DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES			PRINTED:5/27/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 345370	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2016
NAME OF PROVIDER OF SUI PINEHURST HEALTHCARE	PPLIER	STREET ADDR 300 BLAKE BO PINEHURST, N	ESS, CITY, STATE, ZIP DULEVARD NC 28374
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state sur	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE MATION)	PRECEDED BY FULL REGULATORY
F 0223		ouse, physical punishment, and being separated	from
Level of harm - Immediate jeopardy	**NOTE- TERMS IN BRACKET	'S HAVE BEEN EDITED TO PROTECT CONFIL taff and resident interviews the facility failed to pro-	
Level of harm - Immediate jeopardy Residents Affected - Few	Based on medical record review; ; from physical abuse for 1 of 1 Re (Immediate jeopardy began on 12/ on 1/7/16 when an acceptable cre (isolated with no actual harm with monitoring systems put into place Findings included: Resident #1 was admitted on [DA revealed that the resident was understood a Interview of Mental Status (BIM: moment. A BIMS score of three i coded as not displaying physical screaming during the past 1-3 dag Medical record review revealed a through next review. Intervention behavior is disruptive. Review of the statement written o room around 9:30am-10 am. (Re: room to perform ADL (activity o Resident #1 was still fussing calli face. I then proceeded to go get n nursing assistants help her get the to be combative. I was in the roon moment. NA #2 helped but more supervisor) about the situation th During interview with (NA) #1 at ready to do activity of daily living two other NAs to come help her. room. She said, No one touched 1 calmed down and that there was i morning care. She stated, It wasn interview with NA#2 at 3:25 pm of #1). I said what's wrong? She sait help and went down the hall with one side and NA #3 on the other it he other side. She stated that she reported that NA#1 and #3 were : assistants outside of the bacl. NA #1 and #1) jerking his arm as she was pu towards both of them saying statior on the side of the bacl. NA #1 and #1) jerking his arm as the was pu towards both of them saying they again and NA #3 hit him in the fa- then I left the room. During follow up telephone interv (Resident #1) in the face and NA. swinging but she did not see him reported the incident to the nurse Review of written statement writk assistant) came to me which was (Resident #1 is 7 room. Upon entt #1) was swearing, swinging and 1 and started talking to (Resident # #1) that that kind of behavior wo	taff and resident interviews the facility failed to presidents (#1). 27/15 when Resident # 1 was slapped by two nursir dible allegation was provided. The facility remains 1 potential for more than minimal harm, that is not 2 are effective related to resident rights to be free fre TE] with [DIAGNOSES REDACTED]. Review of and understood others. The resident was coded as h 5). BIMS is a brief snapshot of how well a resident ndicates that the resident had problems with memo- behavioral symptoms. He was coded as displaying rs. care plan goal 12/17/15 which stated will have 1 or s included, approach resident warmly and positivel n 12/27/15 by nursing assistant (NA) #1 revealed, I ident #1) was already fussy this morning before pr f daily living) care. (Resident #1) started to fuss at 1 ng me pathetic and all other names. He then raised n tub she was on break. The statement revea resident ready. The statement continued, Once ins n but did not proceed getting him ready. NA #3 dre y observed. Once finished, he was pushed down to t had occurred. 4:20 pm on 12/31/15 she stated, Resident #1 was as g care, he hit me in my face. NA #1 reported that sh NA #1 reported that Resident #1 was basically give im but NA #3 when we went back to the roonm. NA to abuse. NA #1 reported that Resident #1 was as ident #1) is getting on my damn nerves. NA #1 (Resident #1) is agting on my damn nerves. NA #1 (Resident #1) stand up and put on his shoes iaying a bunch of curse words. NA #2 said that she y NA #2 revealed the following, NA #1 was comin nd go home. I asked her what was wrong. She said then NA#3 came up and we all went to (Resident #1) was on hat (Resident #1) in the face con his left side. I helped put his pants and shoes iew with NA #2 on 1/5/16 at 8:45 pm she stated the id NA #1 was on her left side and NA #3 was on the left side was in a boxing stance when she hit the resident hit either NA #1 or #3. NA #2 said that she toid NA sit was in a boxing stance when she hit the