the facility for admission on that date of 10/24/2014. This SDNN further documented that upon facility admission, Resident #2 was placed in resident room 260B (thereby making her the roommate of Resident #1 who resided in resident room 260A, as referenced above). Further record review for Resident #2 revealed an Admission MDS assessment having an Assessment Reference Date of 10/31/2014 which documented in Section I - Active [DIAGNOSES REDACTED]. Section C - Cognitive Patterns of this MDS documented that Resident #2 had a BIMS Summary Score of 4, indicating severe cognitive impairment, and Section G - Functional Status documented the resident required only limited assistance with walking. Continued review of the clinical record of Resident #1 revealed a SDNN of 10/25/2014 timed at 8:00 a.m. (the day after Resident #2's facility admission and placement in Resident #1's room as her roommate, as documented in Resident #2's 10/24/2014, 11:10 a.m. SDNN referenced above) which documented that Resident #1 was calm, cooperative, and taking her medication with no concerns at that time. This SDNN further indicated that staff would continue to monitor Resident #1 for any changes in status. A Physician's Progress Notes entry for Resident #1 dated 10/28/2014 (four days after Resident #2's placement as Resident #1's roommate, and one week after Resident #1's 10/21/2014 discharge from the Behavior Management Program, as documented on the Behavior Management Documentation Form referenced above) documented that Resident #1 was pleasantly confused at that time. This Physician's Progress Notes entry for Resident #1 further documented that Resident #1's mood was stable at present in relation to her Bipolar Disorder, and that her Schizophrenia and Dementia were stable at that time. However, further review of Resident #1's clinical record revealed a Nurse's Notes (NN) entry of 11/02/2014 at 11:00 a.m. (approximately one week after the 10/25/2014, 8:00 a.m. SDNN referenced above documented the resident to be calm and cooperative, and 5 days after the 10/28/2014 Physician's Progress Notes entry referenced above documented the resident's mood, Schizophrenia, and Dementia were stable) which documented that Resident #1 had made verbal threats against another resident (Resident #2) and that Resident #1 became aggressive. This SDNN documented the administration of a 0.5 ml intramuscular dose of Ativan to Resident #1. In the investigation summary (IS) completed by the facility as part of the facility's investigation into the 11/11/2014 altercation involving Resident #1 and Resident #2, as documented in ERII Number GA 575 referenced above, the facility documented that on 11/02/2014 (nine days prior to the 11/11/2014 altercation), Resident #1 was observed by staff carrying a picture of family members. This facility IS documented that Resident #1 alleged to a CNA that a family member had been murdered a number of years ago, an allegation which the facility had not determined to be valid. The facility IS documented that Resident #1's behavior of 11/02/2014 seemed to change suddenly, and she was observed holding the family picture up to the window of the Secured Unit and accusing a male resident, as he walked by, of being the one who murdered her family member. The IS documented that at 11:00 a.m. on 11/02/2014, Resident #1 put the family picture in the face of an unnamed female resident, who slapped the picture away from her face. Resident #1 then put the family picture in the face of Resident #2, who did not respond, and both Resident #1 and Resident #2 were redirected. This facility IS documented that as the CNA was redirecting Resident #1, Resident #1 stated I am going to get you, and then told the staff, If you don't get her, I am going to get her. This IS documented that later in the day of 11/02/2014, Resident #1 stated to the CNA, while referring to Resident #2, I'm going to get that b---h. The IS documented that Resident #1 told the CNA that the room in which she resided was her room, but that Resident #2 was using the bathroom of the room they shared, and accused Resident #2 of wearing her clothes. The IS documented that at that point, the CNA informed Resident #1 that Resident #2 was wearing her own clothes and assisted Resident #1 to lie down. During an interview with the Administrator conducted on 11/18/2014 at 12:20 p.m., the Administrator identified CNA CC as the CNA referenced in the facility IS as hearing Resident #1 threaten Resident #2 on 11/02/2014. During an interview with CNA CC conducted on 11/18/2014 at 1:50 p.m., CNA CC acknowledged she was working on the Secured Unit on 11/02/2014, but stated she did not actually witness the incident during which Resident #1 placed a picture in the face of Resident #2. However, CNA CC further stated that later on 11/02/2014, after lunch, Resident #1 was sitting in the dining room, and CNA CC stated she heard Resident #1 say I'm gonna get that b---h. CNA CC stated she asked Resident #1 to whom she was referring, and Resident #1 named Resident #2 (who CNA CC stated was not in the dining room at that time). CNA CC stated that she told Resident #1 she could not talk like that and that the facility would have to call the police, but stated that Resident #1 then said Go ahead and call, I'm still gonna get her. CNA CC stated that CNA EE was also present at the time Resident #1 made the verbal threats toward Resident #2, and that Licensed Practical Nurse (LPN) DD, who was also present and overheard Resident #1's threat toward Resident #2, stated she would call the supervisor. CNA CC further stated that, prior to these 11/02/2014 incidents during which Resident #1 was aggressive toward Resident #2 and other residents, she had not observed Resident #1 to make threats or be aggressive toward residents in the past, and that Resident #1 had only been aggressive toward staff at times. During an interview with CNA EE conducted on 11/18/2014 at 5:09 p.m., CNA EE stated that on 11/02/2014, while in the hallway of the Secured Unit, Resident #1 had held a family picture up to Resident #2's face (as indicated in the facility's IS referenced above), and then both residents were separated. CNA EE stated that Resident #2 then came back up the hall and Resident #1 again put the family picture in Resident #2's face. CNA EE stated that at that time, staff separated the two residents, with Resident #1 going to the dining room and Resident #2 going to the activity area. CNA EE stated that while Resident #1 was sitting at a table in the dining room, Resident #1 started saying things like I'm a gonna get her. CNA EE further stated that the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **115385**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/21/2014**
NAME OF PROVIDER OF SUPPLIER **PRUITTHEALTH - CRESTWOOD**		STREET ADDRESS, CITY, STATE, ZIP **415 PENDLETON PLACE** **VALDOSTA, GA 31602**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) overheard this, and instructed this CNA to watch Resident #1 to make sure Resident #1 did not go back to confront Resident #2, to allow the nurse to go make a telephone call. CNA EE stated that she had not observed Resident #1 to be aggressive toward other residents before this 11/02/2014 incident. In a written statement provided by LPN DD dated 11/14/2014, LPN DD documented that on 11/02/2014 at approximately 11:00 a.m., Resident #1 was walking in the hallway when she placed the family picture in the face of Resident #2, at which time the residents were redirected. LPN DD documented that as Resident #1 was being redirected, Resident #1 pointed at Resident #2 and stated I am going to get you, I am going to get you. LPN DD documented that she and the CNA encouraged Resident #1 to not say that, but that Resident #1 then stated If you don't get her, I am going to get her. LPN DD documented that Resident #1 then approached another resident but was redirected by staff, and after refusing to take a dose of Ativan by mouth, was escorted to her room and was administered an IM dose of Ativan. LPN DD further documented that she then reported the incident to the Director of Nursing (DON). During an interview with LPN DD and the DON conducted on 11/18/2014 at 12:45 p.m., LPN DD acknowledged awareness of the 11/02/2014 incident during which Resident #1 threatened Resident #2 and held a family picture in the face of Resident #2. LPN DD acknowledged that Resident #1 had been given an IM dose of Ativan after this incident, and stated that this behavior regarding Resident #1 threatening another resident and getting upset about the picture on 11/02/2014 was a new behavior for Resident #1. LPN DD stated she reported this behavior involving Resident #1 to the DON. The DON stated, during this interview, that she was not at work on 11/02/2014 (Sunday), but rather was at church when she received the telephone call from the nursing facility regarding Resident #1. The DON stated she returned the call later in the day of 11/02/2014, was told about the incident involving Resident #1 threatening Resident #2 and of the actions staff had taken to intervene, and was told that Resident #1 was calm at that time. During this interview, LPN DD asserted she was not aware that Resident #1 had threatened Resident #2 later in the day of 11/02/2014 (after the earlier 11:00 a.m. incident of 11/02/2014 of which LPN DD did acknowledge awareness, as she documented in her written statement referenced above, when Resident #1 pointed at Resident #2, stated I am going to get you, I am going to get you, and stating If you don't get her, I am going to get her.). LPN DD stated that if she had been made aware of the second threat, she would have called the DON again. The DON stated that if she had been made aware of Resident #1's second threat toward Resident #2, she would have had Resident #1 transferred to the hospital at that time. However, despite LPN DD's acknowledgement, per her 11/14/2014 written statement referenced above, that she had witnessed and overheard Resident #1 making verbal threats toward Resident #2 on 11/02/2014, despite LPN DD stating during the 11/18/2014, 12:45 p.m. interview referenced above that Resident #1's behavior of threatening another resident on 11/02/2014 was a new behavior for the resident, and despite the DON's acknowledgement, during the 11/18/2014, 12:45 p.m. interview referenced above, that she was made aware on 11/02/2014 of Resident #1's verbal threat toward another resident on that date, further record review revealed no evidence to indicate that Resident #1's physician was notified of the resident's verbal threats against Resident #2, or of the resident's 11/02/2014 aggressive behavior toward residents. Additionally, record review for Resident #1 revealed no evidence to indicate that the facility developed and implemented additional interventions, monitoring, or supervision on or after 11/02/2014, after Resident #1's new behavior involving verbal threats and aggression against Resident #2, to address Resident #1's newly exhibited change in behavior, to both ensure the supervision and monitoring of Resident #1 related to this behavior and to ensure the safety of Resident #2. In addition, further review of the facility's Behavior Management Policy referenced above revealed the Policy to specify, in the Determining Placement of Patient/Residents On Behavior Management Program section, that any resident identified to have a new behavior or change in existing behavior, to include an event of even one (1) altercation involving resident-to-resident verbal threats, would be placed on a Behavior Management Program. This Behavior Management Policy further indicated that placement on the Behavior Management Program would be made due to events which resulted in injury, but also for behaviors, including verbal threats, having the potential for serious harm. However, review of Resident #1's clinical record revealed no evidence to indicate that Resident #1 was either placed on, or was considered for placement on, a Behavior Management Program (after having been discharged from the Program on 10/21/2014, as referenced above) after the incidents of 11/02/2014 during which Resident #1 exhibited the new behavior of voicing verbal threats against Resident #2. The facility's failure to place Resident #1 back on a Behavior Management Program (after her discharged from the Program on 10/21/2014, as documented on Behavior Management Documentation Form referenced above) was despite the fact that Resident #1's Behavior Management Documentation Form of 09/09/2014 (referenced above) documented only physically aggressive behaviors as the reason for her initial enrollment on a Behavior Management Program on 09/09/2014, and despite the fact that Resident #1 had subsequently exhibited a new aggressive behavior (verbally threatening Resident #2 on 11/02/2014). This was also despite the fact that the Behavior Management Program Policy referenced above specifically indicated that any resident identified to have a new behavior or change in existing behavior, to include an event of even one (1) altercation involving resident-to-resident verbal threats, would be placed on the Behavior Management Program. During an interview with the Administrator conducted on 11/19/2014 at 12:20 p.m., the Administrator was questioned regarding the failure of the facility to place Resident #1 on a Behavior Management Program after Resident #1's 11/02/2014 verbal threats toward Resident #2, which were a change in behavior for Resident #1. The Administrator stated that the 11/02/2014 incident involving Resident #1's verbal threat toward Resident #2 had been discussed in the morning meeting involving facility management staff on 11/03/2014. During a subsequent interview with the Administrator conducted on 11/19/2014 at 1:40 p.m., the Administrator stated that after discussion of the 11/02/2014 incident involving Resident #1's verbal threats toward Resident #2 in the morning meeting of 11/03/2014, a decision was made not to place Resident #1 on a Behavior Management Program because the altercation was without injury and was only one (1) altercation. When asked about the Behavior Management Program Policy (referenced above) which specified that altercations with injury were not the only criteria for placement on Behavior Management, and that the Policy specified verbal threats (even just one (1) threat) as criteria for placement on Behavior Management, the Administrator acknowledged that statement, but stated she did not interpret the Policy that way. When questioned regarding the failure of the facility to notify Resident #1's physician of Resident #1's change in behavior involving her multiple threats against Resident #2 on 11/02/2014, the failure to develop and implement any further interventions to prevent a recurrence, and the failure to place Resident #1 on a Behavior Managemen
F 0406 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Give or get specialized rehabilitative services per the patient's assessment or plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigation summary review, Behavior Management Documentation Form review, Preadmission Screening and Resident Review (PASRR) Level I Application - Resident Identification Screening Instrument Form review, PASRR Review Outcome Notification form review, PASRR Psychiatric and MR/RC Evaluation and Medical History form review, and staff interview, the facility failed to provide specialized services, related to a psychiatric consultation/evaluation, for one (1) resident (Resident #1) as recommended by the PASRR Assessment, even though Resident #1 had a history of [REDACTED].#2). The total survey sample was eleven (11) residents. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1's PASRR Psychiatric and MR/RC Evaluation and Medical History form recommended a psychiatric consultation/evaluation by a psychiatrist. After facility admission, Resident #1 exhibited aggressive behaviors toward staff, including hitting staff and pulling staffs' hair. There was no evidence, however, to indicate that the facility provided Resident #1 with a psychiatric consultation/evaluation, or assessed the resident for the need for this psychiatric consultation/evaluation, even after Resident #1 was reported by facility staff to make verbal threats on 11/02/2014 against Resident #2. Resident #1's verbal threats toward Resident #2 were reported to include If you don't get her, I am going to get her, and I'm going to get that b---h. Then, on 11/11/2014, Resident #2 was discovered on the floor and was not breathing, had no pulse, and had an electric bed cord around her neck. Resident #1 was documented as stating to facility staff that she had killed Resident #2, and Resident #1 was later arrested and charged with felony murder and aggravated assault. This resulted in a situation in which the facility's noncompliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment or death to residents. The facility's Administrator and Corporate Consultant were informed of the immediate jeopardy on November 19, 2014 at 3:36 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on November 11, 2014, the date Resident #1 was documented as stating she killed her roommate, Resident #2, after Resident #2 was found to have no respirations, no pulse, and with an electric cord around her neck, and nine (9) days after November 2, 2014, when the facility failed to enact interventions in response to Resident #1's verbal threats against Resident #2. The immediate jeopardy continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **115385**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/21/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH - CRESTWOOD	**415 PENDLETON PLACE VALDOSTA, GA 31602**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0406 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) through November 20, 2014, and was removed on November 21, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on November 20, 2014. During interviews with the Administrator conducted on 11/19/2014 at 2:05 p.m. and the Director of Nursing (DON) on 11/19/2014, at 2:45 p.m., these facility staff provided no information to indicate that Resident #1 had received a psychiatric consultation/evaluation, as per the PASRR recommendation. An allegation of jeopardy removal was received on November 20, 2014. Based on the corrective plans which had been developed and implemented by the facility via a credible allegation of jeopardy removal on November 20, 2014, the immediacy of the deficient practice was determined to have been removed on November 21, 2014. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of staffs' monitoring of resident behaviors, resident screening and placement in the Behavior Management Program as indicated, resident Care Plan updating and implementation regarding resident behaviors, and physician notification of resident behavioral changes, in accordance with facility policies and procedures. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about facility policies and procedures governing resident monitoring and the reporting of resident behavioral changes to supervisors and the physician, to therefore ensure resident safety. Resident records were reviewed to ensure that resident assessments and Care Plans accurately reflected the current status of residents, including the development and implementation of interventions to address aggressive behaviors. Findings include: Resident #1's Admission Minimum Data Set of 09/10/2014 documented an admission date of [DATE], and Section I - Active [DIAGNOSES REDACTED]. Section E-Behavior documented Resident #1 had physical behavioral symptoms toward others 1 to 3 days during the look-back period. A 09/03/2014, 4:10 p.m. Daily Skilled Nurses Notes (DSNN) entry documented Resident #1's facility admission from an Intensive Treatment center, and documented additional [DIAGNOSES REDACTED]. Admission physician's orders [REDACTED].#1 receive the antipsychotic [MEDICATION NAME] two (2) milligrams (mgs) by mouth at bedtime and the antianxiety drug [MEDICATION NAME] ([MEDICATION NAME]) one (1) mg, either by mouth or intramuscularly (IM), every six (6) hours as needed for agitation. Further record review for Resident #1 revealed a Preadmission Screening and Resident Review (PASRR) Level I Application, Resident Identification Screening Instrument Form which was signed by a physician and dated 09/03/2014, the date of Resident #1's nursing facility admission. This PASRR Level I Application documented, in Section 2, that Resident #1 had the mental illness of [MEDICAL CONDITION] - Residual Type as a primary (Axis 1) diagnosis, and Section 3 of this Level I Application documented that the resident did not have an Axis II [DIAGNOSES REDACTED]. A related PASRR Review Outcome Notification form dated 09/18/2012 documented that Resident #1's Level II PASRR review found Resident #1 to meet a nursing facility level of care and to be eligible to receive additional specialized services according to a plan of care to treat the resident's serious mental illness. This PASRR Review Outcome Notification form further indicated that a copy of the PASRR Medical Assessment form, which included treatment recommendations, was enclosed. Review of this attached PASRR Psychiatric and MR/RC Evaluation and Medical History form for Resident #1 revealed Section X(1.1) documented approval of nursing facility services due to a serious mental illness and specialized services. Section XI, Service Planning Recommendations of this form for Resident #1 documented a recommendation for a psychiatric consultation/evaluation by a psychiatrist for reasons including, but not limited to, management of [MEDICAL CONDITION] medications and an extensive history of cheeking medications. A facsimile date of 09/03/2014 was stamped at the top of the PASRR Review Outcome Notification and Psychiatric and MR/RC Evaluation and Medical History forms, thus documenting the facility's receipt of these documents on Resident #1's 09/03/2014 date of facility admission. However, further review of Resident #1's medical record revealed that, even though Resident #1's PASRR Review Outcome Notification and Psychiatric and MR/RC Evaluation and Medical History forms referenced above had recommend that Resident #1 receive a psychiatric consultation/evaluation by a psychiatrist, there was no evidence to indicate that Resident #1 had been evaluated by a psychiatrist, or assessed for the need to be examined by a psychiatrist, upon or after her 09/03/2014 facility admission. During an interview with the Director of Nursing (DON) conducted on 11/19/2014 at 2:45 p.m., the DON was asked about the process by which resident PASRR recommendations were addressed upon a resident's admission to the facility. The DON stated she would inquire as to this process and would provide additional information. During a subsequent interview with the DON conducted on 11/19/2014 at 3:00 p.m., the DON stated that when residents were admitted to the facility, the admission packet documents were sent by facility Admission Department personnel to the physician for his review. The DON further stated that the admission packet documents would include PASRR Level II documents, which the physician would review and give orders for treatment. However, even though the DON indicated in the 11/19/2014, 3:00 p.m. interview referenced above that Resident #1's admission documents (including the PASRR Level II forms recommending a psychiatric consultation/evaluation) should have been provided to the attending physician upon the resident's 09/30/2014 facility admission, record review revealed no evidence, nor did the facility provide evidence, to indicate the PASRR documents, including the recommendation for a psychiatric consultation/evaluation, were reviewed by the physician when Resident #1 was admitted . A Behavior Management Documentation Form for Resident #1 indicated that on 09/09/2014, approximately one (1) week after facility admission, Resident #1 was placed in a Behavioral Management Program. A related Behavioral Symptom Screening Form of 09/10/2014 documented Resident 1's [MEDICAL CONDITION], Dementia with Behavioral Disturbances, and [MEDICAL CONDITION], and documented a history of physical aggression towards staff, refusing medications, and pocketing (cheeking) medications. A 09/18/2014, 7:00 a.m. DSNN entry documented Resident #1's physician had bee notified of continued escalating behaviors, and the physician ordered the addition of [MEDICATION NAME] one (1) mg each morning. A 09/20/2014, 7:14 a.m. DSNN then documented Resident #1 had hit a certified nursing assistant (CNA), and a 09/28/2014, 1:40 p.m. DSNN documented that Resident #1 received a dose of IM [MEDICATION NAME] for increased agitation after slapping staff and pulling staffs' hair out. Review of Resident #1's Care Plan, dated as originating on 09/18/2014, revealed the Care Plan documented [DIAGNOSES REDACTED]. However, further record review for Resident #1 revealed no evidence of, or assessment for the need for, a psychiatric consultation/evaluation, as recommended on Resident #1's PASRR Psychiatric and MR/RC Evaluation and Medical History form referenced above, upon the resident's 09/09/2014 inclusion in a Behavior Management Program, or after the resident's placement in the Behavior Management Program. This was despite the fact that, as documented in the 09/20/2014, 7:14 a.m. and 09/28/2014, 1:40 p.m. DSNN entries referenced above, Resident #1 continued to show agitated behaviors of slapping staff and pulling staffs' hair. This was also despite the fact that Resident #1's Care Plan, as referenced above, specified that Resident #1 would receive a psychiatric consultation as needed, and despite Resident #1's PASRR Review Outcome Notification form indicating Resident #1 to be eligible to receive specialized services (psychiatric consultation/evaluation) according to the plan of care (Care Plan) to treat serious mental illness. Then, further record review for Resident #1 revealed an 11/02/2014, 11:00 a.m. Nurse's Notes (NN) entry which documented Resident #1 to have made verbal threats against another resident (Resident #2, who was the roommate of Resident #1), and that Resident #1 had received an IM dose of [MEDICATION NAME]. A subsequent NN entry for Resident #1 dated 11/11/2014 at 7:00 a.m. (nine days after Resident #1's documented verbal threats against Resident #2, per the 11/02/2014, 11:00 a.m. NN above) documented nursing staff had found Resident #2 not breathing and having no pulse, and with an electric cord around her neck. In an investigation summary (IS) completed by the facility as part of an investigation of the 11/11/2014 incident involving Resident #2 described in the 11/11/2014, 7:00 a.m. NN referenced above, the facility also documented the earlier, 11/02/2014 altercation which involved Resident #2 and her roommate, Resident #1. This IS documented that on 11/02/2014, staff observed Resident #1 carrying a family picture which she put in the face of Resident #2. As staff redirected Resident #1 and Resident #2, this facility IS documented that Resident #1 stated to staff I am going to get you, and then told staff, If you don't get her, I am going to get her. This IS documented that later, Resident #1 stated to the CNA I'm going to get that b---h, referring to Resident #2. During an interview with License Practical Nurse (LPN) DD conducted on 11/18/2014 at 12:45 p.m., LPN DD acknowledged that on 11/02/2014, Resident #1 had threatened Resident #2 and held a picture in Resident #2's face. LPN DD also stated that Resident #1's behavior of threatening another resident on 11/02/2014 was new behavior. However, further record review for Resident #1 revealed no evidence to indicate that, even after Resident #1 exhibited aggressive behavior by verbally threatening Resident #2, as documented in Resident #1's 11/02/2014, 11:00 a.m. NN entry referenced above, and even though this was a new form of aggressive behavior for Resident #1, as indicated in LPN DD's 11/18/2014, 12:45 p.m. interview referenced above, there was no evidence to indicate that Resident #1 received, or was assessed for the need for, a psychiatric consultation/evaluation, as recommended by the PASRR Review Outcome Notification/Psychiatric and MR/RC Evaluation and Medical History forms referenced above. During an interview with the Administrator conducted on 11/19/2014 at 2:05 p.m., the Administrator was questioned regarding the process by which PASRR recommendations, such as Resident #1's PASRR recommendation for a psychiatric consultation/evaluation, would be obtained. During this interview, the Administrator provided no information to indicate that Resident #1's psychiatric

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0406

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 10)
consultation/evaluation had been obtained, per the PASRR recommendation. During a subsequent interview with the Director of Nursing (DON) conducted on 11/19/2014 at 2:45 p.m., when asked about a psychiatric consultation/recommendation for Resident #1 as recommended on the resident's PASRR Assessment, the DON provided no evidence of Resident #1 having received a psychiatric consultation/evaluation. Further review of the facility's IS referenced above related Resident #2's 11/11/2014 death revealed the IS to document that, based on verbal reports from sources close to the police department, Resident #2's autopsy report concluded Resident #2's trachea was crushed, with a determination that Resident #1 used her hands. This facility IS documented that Resident #1 told a nurse consultant that she killed Resident #2, and further documented that Resident #1 had been arrested on 11/13/2014 and charged with felony murder and aggravated assault. Based on the above, Resident #1's [DIAGNOSES REDACTED]. Resident #1 received [MEDICAL CONDITION] medications and was admitted to the facility
on [DATE] having a PASRR recommendation for a psychiatric evaluation/consultation. However, despite Resident #1 continuing to exhibit aggressive behaviors, to include hitting staff and verbally threatening Resident #2, the facility failed to provide a psychiatric consultation/evaluation for Resident #1. Then, on 11/11/2014, Resident #2 was found on the floor in her room with an electric cord around her neck, not breathing and having no pulse. Resident #1 later stated to facility staff that she had killed Resident #2, was arrested, and was charged with felony murder and aggravated assault. Cross refer to F323 for more information regarding Resident #1. The facility presented a credible allegation of jeopardy removal (CAJR) on 11/20/2014, and it was determined that the immediate jeopardy was removed on 11/21/2014, at which time the facility had implemented the following interventions: 1. On 11/11/2014, upon the discovery of the incident of that date, Resident #1 was immediately placed on one-to-one staff observation until she was later transferred out of the facility. 2. On 11/13/2014, the facility's Interdisciplinary Team (consisting of the Administrator, DON, ADON, Admissions Personnel, LPN Supervisor, and Social Services Director) completed Behavioral Symptom Screening Forms on every facility resident. This process of resident behavior screening had been initiated on 11/12/2014. All residents screened during this process and identified as having had physical or verbal behaviors in the previous month were placed on the Behavior Monitoring Program, to ensure the monitoring of these residents and to ensure that no further behavioral interventions were necessary. All residents will have a behavior screen done upon facility admission, quarterly, upon significant change in status, and with any new behavior. 3. On 11/13/2014, the facility's Interdisciplinary Team completed a review, initially begun on 11/12/2014, of the Care Plans of all residents having any physical or verbal behaviors in the previous month. These Care Plans were revised as needed, based on these reviews. Resident Care Plans will be reviewed quarterly, annually, with a significant change in condition, and with any new behavior. 4. On 11/14/2014, the facility's Medical Director reviewed Resident #1's medical record, making no recommendations. 5. On 11/19/2014, the facility implemented a procedure by which the Interdisciplinary Team would screen and review all new resident admissions. This screening process would apply to all new resident admissions, and no resident would be admitted until a detailed review of the resident's mental condition and the potential for aggressive or physical behaviors can be assessed. This resident screening and review will be documented on the Admission Audit Tool, which documents: the date; the resident's name; the History and Physical; PASRR Level II; Nurse' Notes/MR notation; any Consultation Information; and a signature of the reviewer. 6. On 11/20/2014, the facility implemented a new procedure by which the Administrator would conduct a monthly audit of a minimum of 10 percent of the Resident Behavioral Symptom Screening forms and resident Care Plans for residents in behavioral management, to ensure the accuracy and completion of these documents. The Administrator will conduct a monthly audit of a minimum of 10 percent of the Behavior Management Documentation Form for residents in behavioral management, to ensure the accuracy and completion of this Form. This Form (a previously existing form) allows for the weekly documentation of residents in the Behavior Management Program, the tracking of the effectiveness of existing behavioral interventions, and the documentation of any newly developed interventions. In addition, the Administrator will conduct a monthly audit of a minimum of 10 percent of the Behavior Management Log Forms (a previously existing form) for all residents in a Behavior Management Program, to ensure accuracy and completion of this Form. This Form serves to document any observed behaviors, including agitated or combative behaviors, per day and per shift. These monthly form audits referenced above will be documented by the Administrator dating and signing the review of each of the referenced forms. 7. On 11/20/2014, the facility implemented a procedure by which a designated CNA was to document, using the Behavior Monitoring Form, continuous rounds in the Memory Support Unit on the hallways and resident areas to monitor for any aggressive resident behavior. This Behavior Monitoring Form allows for the documentation of resident behaviors, interventions, the reporting of the behavior(s) to the Charge Nurse and the identity of the staff member reporting the behavior, and a signature of the nurse of verification. If, during these continuous rounds conducted on the Memory Support Unit, behaviors were observed, this staff member was to intervene as necessary to de-escalate the behavior, and also to report the resident behavior to the Charge Nurse. This monitoring was actually initiated on 11/11/2014, when the staff member was immediately assigned to the Memory Support Unit to begin the continuous rounds. 8. On 11/20/2014, the facility's Interdisciplinary Team continued the process of reviewing resident Preadmission Screening and Resident Review (PASRR) Level II Assessments. This review revealed three (3) residents having PASRR Level II assessments with a recommendation for a psychiatric consultation. One (1) of these residents was seen by a psychiatrist on a regular basis. Appointments were made on 11/20/2014 for the remaining two (2) residents, identified with recommendations for a psychiatric consultation, to have a consultation with a psychiatrist. On 11/20/2014, the facility implemented a procedure by which the Administrator or Social Service Director will make a copy of each resident's PASRR, and initial and date that copy, which will then be kept in the resident's medical record. 9. On 11/20/2014, the facility's Interdisciplinary Team continued to provide staff in-service training related to a number of areas. In-service training was provided to staff to educate them in ways to prevent abuse, including behaviors what to report, and to whom to report observations of resident abuse. This included both physical and verbal resident behaviors. This in-service training also addressed how to identify abuse by observation of residents having suspicious bruising, showing signs of being afraid, or patterns of behaviors. Staff were informed that any resident suspected of any alleged abuse would be protected from any further abuse by the removal of the alleged perpetrator from the facility, as deemed appropriate. Staff were advised of reporting any alleged abuse immediately to their supervisor, leading up to the Administrator, who would then report the allegation of abuse to the appropriate State and corporate agencies. In-service training was also provided regarding employment screening, via criminal background checks, reference checks, and licensure/certification verification. As of 11/20/2014, eighty-nine (89) of one-hundred-and-two (102) staff had received this in-service training. This number included thirty-three (33) of thirty-seven (37) CNA staff; thirteen (13) of fourteen (14) LPN staff; nine (9) of eleven (11) housekeepers; four (4) of five (5) laundry workers; seventeen (17) of twenty (20) dietary workers; seven (7) of eight (8) Registered Nurses; seven (7) of seven (7) department heads (not including the DON, ADON, LPN Supervisor, Senior Care Partner, and MDS Nurse) that did not include nurses, including the Activities Director, Social Worker, Maintenance Director, Financial Counselor, Medical Records, Admissions Coordinator, and Housekeeping Supervisor. The remaining four (4) CNA staff, one (1) LPN staff, two (2) housekeepers, one (1) laundry worker, three (3) dietary workers, and one (1) Registered Nurse who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. Additionally, going forward, all employees will receive training upon hire during the orientation process, and quarterly, related to resident abuse, resident neglect, and the procedures by which to deal with residents having verbal or physical behaviors. 10. On 11/20/2014, the Interdisciplinary Team continued to conduct additional staff in-service training, originally initiated on 11/14/2014, specifically intended for licensed nursing staff and CNA staff regarding the resident behavior management policies and the documentation of resident behaviors. As of 11/20/2014, six (6) of eight (8) Registered Nurses, thirteen (13) of fourteen (14) LPN staff, and thirty-one (31) of thirty-seven (37) CNA staff had received this in-service training. The remaining two (2) Registered Nurses, one (1) LPN, and six (6) CNA staff who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. 11. On 11/20/2014, staff in-service training was conducted regarding the notification of the physician of a change in condition and of new resident behaviors. As of 11/20/2014, eleven (11) of fourteen (14) LPN staff and seven (7) of eight (8) Registered Nurses had received this training. The remaining three (3) LPN staff and one (1) Registered Nurse who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. 12. On 11/20/2014, the facility implemented a new procedure by which the results of Administrator and/or Social Service Director audits of the Admission Audit Tool, Behavior Monitoring Form, Behavior Management Documentation Form, Behavior Symptom Screening Form, Management