resident hit eith	otect a resident 's right to be free ng assistants. Immediate jeopardy was removed out at a lower scope and severity of D immediate jeopardy) to ensure our abuse. If the Minimum Data Set Assessment 10/22/15 the Set Combative/verbal abuse behavior ly, talk with resident in calm voice when I (NA #1), went into (Resident #1 ' s) roceeding into his room. I went into his me. As I went to go get him dressed, his hand and slapped me across the the d that she requested that 2 other ide the room, (Resident #1) continued essed him since he was more calmer at the the activities and I did report to (nurse regitated during breakfast. As I was getting he went to get the nurse and asked en care by NA #3 when they returned to the A #1 further stated that the resident had when she first attempted to give him is hand came up and I left the room. Nown the hall. NA #1 was upset about (Resident #2 said she told NA #1 that she would on the side of the bed with NA #1 on sident #1) in the face. Then NA #3 swung on is and went out of the room. NA #2 e did not know the other two nursing and down from 200 Hall towards nursing station that (Resident #1) was swinging his arms to con his right side, then he swung on and made sure he was in his chair at she was standing right in front of er right side. She stated that NA #1 hit t. NA #2 reported that (Resident #1) was A #1 and #2 to stop. NA #2 said that she :00am another CNA (certified nursing in the hallway and followed NA #1 and into was being loud and comb
	(Resident #1) calm and putting hi (activities) and reported to the nu During interview on 12/31/15 at 3 better come down and stated that He was waving his hands. I took clothes on and get dressed for the reported that no one helped her d resident was agitated she put her before and he can get a little rown	I in the room, but just standing there. (NA#2) then s clothes on. Once (Resident #1) was dressed, I too rse that he was being combative. :36 pm with NA #3, she reported that on Sunday 12 (Resident #1) was being combative. Soon as we we his hands in mine and said you need to calm down. day. I said will you do that for me? He calmed dow ress him. I told them (NA#1 and #2) to just let me of hands up and called his name several times. She sai ly. NA #3 reported that NA #1 was standing behind ide of the bed when they were all in the room. She	ok him out of the room and to church 2/27/15 around 9/9:30 NA #1 said to her you alked to the door he was already combative. I told him that he needed to put his wn, I put his clothes on. NA #3 do it. The NA stated that when the id she has worked with (Resident #1) d her, NA #2 was at the door and
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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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1011

Facility ID: 345370

If continuation sheet Page 1 of 5

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED:5/27/2016 FORM APPROVED OMB NO. 0938-0391
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AME OF PROVIDER OF SU	PPLIER		RESS, CITY, STATE, ZIP
NEHURST HEALTHCAR		300 BLAKE BC PINEHURST, M	NC 28374
or information on the nursing (X4) ID PREFIX TAG	•	cy, please contact the nursing home or the state sur EFICIENCIES (EACH DEFICIENCY MUST BE	
. ,	OR LSC IDENTIFYING INFORM		
F 0223 Level of harm - Immediate jeopardy Residents Affected - Few	the incident) she reported that she medication. She said that his face supervisor. Nurse #1 reported tha wheelchair in the hallway when s two of them but she helped me ar with the nurse supervisor he was Review of the statement written b	Nurse #1 (nurse assigned to the resident 's hall o	n to give Resident #1 his morning when she went in with the nurse aid she saw Resident #1 up in his bed that Resident #1 said Yeah, there were when she went to talk to the resident on 12/27/15) revealed the following,
	to help with (Resident #1). NA #2 above stood on either side of the : his face, then immediately after () more agitated and combative. I sp them back, then he pointed to NA marks at that time. During telephone interview with t pm on Sunday 12/27/15. She said Resident #1 if anyone hit him and	) that this morning around 9:45-10:15 am another stated while she was in (Resident #1) room with ( esident as she was assisting place his pants on him VA#3) slapped him as well. NA #2 also stated both oke with resident and he said two women were in #2 saying she was there, but she was the one that ne nursing supervisor on 1/6/16 at 2:32 pm she stat that when she went to the room he was kind of as he said no. The supervisor said that the girl who y that she has not known the resident to have any lux	(NA #1 and NA #3), the two cna's listed n, one CNA (NA#1) slapped resident in h CNA's were causing resident to become his room and they hit him, but that he hit helped me. Resident did not have any ted that she saw the resident around 3:30 leep and she had to wake him up. She asked witnessed it reported the incident at