Log Form, and Care Plan and PASRR Assessment reviews would be presented to the QA Sub-Committee each week for four (4)

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NAME OF PROVIDER OF SUPPLIER **PRUITTHEALTH - CRESTWOOD**		STREET ADDRESS, CITY, STATE, ZIP **415 PENDLETON PLACE VALDOSTA, GA 31602**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0406 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 11) weeks, then monthly by the Administrator or Director of Health Services. This process will allow the QA Sub-Committee to monitor staff compliance with the facility's policies and procedures regarding residents having verbal and/or physically aggressive behaviors which could have the potential to lead to resident abuse. Audit results will also be presented to the facility's QA Committee quarterly for the Committee's review and oversight of facility staff conformance with facility policies and procedures related to the management of resident behaviors, the screening of resident behaviors, physician notification, and resident monitoring. During this abbreviated survey, the State Survey Agency reviewed the corrective actions implemented by the facility, as reflected in the CAJR referenced above, with findings as follow: - On 11/21/2014, a review of facility investigative documents, including the facility IS, confirmed that Resident #1 was immediately placed on one-to-one observation on 11/11/2014 immediately after the incident involving Resident #1 and Resident #2, as indicated in Step #1 of the CAJR referenced above. - On 11/21/2014, a sampled review of resident records completed on that date, but which had been ongoing throughout the abbreviated survey, revealed that the Interdisciplinary Team had conducted behavioral screenings on residents for the purpose of ensuring appropriate resident placement in the Behavioral Monitoring Program, as indicated in Step #2 of the CAJR referenced above. - On 11/21/2014, a sampled review of multiple resident records, but which had been ongoing throughout the abbreviated survey, was completed and verified that resident Care Plans had been reviewed and updated by the Interdisciplinary Team, as related to physically/verbally aggressive behaviors. This was in accordance with Step #3 of the CAJR referenced above. - On 11/21/2014, review of facility investigative documents confirmed that the Medical Director had reviewed Resident #1's medical record and submitted a written summary of this information to the facility on [DATE]. This was in accordance with Step #4 of the CAJR referenced above. (Of note, on 11/20/2014 at 11:12 a.m., a telephone call had been placed to Resident #1's physician, but the physician declined interview.) - On 11/21/2014, interview with the Administrator at 11:20 a.m. confirmed that the Interdisciplinary Team will screen and review all new resident admissions, with no resident being admitted until a review of the resident's medical condition and potential for aggressive behaviors can be assessed. This review will be documented using the Admission Audit Tool. This Team will include the Administrator, DON, ADON, Admissions Personnel, an LPN Supervisor, and the Social Services Director. This was in accordance with Step #5 of the CAJR referenced above. - On 11/21/2014, facility document review and interview with the Administrator confirmed that the Administrator will be conducting monthly audits of the Resident Behavioral Symptom Screening forms, the Behavior Management Documentation Forms, the Behavior Management Log Forms, and resident Care Plans for resident requiring behavioral management services. This was in accordance with Step #6 of the CAJR referenced above. - On 11/21/2014, a 9:55 a.m. observation on the Secured Unit confirmed the presence of an assigned staff member to conduct ongoing and continuous rounds for the purpose of observing for any resident aggressive behaviors. These rounds were documented on the Behavior Monitoring Form. In addition, it was confirmed by interview with the Administrator that this process of ongoing, continuous rounds will be a permanent intervention. This was in accordance with Step #7 of the CAJR referenced above. - On 11/21/2014, a sampled review of resident records, which had been ongoing throughout the abbreviated survey, was completed and verified that the Interdisciplinary Team had reviewed all resident PASRR Level II Assessments, with the appropriate follow-up for residents needing additional psychiatric services. This action was also confirmed during an 11/21/2014, 10:45 interview with a Corporate Nursing Consultant. This was in accordance with Step #8 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted staff in-service training for staff, including (but not limited to) licensed nursing staff, CNA staff, Social Services staff, MDS staff, Medical Records staff, the Maintenance Director, and the Admissions Coordinator, regarding resident abuse and the Behavior Management Policy. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #9 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted additional staff in-service training, specific for licensed nursing staff and CNA staff, regarding resident behavior management policies and the documentation of resident behaviors. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #10 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted additional staff in-service training, specific for licensed nursing staff, regarding the notification of the physician for changes in condition and new resident behaviors. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #11 of the CAJR referenced above. - On 11/21/2014, an 11:20 a.m. interview with the Administrator confirmed that the results of all audits, as referenced in the CAJR intended to provide ongoing management level oversight of the assessment, planning of care, and provision of care to residents having behavioral problems, will be reviewed by the QA Committee to provide ongoing QA Committee oversight of this care. This was in accordance with Step #12 of the CAJR referenced above. Based on these corrective actions which had been developed and implemented by the facility as outlined in the CAJR referenced above, it was determined that the immediacy of the deficient practice had been removed on 11/21/2014; however, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. On 11/19/2014, the facility implemented
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility document review, and staff interview, facility administration failed to ensure intervention and supervision in response to verbal threats and aggression exhibited by one (1) resident (Resident #1) toward another resident (Resident #2), on the total survey sample of eleven (11) residents. Resident #1, who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1 was then discontinued from the Behavior Management Program on 10/21/2014, and the physician documented in a 10/28/2014 Physician's Progress Notes entry that the resident's mood, [MEDICAL CONDITION] Disorder, and [MEDICAL CONDITION] were stable. However, the facility failed to notify Resident #1's physician of the resident's ongoing refusal of drug therapy during October of 2014, and failed to notify the physician of an incident of 11/02/2014 when Resident #1 experienced a change in behavior and was reported to have made multiple verbal threats against Resident #2. The facility failed to put measures into place to ensure close monitoring of Resident #1 and failed to place Resident #1 in the Behavior Management Program, as specified by Facility Policy, after this 11/02/2014 incident. The facility also failed to evaluate Resident #1 regarding the need for a psychiatric consultation. On 11/11/2014, Resident #2 was discovered not breathing, having no pulse, and having an electric cord around her neck. Resident #1 stated to facility staff that she had killed Resident #2, and Resident #1 was later arrested and charged with felony murder and aggravated assault. This resulted in a situation in which the facility's noncompliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment or death to residents. The facility's Administrator and Corporate Consultant were informed of the immediate jeopardy on November 19, 2014 at 3:36 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on November 11, 2014, the date Resident #1 was documented as stating she killed her roommate, Resident #2, after Resident #2 was found to have no respirations, no pulse, and with an electric cord around her neck, and nine (9) days after November 2, 2014, when the facility failed to enact interventions in response to Resident #1's verbal threats against Resident #2. The immediate jeopardy continued through November 20, 2014, and was removed on November 21, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on November 20, 2014. During an interview conducted on 11/19/2014 at 12:20 p.m., the Administrator acknowledged the 11/02/2014 incident involving Resident #1's verbal threat toward Resident #2, and stated that Resident #1's verbally threatening behavior was discussed in the facility's morning meeting on 11/03/2014. However, during a later 11/19/2014, 2:30 p.m. interview, the Administrator acknowledged that no new interventions were developed and implemented in response to Resident #1's verbal threats against Resident #2 on 11/02/2014. An allegation of jeopardy removal was received on November 20, 2014. Based on the corrective plans which had been developed and implemented by the facility via a credible allegation of jeopardy removal on November 20, 2014, the immediacy of the deficient practice was determined to have been removed on November 21, 2014. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of staffs' monitoring of resident behaviors, resident screening and placement in the Behavior Management Program as indicated, resident Care Plan updating and implementation regarding resident behaviors, and physician notification of resident behavioral changes, in accordance with facility policies and procedures. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about facility policies and procedures governing resident monitoring and the reporting of resident behavioral changes to supervisors and the physician, to therefore ensure resident safety. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **115385**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/21/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH - CRESTWOOD	**415 PENDLETON PLACE VALDOSTA, GA 31602**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 12) records were reviewed to ensure that resident assessments and Care Plans accurately reflected the current status of residents, including the development and implementation of interventions to address aggressive behaviors. Findings include: Cross refer to F323. Based on clinical record review, facility document review, facility Policy review, and staff interview, the facility failed to provide supervision in response to the verbal threats/aggression of one (1) resident (Resident #1), who made verbal threats toward Resident #2, to ensure the safety of Resident #2, from a total survey sample of eleven (11) residents. Resident #1, who had [DIAGNOSES REDACTED]. Evidence indicated that Resident #1 had no observed/reported behaviors from 10/01/2014 through 10/21/2014, and was discontinued from Behavior Management. On 11/02/2014, Resident #1 was reported to make verbal threats against Resident #2 (Resident #1's roommate), including If you don't get her, I am going to get her, and I'm going to get that b---h; however, the facility failed to develop and implement interventions for monitoring of Resident #1 related to her verbally threatening behavior, failed to place Resident #1 in the Behavior Management Program per Policy, and failed to notify Resident #1's physician regarding this change in behavior for Resident #1. On 11/11/2014, facility staff discovered Resident #2 not breathing, having no pulse, and with an electric cord around her neck. Resident #1 stated to facility staff that she had killed Resident #2, and Resident #1 was arrested and charged with felony murder and aggravated assault. During an interview with the Administrator conducted on 11/19/2014 at 12:20 p.m., the 11/02/2014 incident during which Resident #1 made verbal threats against Resident #2 was discussed. Additionally, the Administrator was asked about the 11/11/2014 altercation between Resident #1 and Resident #2, after which Resident #2 was discovered having no respiration and no pulse, and after which Resident #1 stated to facility staff that she had killed Resident #2. In relation to the 11/02/2014 incident involving Resident #1's verbal threat toward Resident #2, the Administrator acknowledged awareness the incident, stating that this incident had been discussed in the morning staff meeting of 11/03/2014, which she had