	that doesn't make sense. The nurs abuse (NA #2) for 8 years and on During interview with Resident # that he hit them back. The resider anywhere, she went away. He sta Review of the Director of Nurses that 2 CNA's (Certified Nursing A arrived at facility on Monday Dee evidence of any bruising or red m being mean to him or hitting him Interview with the Director of Nur and the resident did not have any yesterday that you need to tell me that she had no complaints from Telephone interview with the Dire person. The DON further stated th The administrator was notified of	on 12/31/15 at 2:50 pm the resident said that som t stated she (the resident was unclear regarding wf ed, I was so angry. Resident #I said this happened DON) statement revealed, It was reported to me o ussistant) slapped a resident during morning ADL ember 28, 2015 I went and did a skin assessment of arks noted on resident. I also asked the resident if	nursing assistant who reported the neone hit him on the hand 2-3 times and ho she was) doesn't belong here or 1 a couple days ago. on Sunday December 27, 2015 at around 3pm (activity of daily living care). When I on resident at 9:30 am. There was no he remembered at any time anyone he went down to see the resident on Monday the resident, Did anything happen hat NA #2 worked every other weekend and t the resident was alert and oriented to
	9:45am to 10:15am. The Charge 1 12:32pm. This skin assessment si allegation. The Charge Nurse not Supervisor removed the CNAs (N RN supervisor went to the room a interview the RN supervisor ask t performed another skin assessme bruising. At this time the RN sup Administrator at 3:05 pm on 12-2 Director of Nursing performed an 9:45 am on 12-28-2015. During t on the facial area in the abuse alle of Nursing on 12-29-15 at 4 pm c that identified resident needed a p am. The Medical Director noted of Responsible Party for the identifi of left shoulder pain. The Respon 1-1-16. The Responsible Party ex the facility about a week ago. The fractures noted. The physician wi facility at 7:45 pm on 1-1-16 with 12-30-15 for accepting money frr # 2) returned to work on 12-30-11 Nursing to be in contact with the substantiated. A police report waa resident and will be interviewing findings on 1/7/16 of his investig the closed the case. The 5 day invi-	ed resident, The Charge Nurse was informed of an Nurse went to the identified resident 's room and c owed some redness but no markings or bruising o fied the RN supervisor around 3:00pm of the abus A # 1 and NA # 3) from the building and suspende t 3 pm to perform an interview and skin assessmet he identified resident if anyone had slapped him, h to n identified resident 's facial area and was unal rvisor contacted the Director of Nursing. The Dir 7-15. The Director of Nursing submitted a 24 hour interview and a skin assessment to the facial area is interview the identified resident denied any abu gation. The Responsible Party for the identified re oncerning the abuse allegation. The Medical Direct hysical examination. The Medical Direct perform Id skin tears but did not note anything about bruisi a dresident requested that the resident be sent out to sible Party signed the resident to und arrived at th planet to the physicai on duty that the resident w physician ordered x-rays and notified Department I send all x-rays to Department of Social Services no acute changes. CNA 1 (NA # 1) that was invol m a family member to wash the resident 's clothes filed on 1-6-16 in regards to this abuse allegation. all parties involved. The Police Report number is . tion that concluded there was not enough evidence stigation was completed and submitted by Directo aff were in serviced on combative and agitated resi-	completed a skin assessment on 12-27-15 at n the face area identified in the abuse se allegation at that time the RN ed them until investigation was completed. The nt on the identified resident, during the tis comment was NO. The RN supervisor ble to identified any markings or ector of Nursing contacted the r report on 12-28-15 at 11:12 am. The identified in the abuse allegation at use and were