attended. During a subsequent interview with the Administrator conducted on 11/19/2014 at 2:30 p.m., the Administrator was again questioned about the 11/02/2014 incident when Resident #1 expressed verbal threats toward Resident #2, and was asked about what specific action or actions were taken after the 11/02/2014 incident to address Resident #1's verbal threats against Resident #2. The Administrator stated that after Resident #1 verbally threatened Resident #2 on 11/02/2014, facility staff administered intramuscular [MEDICATION NAME] to Resident #1, and also redirected the residents. However, the Administrator acknowledged that the administration of the antianxiety medication [MEDICATION NAME] to Resident #1 and the redirection of the residents were interventions which had been in place prior to the 11/02/2014 incident. The Administrator further acknowledged that no new interventions had been developed, or actions taken, after Resident #1 verbally threatened Resident #2 on 11/02/2014. The Administrator could provide no evidence of any new interventions that she had put into place, or actions she had taken, in response to Resident #1's 11/02/2014 threatening behavior toward Resident #2, even though she had been made aware of the incident during the morning staff meeting of 11/03/2014. Subsequent to the 11/02/2014 incident of Resident #1 verbally threatening Resident #2, and to the 11/03/2014 morning staff meeting during which this incident was discussed, Resident #2 was found not breathing, having no pulse, and with an electric cord around her neck on 11/11/2014. Resident #1 later acknowledged to facility staff she had killed Resident #2, and was arrested and charged with felony murder and aggravated assault. The facility presented a credible allegation of jeopardy removal (CAJR) on 11/20/2014, and it was determined that the immediate jeopardy was removed on 11/21/2014, at which time the facility had implemented the following interventions: 1. On 11/11/2014, upon the discovery of the incident of that date, Resident #1 was immediately placed on one-to-one staff observation until she was later transferred out of the facility. 2. On 11/13/2014, the facility's Interdisciplinary Team (consisting of the Administrator, DON, ADON, Admissions Personnel, LPN Supervisor, and Social Services Director) completed Behavioral Symptom Screening Forms on every facility resident. This process of resident behavior screening had been initiated on 11/12/2014. All residents screened during this process and identified as having had physical or verbal behaviors in the previous month were placed on the Behavior Monitoring Program, to ensure the monitoring of these residents and to ensure that no further behavioral interventions were necessary. All residents will have a behavior screen done upon facility admission, quarterly, upon significant change in status, and with any new behavior. 3. On 11/13/2014, the facility's Interdisciplinary Team completed a review, initially begun on 11/12/2014, of the Care Plans of all residents having any physical or verbal behaviors in the previous month. These Care Plans were revised as needed, based on these reviews. Resident Care Plans will be reviewed quarterly, annually, with a significant change in condition, and with any new behavior. 4. On 11/14/2014, the facility's Medical Director reviewed Resident #1's medical record, making no recommendations. 5. On 11/19/2014, the facility implemented a procedure by which the Interdisciplinary Team would screen and review all new resident admissions. This screening process would apply to all new resident admissions, and no resident would be admitted until a detailed review of the resident's mental condition and the potential for aggressive or physical behaviors can be assessed. This resident screening and review will be documented on the Admission Audit Tool, which documents: the date; the resident's name; the History and Physical; PASRR Level II; Nurse' Notes/MR notation; any Consultation Information; and a signature of the reviewer. 6. On 11/20/2014, the facility implemented a new procedure by which the Administrator would conduct a monthly audit of a minimum of 10 percent of the Resident Behavioral Symptom Screening forms and resident Care Plans for residents in behavioral management, to ensure the accuracy and completion of these documents. The Administrator will conduct a monthly audit of a minimum of 10 percent of the Behavior Management Documentation Form for residents in behavioral management, to ensure the accuracy and completion of this Form. This Form (a previously existing form) allows for the weekly documentation of residents in the Behavior Management Program, the tracking of the effectiveness of existing behavioral interventions, and the documentation of any newly developed interventions. In addition, the Administrator will conduct a monthly audit of a minimum of 10 percent of the Behavior Management Log Forms (a previously existing form) for all residents in a Behavior Management Program, to ensure accuracy and completion of this Form. This Form serves to document any observed behaviors, including agitated or combative behaviors, per day and per shift. These monthly form audits referenced above will be documented by the Administrator dating and signing the review of each of the referenced forms. 7. On 11/20/2014, the facility implemented a procedure by which a designated CNA was to document, using the Behavior Monitoring Form, continuous rounds in the Memory Support Unit on the hallways and resident areas to monitor for any aggressive resident behavior. This Behavior Monitoring Form allows for the documentation of resident behaviors, interventions, the reporting of the behavior(s) to the Charge Nurse and the identity of the staff member reporting the behavior, and a signature of the nurse of verification. If, during these continuous rounds conducted on the Memory Support Unit, behaviors were observed, this staff member was to intervene as necessary to de-escalate the behavior, and also to report the resident behavior to the Charge Nurse. This monitoring was actually initiated on 11/11/2014, when the staff member was immediately assigned to the Memory Support Unit to begin the continuous rounds. 8. On 11/20/2014, the facility's Interdisciplinary Team continued the process of reviewing resident Preadmission Screening and Resident Review (PASRR) Level II Assessments. This review revealed three (3) residents having PASRR Level II assessments with a recommendation for a psychiatric consultation. One (1) of these residents was seen by a psychiatrist on a regular basis. Appointments were made on 11/20/2014 for the remaining two (2) residents, identified with recommendations for a psychiatric consultation, to have a consultation with a psychiatrist. On 11/20/2014, the facility implemented a procedure by which the Administrator or Social Service Director will make a copy of each resident's PASRR, and initial and date that copy, which will then be kept in the resident's medical record. 9. On 11/20/2014, the facility's Interdisciplinary Team continued to provide staff in-service training related to a number of areas. In-service training was provided to staff to educate them in ways to prevent abuse, including behaviors what to report, and to whom to report observations of resident abuse. This included both physical and verbal resident behaviors. This in-service training also addressed how to identify abuse by observation of residents having suspicious bruising, showing signs of being afraid, or patterns of behaviors. Staff were informed that any resident suspected of any alleged abuse would be protected from any further abuse by the removal of the alleged perpetrator from the facility, as deemed appropriate. Staff were advised of reporting any alleged abuse immediately to their supervisor, leading up to the Administrator, who would then report the allegation of abuse to the appropriate State and corporate agencies. In-service training was also provided regarding employment screening, via criminal background checks, reference checks, and licensure/certification verification. As of 11/20/2014, eighty-nine (89) of one-hundred-and-two (102) staff had received this in-service training. This number included thirty-three (33) of thirty-seven (37) CNA staff; thirteen (13) of fourteen (14) LPN staff; nine (9) of eleven (11) housekeepers; four (4) of five (5) laundry workers; seventeen (17) of twenty (20) dietary workers; seven (7) of eight (8) Registered Nurses; seven (7) of seven (7) department heads (not including the DON, ADON, LPN Supervisor, Senior Care Partner, and MDS Nurse) that did not include nurses, including the Activities Director, Social Worker, Maintenance Director, Financial Counselor,

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH - CRESTWOOD	**415 PENDLETON PLACE VALDOSTA, GA 31602**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 13) Medical Records, Admissions Coordinator, and Housekeeping Supervisor. The remaining four (4) CNA staff, one (1) LPN staff, two (2) housekeepers, one (1) laundry worker, three (3) dietary workers, and one (1) Registered Nurse who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. Additionally, going forward, all employees will receive training upon hire during the orientation process, and quarterly, related to resident abuse, resident neglect, and the procedures by which to deal with residents having verbal or physical behaviors. 10. On 11/20/2014, the Interdisciplinary Team continued to conduct additional staff in-service training, originally initiated on 11/14/2014, specifically intended for licensed nursing staff and CNA staff regarding the resident behavior management policies and the documentation of resident behaviors. As of 11/20/2014, six (6) of eight (8) Registered Nurses, thirteen (13) of fourteen (14) LPN staff, and thirty-one (31) of thirty-seven (37) CNA staff had received this in-service training. The remaining two (2) Registered Nurses, one (1) LPN, and six (6) CNA staff who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. 11. On 11/20/2014, staff in-service training was conducted regarding the notification of the physician of a change in condition and of new resident behaviors. As of 11/20/2014, eleven (11) of fourteen (14) LPN staff and seven (7) of eight (8) Registered Nurses had received this training. The remaining three (3) LPN staff and one (1) Registered Nurse who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. 12. On 11/20/2014, the facility implemented a new procedure by which the results of Administrator and/or Social Service Director audits of the Admission Audit Tool, Behavior Monitoring Form, Behavior Management Documentation Form, Behavior Symptom Screening Form, Management Log Form, and Care Plan and PASRR Assessment reviews would be presented to the QA Sub-Committee each week for four (4) weeks, then monthly by the Administrator or Director of Health Services. This process will allow the QA Sub-Committee to monitor staff compliance with the facility's policies and procedures regarding residents having verbal and/or physically aggressive behaviors which could have the potential to lead to resident abuse. Audit results will also be presented to the facility's QA Committee quarterly for the Committee's review and oversight of facility staff conformance with facility policies and procedures related to the management of resident behaviors, the screening of resident behaviors, physician notification, and resident monitoring. During this abbreviated survey, the State Survey Agency reviewed the corrective actions implemented by the facility, as reflected in the CAJR referenced above, with findings as follow: - On 11/21/2014, a review of facility investigative documents, including the facility IS, confirmed that Resident #1 was immediately placed on one-to-one observation on 11/11/2014 immediately after the incident involving Resident #1 and Resident #2, as indicated in Step #1 of the CAJR referenced above. - On 11/21/2014, a sampled review of resident records completed on that date, but which had been ongoing throughout the abbreviated survey, revealed that the Interdisciplinary Team had conducted behavioral screenings on residents for the purpose of ensuring appropriate resident placement in the Behavioral Monitoring Program, as indicated in Step #2 of the CAJR referenced above. - On 11/21/2014, a sampled review of multiple resident records, but which had been ongoing throughout the abbreviated survey, was completed and verified that resident Care Plans had been reviewed and updated by the Interdisciplinary Team, as related to physically/verbally aggressive behaviors. This was in accordance with Step #3 of the CAJR referenced above. - On 11/21/2014, review of facility investigative documents confirmed that the Medical Director had reviewed Resident #1's medical record and submitted a written summary of this information to the facility on [DATE]. This was in accordance with Step #4 of the CAJR referenced above. (Of note, on 11/20/2014 at 11:12 a.m., a telephone call