no noted bruising or marks sident was notified by the Director ctor was notified by the Director ctor was notified by the Director ctor was notified on 12-31-15 at 7:30 am med the evaluation that morning around 9 ing or markings to the facial area. The o the emergency room for complaints he emergency room at 3:59 pm on vas assaulted by some of the staff at t of Social Services. There were no acute by 1-6-16. Resident returned to the lved in abuse allegation was terminated on and she never returned to work. CNA 2 (NA dwas forbidden by the Director of ed on 1-6-16 due to the abuse allegation , Police interviewed identified . The Police officer hand delivered his e to prove that an assault did occur and or of Nursing on 12-30-15 at 3:37 pm. 100%
	identified resident was seen by N identified resident 's behaviors. T careful when touching resident ar agitated. The resident will always added to the resident 's Kardex ar to perform care on residents. The CNAs (NA # 1 and # 3) that were facility grounds. For those residents having the pot · Resident still resides in facility, a disciplined. Resident has been int noted. Resident continues to have behavior issues. With all interven · The NH performs background cf to insure there is no abuse or crin that could be consider abusive, th abuse to, to report abuse immedia immediately and remove the alleg · 100% active, part time and as ne agitated residents. Ist step is try t resident away from what is makir and let them try to calm the resid always be kind and respectful . R always has the right to refuse serv	rrse Psychiatrist on 1-7-16 to see if there are any in he interventions that she recommended were to re- ound the wrist, when resident is touched around th have two people in the room when care is being p d care plan on 1-7-16. All CNAs (NAs) must go t identified resident will be continued to be monitor involved in this abuse allegation have been termin ential to the affected by the same alleged deficient Il alleged employees involved in abuse allegation erviewed by psychiatry for any emotional distress behaviors but all staff and new hires have and wil itons in place the identified resident is comfortable ecks on all potential employees before hiring then inal charge that could lead to abuse. If the backgrr e individual is never hired. The abuse policy cover tely when notified or when you see abuse, notify f ed persons from the facility immediately. ded staff were educated from 1-1-16 thru 1-6-16 c o figure out what is making the resident agitated, 2 g them combative or agitated. 3rd if you are unabl int, 4th always take your time and speak clearly an scient 's rights were included in the in service on ice. The two CNAs (NA # 1 and # 3) that were inv	nterventions to help with the direct resident if agitated and be e wrist area it can cause him to be more performed. These interventions have been to the Kardex before each shift to see how red by the Nurse Psychiatrist. Both nated and are banned from coming on the practice: have been terminated or have been from the incident and none has been I be educated on how to deal with e and safe at the facility. n. The Administrator reviews all backgrounds ound check reports any criminal items rs what types of abuse, who to report 'amily immediately, notify physician on how to deal with combative and hol se if you can redirect the le to calm the person, go get someone else d slowly to the resident, and 5th 1-6-16 that included the resident volved in this abuse allegation were
ORM CMS-2567(02-99) revious Versions Obsolete	Event ID: YL1011	Facility ID: 345370	If continuation sheet Page 2 of 5

TATELEXENT OF       (X1) PROVIDER / SUPPLIER       (X3) DATE SUR         PERCENCIES       (X1) MUBER       BUILDING       BUILDING         AND PLANERS       DENNITIFCATION       BUILDING       DUILAGE         ME OF PROVIDER OF SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP         NEHURST HEALTHCARE & REHAB       STREET ADDRESS, CITY, STATE, ZIP         Or 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         C(X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULA OR LSC IDENTIFYING INFORMATION)         F 0223       Continued from page 2)         Level of harm - Immediate       'The Social Worker contacted all responsible parties of residents that tennot speak for themselves to inquire of any concerns or changes in resident 's behavior that could indicate possible abase on 1.6-15. These interviews included the residents that the two accused CNAs (NA) were assigned ap performed care on. These skin audits were or formed care on these shin audits tor injuries of unknown origin for 100% of residents, this includes 100% of residents that the two accused CNAs (NA) were assigned ap performed care on These skin audits were or formed care on. These skin audits were or formed care on these shin audits tor injuries of unknown origin for 100% of residents, this includes 100% of resident that the two accused CNA's (NA # 1 and # 3) that were named in the abuse all resident includes there in the streaked to 10 for sident state includes the resident for the facility. This includes all resident includes approve	EPARTMENT OF HEALTH ENTERS FOR MEDICARE			PRINTED:5/27/2016 FORM APPROVED	