had been placed to Resident #1's physician, but the physician declined interview.) - On 11/21/2014, interview with the Administrator at 11:20 a.m. confirmed that the Interdisciplinary Team will screen and review all new resident admissions, with no resident being admitted until a review of the resident's medical condition and potential for aggressive behaviors can be assessed. This review will be documented using the Admission Audit Tool. This Team will include the Administrator, DON, ADON, Admissions Personnel, an LPN Supervisor, and the Social Services Director. This was in accordance with Step #5 of the CAJR referenced above. - On 11/21/2014, facility document review and interview with the Administrator confirmed that the Administrator will be conducting monthly audits of the Resident Behavioral Symptom Screening forms, the Behavior Management Documentation Forms, the Behavior Management Log Forms, and resident Care Plans for resident requiring behavioral management services. This was in accordance with Step #6 of the CAJR referenced above. - On 11/21/2014, a 9:55 a.m. observation on the Secured Unit confirmed the presence of an assigned staff member to conduct ongoing and continuous rounds for the purpose of observing for any resident aggressive behaviors. These rounds were documented on the Behavior Monitoring Form. In addition, it was confirmed by interview with the Administrator that this process of ongoing, continuous rounds will be a permanent intervention. This was in accordance with Step #7 of the CAJR referenced above. - On 11/21/2014, a sampled review of resident records, which had been ongoing throughout the abbreviated survey, was completed and verified that the Interdisciplinary Team had reviewed all resident PASRR Level II Assessments, with the appropriate follow-up for residents needing additional psychiatric services. This action was also confirmed during an 11/21/2014, 10:45 interview with a Corporate Nursing Consultant. This was in accordance with Step #8 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted staff in-service training for staff, including (but not limited to) licensed nursing staff, CNA staff, Social Services staff, MDS staff, Medical Records staff, the Maintenance Director, and the Admissions Coordinator, regarding resident abuse and the Behavior Management Policy. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #9 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted additional staff in-service training, specific for licensed nursing staff and CNA staff, regarding resident behavior management policies and the documentation of resident behaviors. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #10 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted additional staff in-service training, specific for licensed nursing staff, regarding the notification of the physician for changes in condition and new resident behaviors. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #11 of the CAJR referenced above. - On 11/21/2014, an 11:20 a.m. interview with the Administrator confirmed that the results of all audits, as referenced in the CAJR intended to provide ongoing management level oversight of the assessment, planning of care, and provision of care to residents having behavioral problems, will be reviewed by the QA Committee to provide ongoing QA Committee oversight of this care. This was in accordance with Step #12 of the CAJR referenced above. Based on these corrective actions which had been developed and implemented by the facility as outlined in the CAJR referenced above, it was determined that the immediacy of the deficient practice had been removed on 11/21/2014; however, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. On 11/19/2014, the facility implemented a procedure by which the Interdisciplinary Team will screen and review all new resident admissions, and no resident will be admitted until a detailed review of the resident's mental condition and the potential for aggressive or physical behaviors can be assessed. This resident screening and review will be documented on the Admission Audit Tool. This was, however, a new procedure, having been implemented on 11/19/2014, only two (2) days prior to the 11/21/2014 exit date of this abbreviated survey; therefore, the Interdisciplinary Team's ongoing compliance with this newly-implemented procedure could not be fully evaluated at the time of survey exit, and will need further review on a future date. On 11/20/2014, the facility implemented a new procedure by which designated staff was to document, using the Behavior Monitoring Form, continuous rounds in the Memory Support Unit on the hallways and resident areas to monitor for any aggressive resident behavior. The use of this Behavior Monitoring Form was, however, only implemented as of 11/20/2014, one (1) day prior to the 11/21/2014 date of survey exit, thereby preventing the evaluation of facility staffs' ongoing compliance with the use of this Form and concomitant monitoring of aggressive resident behaviors. Such compliance will require further review on a future date. In addition, on 11/20/2014, the facility's Interdisciplinary Team continued to provide staff in-service training which included abuse prevention and reporting, and the identification of abuse by observation of residents having suspicious bruising, showing signs of being afraid, or patterns of behaviors. As of 11/20/2014, thirty-three (33) of thirty-seven (37) CNA staff, thirteen (13) of fourteen (14) LPN staff, nine (9) of eleven (11) housekeepers, four (4) of five (5) laundry workers, seventeen (17) of twenty (20) dietary workers, and seven (7) of eight (8) Registered Nurses had received this in-service training. The remaining four (4) CNA staff, one (1) LPN staff, two (2) housekeepers, one (1)

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NAME OF PROVIDER OF SUPPLIER **PRUITTHEALTH - CRESTWOOD**		STREET ADDRESS, CITY, STATE, ZIP **415 PENDLETON PLACE VALDOSTA, GA 31602**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 14) laundry worker, three (3) dietary workers, and one (1) Registered Nurse who had not been available due to being off duty or on leave will receive this in-service training upon their return to work. On 11/20/2014, the Interdisciplinary Team continued to conduct additional staff in-service training for licensed nursing staff and CNA staff regarding the resident behavior management policies and the documentation of resident behaviors. As of 11/20/2014, six (6) of eight (8) Registered Nurses, thirteen (13) of fourteen (14) LPN staff, and thirty-one (31) of thirty-seven (37) CNA staff had received this in-service training. The remaining two (2) Registered Nurses, one (1) LPN, and six (6) CNA staff will need to receive this in-service training upon their return to work. Also, on 11/20/2014, staff in-service training was conducted regarding the notification of the physician of a change in condition and of new resident behaviors for eleven (11) of fourteen (14) LPN staff and seven (7) of eight (8) Registered Nurses, but the remaining three (3) LPN staff and one (1) Registered Nurse will receive this in-service training upon their return to work. Therefore, due to multiple licensed and certified staff members yet remaining to receive in-service training at the time of survey exit, their completion of this required training could not be assessed at the time of survey exit, and will need to be evaluated at a future time. Therefore, due to the need for future evaluation and assessment of the facility's ongoing compliance with newly-implemented procedures regarding the assessment, supervision, and monitoring of residents having aggressive behaviors, to include pending staff in-service training regarding these issues, the noncompliance continues, with the scope and severity of the deficiency reduced to the D level.
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility document review, and staff interview, the facility failed to ensure the involvement of the Quality Assurance (QA) Committee in the development of a corrective action plan formulated in response to 11/02/2014 and 11/11/2014 altercations between Resident #1 and Resident #2. Resident #1 had [DIAGNOSES REDACTED].#2. However, the facility failed to notify Resident #1's physician of this 11/02/2014 incident when Resident #1 experienced a change in behavior by making these verbal threats against Resident #2. The facility failed to ensure close monitoring of Resident #1 and failed to place Resident #1 in the Behavior Management Program per facility Policy after this incident, and also failed to evaluate Resident #1 for the need for a psychiatric consultation. On 11/11/2014, Resident #2 was discovered not breathing, having no pulse, and having an electric cord around her neck. Resident #1 was documented as reporting to facility staff that she had killed Resident #2, and Resident #1 was later arrested and charged with felony murder and aggravated assault. This resulted in a situation in which the facility's noncompliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment or death to residents. The facility's Administrator and Corporate Consultant were informed of the immediate jeopardy on November 19, 2014 at 3:36 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on November 11, 2014, the date Resident #1 was documented as stating she had killed her roommate, Resident #2, after Resident #2 was found to have no respirations, no pulse, and with an electric cord around her neck, and nine (9) days after November 2, 2014, when the facility failed to enact interventions in response to Resident #1's verbal threats against Resident #2. The immediate jeopardy continued through November 20, 2014, and was removed on November 21, 2014. The facility implemented a credible allegation of jeopardy removal (CAJR) related to the immediate jeopardy on November 20, 2014. During an interview conducted on 11/21/2014 at 11:20 a.m., the Administrator stated that a QA Sub-Committee had met to discuss the issues involved in the 11/02/2014 and 11/11/2014 incidents involving Resident #1 and Resident #2, and to discuss the corrective action plan formulated related to these incidents. However, the Administrator acknowledged that a formal QA Committee meeting had not been held to review and discuss these identified quality deficiencies. The Administrator further acknowledged that, while all members of the QA Committee had reviewed and approved the CAJR, this review was not completed until 11/21/2014, the exit date of this abbreviated survey, and provided no evidence to indicate that the QA Committee had been involved in the formulation of this CAJR. An allegation of jeopardy removal was received on November 20, 2014. Based on the corrective plans which had been developed and implemented by the facility via a credible allegation of jeopardy removal on November 20, 2014, the immediacy of the deficient practice was determined to have been removed on November 21, 2014. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of staffs' monitoring of resident behaviors, resident screening and placement in the Behavior Management Program as indicated, resident Care Plan updating and implementation regarding resident behaviors, and physician notification of resident behavioral changes, in accordance with facility policies and procedures. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about facility policies and procedures governing resident monitoring and the reporting of resident behavioral changes to supervisors and the physician, to therefore ensure resident safety. Resident records were reviewed to ensure that resident assessments and Care Plans accurately reflected the current status of residents, including the development and implementation of interventions to address aggressive behaviors. Findings include: Cross refer to F323. Based on record review, facility document review, facility Policy review, and staff interview, the facility failed to supervise one (1) resident (Resident #1) to ensure the safety of her roommate (Resident #2), toward whom Resident #1 had made verbal threats. The total survey sample was eleven (11) residents. Resident #1 had [DIAGNOSES REDACTED]. Nursing documentation indicated Resident #1 had no observed/reported behaviors from 10/01/2014 through 10/21/2014, and she was discontinued from Behavior Management. Resident #1 was then reported to make verbal threats against Resident #2 on 11/02/2014, including If you don't get her, I am going to get her, and I'm going to get that b---h. However, the facility developed and implemented no interventions for monitoring Resident #1 in response to this incident, did not place Resident #1 in the Behavior Management Program as the Program Policy specified, and did not notify Resident #1's physician of this change in behavior. On 11/11/2014, Resident #2 was found not breathing, with no pulse, and with an electric cord around her neck. Resident #1 stated to staff that she had killed Resident #2 and was arrested and charged with felony murder and aggravated assault. During an interview with the Administrator conducted on 11/21/2014 at 11:20 a.m., the Administrator was questioned about the facility's Quality Assurance (QA) Committee Process. During this interview, the Administrator was asked if the facility had identified a problem related to resident altercations or the Behavior Management Program prior to the 11/11/2014 incident involving Resident #1 and Resident #2. During this interview, the Administrator stated that prior to the 11/11/2014 altercation between Resident #1 and Resident #2, the facility had identified no problems or quality deficiencies related to resident-to-resident incidents or related to the facility's Behavior Management Program. During the 11/21/2014, 11:20 a.m. interview referenced above, the Administrator was also questioned about the QA Committee's review of the 11/02/2014 incident of Resident #1 voicing verbal threats toward Resident #2 and the 11/11/2014 incident involving Resident #2 being found not breathing and with no pulse, after which Resident #1 acknowledged to staff that she had killed Resident #2. In addition, during this interview, the Administrator was asked about the QA Committee's involvement in the development of the corrective action plan which was formulated and implemented by the facility (and subsequently submitted on 11/20/2014 as the CAJR) in response to the 11/02/2014 and 11/11/2014 altercations between Resident #1 and #2. The Administrator stated that a QA Sub-Committee (which, as documented in the CAJR, would have included the Administrator, DHS, Assistant DHS, MDS staff, Activities Director, Social Worker, Senior Care Partner, Maintenance Director, Financial Counselor, Medical Records personnel, Dietary Manager, Admissions Coordinator, Licensed Practical Nurse Supervisor, and Housekeeping Supervisor) had met to discuss the issues involved in the 11/02/2014 and 11/11/2014 incidents which resulted in immediate jeopardy. The Administrator stated that the QA Sub-Committee had also discussed the corrective action plan which was submitted by the facility as the CAJR related to the immediate jeopardy. The Administrator further stated, however, that the formal QA Committee had not yet met to review and discuss the identified quality deficiencies related to the 11/02/2014 and 11/11/2014 altercations involving Resident #1 and Resident #2. Rather, a date had been set for the QA Committee to meet the first week of December 2014 to begin that process. During the 11/21/2014, 11:20 a.m. interview with the Administrator referenced above, the Administrator was also asked whether, in the absence of any actual QA Committee meeting, all members of the QA Committee had reviewed and approved the CAJR, and if so, when this review had been completed. In an 11/21/2014, 12:11 P.M. follow-up interview with the Administrator, the Administrator again stated that the QA Committee had not met as a whole group as of that time, but that all QA Committee members had reviewed and approved the CAJR as of that morning of 11/21/2014. Additionally, although the Administrator indicated in the 11/21/2014, 12:11 p.m. interview referenced above that the QA Committee had, as of the morning of

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH - CRESTWOOD	**415 PENDLETON PLACE VALDOSTA, GA 31602**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 15) 11/21/2/14, reviewed and approved the CAJR formulated in response to the immediate jeopardy related to the 11/02/2014 and 11/11/2014 incidents, no evidence was presented to indicate that the QA Committee had been involved in the formulation of this CAJR. This was despite facility staff having developed and implemented, as documented in the CAJR, corrective actions which included: the 11/13/2014 behavioral screenings of all residents for inclusion in the Behavior Monitoring Program; the 11/13/2014 Care Plan review of all residents having physical/verbal behaviors in the past month to determine to need for revision; the 11/20/2014 initiation of a process involving a 10 percent minimum monthly audit by the Administrator of resident behavior screens, Behavior Management Documentation Forms, and Care Plans utilizing the Behavior Management Log Form; and the completion, by 11/20/2014, of in-service training of the majority of the facility's staff (as documented in the CAJR) regarding dealing with residents having behavior, the reporting of resident altercations, and physician notification of changes in condition and new resident behaviors. In addition, the facility presented no evidence to indicate that the QA Committee had evaluated and analyzed the facility's systems (which had been in effect prior to the 11/02/2014 and 11/11/2014 incidents referenced above) regarding resident monitoring/supervision of residents having behaviors to ensure resident safety, facility response to significant changes in resident behaviors, Behavior Monitoring Program referral, and facility staff response to resident-to-resident incidents. This was despite quality deficiencies having been identified regarding the 11/02/2014 incident when Resident #1 verbally threatened Resident #2, related to the facility's failure to: implement immediate interventions to ensure resident monitoring/supervision to protect resident safety; ensure the referral and inclusion of residents in a Behavior Monitoring Program, per facility policy; ensure physician consultation for resident changes in status, including behavior changes. This was also despite the incident of 11/11/2014, when Resident #2 was found with no respirations or pulse, after which Resident #1 was documented as admitting to killing Resident #2. Based on the above, on 11/02/2014, Resident #1 verbally threatened Resident #2 (a new behavior for Resident #1), but the facility failed to implement immediate interventions to ensure resident monitoring/supervision and resident safety; failed to consult with the physician regarding Resident #1's verbally threatening behavior toward Resident #2; and failed to refer Resident #1 to the Behavior Monitoring Program, per facility policy. Then, on 11/11/2014, Resident #2 was found with no respirations or pulse and with an electric cord around her neck, and Resident #1 stated to staff she had killed Resident #2. In response to Resident #2's 11/11/2014 death, the facility identified quality deficiencies and developed and implemented new procedures, reflected on a corrective action plan, which included: behavioral screenings of all residents for inclusion in the Behavior Monitoring Program; Care Plan review and revision; a monthly audit by the Administrator of resident behavior screens, Behavior Management Documentation Forms, and Care Plans; and staff training. However, even though these new procedures were developed and implemented, and even though the facility conducted staff in-service training, beginning on 11/14/2014, there was no evidence to indicate that the QA Committee had been involved in the formulation of this CAJR developed in response to the 11/11/2014 incident resulting in Resident #2's death. There was also no evidence of QA Committee evaluation and analysis of facility systems in effect prior to the 11/11/2014 incident related to resident monitoring/supervision, response to significant changes in behaviors, Behavior Monitoring Program referral, and response to resident-to-resident altercations. The facility presented a CAJR on 11/20/2014, and it was determined that the immediate jeopardy was removed on 11/21/2014, at which time the facility had implemented the following interventions: 1. On 11/11/2014, upon the discovery of the incident of that date, Resident #1 was immediately placed on one-to-one staff observation until she was later transferred out of the facility. 2. On 11/13/2014, the facility's Interdisciplinary Team (consisting of the Administrator, DON, ADON, Admissions Personnel, LPN Supervisor, and Social Services Director) completed Behavioral Symptom Screening Forms on every facility resident. This process of resident behavior screening had been initiated on 11/12/2014. All residents screened during this process and identified as having had physical or verbal behaviors in the previous month were placed on the Behavior Monitoring Program, to ensure the monitoring of these residents and to ensure that no further behavioral interventions were necessary. All residents will have a behavior screen done upon facility admission, quarterly, upon significant change in status, and with any new behavior. 3. On 11/13/2014, the facility's Interdisciplinary Team completed a review, initially begun on 11/12/2014, of the Care Plans of all residents having any physical or verbal behaviors in the previous month. These Care Plans were revised as needed, based on these reviews. Resident Care Plans will be reviewed quarterly, annually, with a significant change in condition, and with any new behavior. 4. On 11/14/2014, the facility's Medical Director reviewed Resident #1's medical record, making no recommendations. 5. On 11/19/2014, the facility implemented a procedure by which the Interdisciplinary Team would screen and review all new resident admissions. This screening process would apply to all new resident admissions, and no resident would be admitted until a detailed review of the resident's mental condition and the potential for aggressive or physical behaviors can be assessed. This resident screening and review will be documented on the Admission Audit Tool, which documents: the date; the resident's name; the History and Physical; PASRR Level II; Nurse' Notes/MR notation; any Consultation Information; and a signature of the reviewer. 6. On 11/20/2014, the facility implemented a new procedure by which the Administrator would conduct a monthly audit of a minimum of 10 percent of the Resident Behavioral Symptom Screening forms and resident Care Plans for residents in behavioral management, to ensure the accuracy and completion of these documents. The Administrator will conduct a monthly audit of a minimum of 10 percent of the Behavior Management Documentation Form for residents in behavioral management, to ensure the accuracy and completion of this Form. This Form (a previously existing form) allows for the weekly documentation of residents in the Behavior Management Program, the tracking of the effectiveness of existing behavioral interventions, and the documentation of any newly developed interventions. In addition, the Administrator will conduct a monthly audit of a minimum of 10 percent of the Behavior Management Log Forms (a previously existing form) for all residents in a Behavior Management Program, to ensure accuracy and completion of this Form. This Form serves to document any observed behaviors, including agitated or combative behaviors, per day and per shift. These monthly form audits referenced above will be documented by the Administrator dating and signing the review of each of the referenced forms. 7. On 11/20/2014, the facility implemented a procedure by which a designated CNA was to document, using the Behavior Monitoring Form, continuous rounds in the Memory Support Unit on the hallways and resident areas to monitor for any aggressive resident behavior. This Behavior Monitoring Form allows for the documentation of resident behaviors, interventions, the reporting of the behavior(s) to the Charge Nurse and the identity of the staff member reporting the behavior, and a signature of the nurse of verification. If, during these continuous rounds conducted on the Memory Support Unit, behaviors were observed, this staff member was to intervene as necessary to de-escalate the behavior, and also to report the resident behavior to the Charge Nurse. This monitoring was actually initiated on 11/11/2014, when the staff member was immediately assigned to the Memory Support Unit to begin the continuous rounds. 8. On 11/20/2014, the facility's Interdisciplinary Team continued the process of reviewing resident Preadmission Screening and Resident Review (PASRR) Level II Assessments. This review revealed three (3) residents having PASRR Level II assessments with a recommendation for a psychiatric consultation. One (1) of these residents was seen by a psychiatrist on a regular basis. Appointments were made on 11/20/2014 for the remaining two (2) residents, identified with recommendations for a psychiatric consultation, to have a consultation with a psychiatrist. On 11/20/2014, the facility implemented a procedure by which the Administrator or Social Service Director will make a copy of each resident's PASRR, and initial and date that copy, which will then be kept in the resident's medical record. 9. On 11/20/2014, the facility's Interdisciplinary Team continued to provide staff in-service training related to a number of areas. In-service training was provided to staff to educate them in ways to prevent abuse, including behaviors what to report, and to whom to report observations of resident abuse. This included both physical and verbal resident behaviors. This in-service training also addressed how to identify abuse by observation of residents having suspicious bruising, showing signs of being afraid, or patterns of behaviors. Staff were informed that any resident suspected of any alleged abuse would be protected from any further abuse by the removal of the alleged perpetrator from the facility, as deemed appropriate. Staff were advised of reporting any alleged abuse immediately to their supervisor, leading up to the Administrator, who would then report the allegation of abuse to the appropriate State and corporate agencies. In-service training was also provided regarding employment screening, via criminal background checks, reference checks, and licensure/certification verification. As of 11/20/2014, eighty-nine (89) of one-hundred-and-two (102) staff had received this in-service training. This number included thirty-three (33) of thirty-seven (37) CNA staff; thirteen (13) of fourteen (14) LPN staff; nine (9) of eleven (11) housekeepers; four (4) of five (5) laundry workers; seventeen (17) of twenty (20) dietary workers; seven (7) of eight (8) Registered Nurses; seven (7) of seven (7) department heads (not including the DON, ADON, LPN Supervisor, Senior Care Partner, and MDS Nurse) that did not include nurses, including the Activities Director, Social Worker, Maintenance Director, Financial Counselor, Medical Records, Admissions Coordinator, and Housekeeping Supervisor. The remaining four (4)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 16) CNA staff, one (1) LPN staff, two (2) housekeepers, one (1) laundry worker, three (3) dietary workers, and one (1) Registered Nurse who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. Additionally, going forward, all employees will receive training upon hire during the orientation process, and quarterly, related to resident abuse, resident neglect, and the procedures by which to deal with residents having verbal or physical behaviors. 10. On 11/20/2014, the Interdisciplinary Team continued to conduct additional staff in-service training, originally initiated on 11/14/2014, specifically intended for licensed nursing staff and CNA staff regarding the resident behavior management policies and the documentation of resident behaviors. As of 11/20/2014, six (6) of eight (8) Registered Nurses, thirteen (13) of fourteen (14) LPN staff, and thirty-one (31) of thirty-seven (37) CNA staff had received this in-service training. The remaining two (2) Registered Nurses, one (1) LPN, and six (6) CNA staff who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. 11. On 11/20/2014, staff in-service training was conducted regarding the notification of the physician of a change in condition and of new resident behaviors. As of 11/20/2014, eleven (11) of fourteen (14) LPN staff and seven (7) of eight (8) Registered Nurses had received this training. The remaining three (3) LPN staff and one (1) Registered Nurse who had not been available due to being off duty or on leave will receive this in-service training upon their return to work, and will not be allowed to work until in-service is completed. 12. On 11/20/2014, the facility implemented a new procedure by which the results of Administrator and/or Social Service Director audits of the Admission Audit Tool, Behavior Monitoring Form, Behavior Management Documentation Form, Behavior Symptom Screening Form, Management Log Form, and Care Plan and PASRR Assessment reviews would be presented to the QA Sub-Committee each week for four (4) weeks, then monthly by the Administrator or Director of Health Services. This process will allow the QA Sub-Committee to monitor staff compliance with the facility's policies and procedures regarding residents having verbal and/or physically aggressive behaviors which could have the potential to lead to resident abuse. Audit results will also be presented to the facility's QA Committee quarterly for the Committee's review and oversight of facility staff conformance with facility policies and procedures related to the management of resident behaviors, the screening of resident behaviors, physician notification, and resident monitoring. During this abbreviated survey, the State Survey Agency reviewed the corrective actions implemented by the facility, as reflected in the CAJR referenced above, with findings as follow: - On 11/21/2014, a review of facility investigative documents, including the facility IS, confirmed that Resident #1 was immediately placed on one-to-one observation on 11/11/2014 immediately after the incident involving Resident #1 and Resident #2, as indicated in Step #1 of the CAJR referenced above. - On 11/21/2014, a sampled review of resident records completed on that date, but which had been ongoing throughout the abbreviated survey, revealed that the Interdisciplinary Team had conducted behavioral screenings on residents for the purpose of ensuring appropriate resident placement in the Behavioral Monitoring Program, as indicated in Step #2 of the CAJR referenced above. - On 11/21/2014, a sampled review of multiple resident records, but which had been ongoing throughout the abbreviated survey, was completed and verified that resident Care Plans had been reviewed and updated by the Interdisciplinary Team, as related to physically/verbally aggressive behaviors. This was in accordance with Step #3 of the CAJR referenced above. - On 11/21/2014, review of facility investigative documents confirmed that the Medical Director had reviewed Resident #1's medical record and submitted a written summary of this information to the facility on [DATE]. This was in accordance with Step #4 of the CAJR referenced above. (Of note, on 11/20/2014 at 11:12 a.m., a telephone call had been placed to Resident #1's physician, but the physician declined interview.) - On 11/21/2014, interview with the Administrator at 11:20 a.m. confirmed that the Interdisciplinary Team will screen and review all new resident admissions, with no resident being admitted until a review of the resident's medical condition and potential for aggressive behaviors can be assessed. This review will be documented using the Admission Audit Tool. This Team will include the Administrator, DON, ADON, Admissions Personnel, an LPN Supervisor, and the Social Services Director. This was in accordance with Step #5 of the CAJR referenced above. - On 11/21/2014, facility document review and interview with the Administrator confirmed that the Administrator will be conducting monthly audits of the Resident Behavioral Symptom Screening forms, the Behavior Management Documentation Forms, the Behavior Management Log Forms, and resident Care Plans for resident requiring behavioral management services. This was in accordance with Step #6 of the CAJR referenced above. - On 11/21/2014, a 9:55 a.m. observation on the Secured Unit confirmed the presence of an assigned staff member to conduct ongoing and continuous rounds for the purpose of observing for any resident aggressive behaviors. These rounds were documented on the Behavior Monitoring Form. In addition, it was confirmed by interview with the Administrator that this process of ongoing, continuous rounds will be a permanent intervention. This was in accordance with Step #7 of the CAJR referenced above. - On 11/21/2014, a sampled review of resident records, which had been ongoing throughout the abbreviated survey, was completed and verified that the Interdisciplinary Team had reviewed all resident PASRR Level II Assessments, with the appropriate follow-up for residents needing additional psychiatric services. This action was also confirmed during an 11/21/2014, 10:45 interview with a Corporate Nursing Consultant. This was in accordance with Step #8 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted staff in-service training for staff, including (but not limited to) licensed nursing staff, CNA staff, Social Services staff, MDS staff, Medical Records staff, the Maintenance Director, and the Admissions Coordinator, regarding resident abuse and the Behavior Management Policy. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #9 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted additional staff in-service training, specific for licensed nursing staff and CNA staff, regarding resident behavior management policies and the documentation of resident behaviors. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #10 of the CAJR referenced above. - On 11/21/2014, review of facility staff in-service documentation, to include facility Inservice Report Sign-In Sheet Form review, revealed that the facility had conducted additional staff in-service training, specific for licensed nursing staff, regarding the notification of the physician for changes in condition and new resident behaviors. All staff having not yet completed this in-service training will receive training upon their return to work. This was in accordance with Step #11 of the CAJR referenced above. - On 11/21/2014, an 11:20 a.m. interview with the Administrator confirmed that the results of all audits, as referenced in the CAJR intended to provide ongoing management level oversight of the assessment, planning of care, and provision of care to residents having behavioral problems, will be reviewed by the QA Committee to provide ongoing QA Committee oversight of this care. This was in accordance with Step #12 of the CAJR referenced above. Based on these corrective actions which had been developed and implemented by the facility as outlined in the CAJR referenced above, it was determined that the immediacy of the deficient practice had been removed on 11/21/2014; however, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. On 11/19/2014, the facility implemented a procedure by which the Interdisciplinary Team will screen and review all new resident admissions, and no resident will be admitted until a detailed review of the resident's mental condition and the potential for aggressive or physical behaviors can be assessed. This resident screening and review will be documented on the Admission Audit Tool. This was, however, a new procedure, having been implemented on 11/19/2014, only two (2) days prior to the 11/21/2014 exit date of this abbreviated survey; therefore, the Interdisciplinary Team's ongoing compliance with this newly-implemented procedure could not be fully evaluated at the time of survey exit, and will need further review on a future date. On 11/20/2014, the facility implemented a new procedure by which designated staff was to document, using the Behavior Monitoring Form, continuous rounds in the Memory Support Unit on the hallways and resident areas to monitor for any aggressive resident behavior. The use of this Behavior Monitoring Form was, however, only implemented as of 11/20/2014, one (1) day prior to the 11/21/2014 date of survey exit, thereby preventing the evaluation of facility staffs' ongoing compliance with the use of this Form and concomitant monitoring of aggressive resident behaviors. Such compliance will require further review on a future date. In addition, on 11/20/2014, the facility's Interdisciplinary Team continued to provide staff in-service training which included abuse prevention and reporting, and the identification of abuse by observation of residents having suspicious bruising, showing signs of being afraid, or patterns of behaviors. As of 11/20/2014, thirty-three (33) of thirty-seven (37) CNA staff, thirteen (13) of fourteen (14) LPN staff, nine (9) of eleven (11) housekeepers, four (4) of five (5) laundry workers, seventeen (17) of twenty (20) dietary workers, and seven (7) of eight (8) Registered Nurses had received this in-service training. The remaining four (4) CNA staff, one (1) LPN staff, two (2) housekeepers, one (1) laundry worker, three (3) dietary workers, and one (1) Registered Nurse who had not been available due to being off duty or

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 17) on leave will receive this in-service training upon their return to work. On 11/20/2014, the Interdisciplinary Team continued to conduct additional staff in-service training for licensed nursing staff and CNA staff regarding the resident behavior management policies and the documentation of resident behaviors. As of 11/20/2014, six (6) of eight (8) Registered Nurses, thirteen (13) of fourteen (14) LPN staff, and thirty-one (31) of thirty-seven (37) CNA staff had received this in-service training. The remaining two (2) Registered Nurses, one (1) LPN, and six (6) CNA staff will need to receive this in-service training upon their return to work. Also, on 11/20/2014, staff in-service training was conducted regarding the notification of the physician of a change in condition and of new resident behaviors for eleven (11) of fourteen (14) LPN staff and seven (7) of eight (8) Registered Nurses, but the remaining three (3) LPN staff and one (1) Registered Nurse will receive this in-service training upon their return to work. Therefore, due to multiple licensed and certified staff members yet remaining to receive in-service training at the time of survey exit, their completion of this required training could not be assessed at the time of survey exit, and wil