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CREASE DESTRIPTING ENFORMATION)           F1223         (continuedfom page 2) minually.           Level of harm - Intraction         The Social Worker contracted all responsible parties of noiseling and the appoint of any control of the provide parties of noise accord CNAs (NA) were assigned A performed care on. There were no concerns voided by the parties. In exploring of any characterization of particle activity of the provide particle activity of the accord CNAs (NA) were assigned A performed care on. There were no concerns voided by the regarding the performance care on There were no concerns voided by the regarding to the social of the performance care on The social All residues and the social activity of the performance care on The social All residues and the performance care on The social All residues and the performance care on The social Worker, Administora CONAN (NA 1 and 12) were assigned and performed care on These were and the the above all regarding the performance care on the performa	or information on the nursing	home's plan to correct this deficient	cy, please contact the nursing home or the sta	te survey agency.	
<ul> <li>F023</li> <li>cardinadi from page 2) annually.</li> <li>The Social Worker connected all responsible parties of residents that cannot speak for themselves to impair of any concers on transps in resident. * Jelanvior that could indicate possible parties.</li> <li>The Social Worker connected all sequencing of the sequence speak partice.</li> <li>The Norma start completed with analist for impaired in a first comparison of the sequence speak partice.</li> <li>The Norma start completed with analist for impaired or all sectors of the sequence speak partice.</li> <li>The Norma start completed with a marker of impaired or all sectors of the sequence speak partice.</li> <li>The Norma start completed with analist for impaired or all sectors of the sequence speak partice.</li> <li>The Norma start completed with the phale vert fort impaired and y and the sequence and the sequence of the sequence speak partice.</li> <li>The Norma start complete partice of the sequence of the sequence of the sequence and the sequence and the sequence of the sequence</li></ul>	X4) ID PREFIX TAG			T BE PRECEDED BY FULL REGULATORY	
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<ul> <li>residents that the two accused CMAs (N # 1 and # 3) were assigned and performed are on. These skin andits were or from 1-16 to 1-7-16. No skin adjust are of majori and Clinical Spreenviews sket all residents capable being interviewed (if they had ever fail mistrated by a stiff member of the facility, this included all residents capable the one staff. All interviews were completed on 1-6-16 at §8m.</li> <li>Review of member of the staff. All interviews were completed on 1-6-16 at §8m.</li> <li>Review of mestrical resident (indiphyda ggressive bhaviors and actions to be taken if abuse sease otherword and/or suspected.</li> <li>Review of mestrical resolution (indiphyda ggressive bhaviors and actions to be taken if abuse sease otherword and/or suspected.</li> <li>F0226</li> <li>F0226</li></ul>	jeopardy	concerns or changes in resident 's residents that the two accused CN parties, no report of any behaviors	s behavior that could indicate possible abuse of IAs (NAs) were assigned & performed care of s or physical signs reported by any of the resp	on 1-6-15. These interviews included those n. There were no concerns voiced by responsible ponsible parties.	
<ul> <li>housekceping, dietary, maintenance, transportation, administrative saff, activities, social worker) had been in-serviced by 1/716 on the abuse policy and proceedures to be initiated if abuse was observed/suspected.</li> <li>F0226</li> <li>Level of harm - Immediate isoparty.</li> <li>Bevelop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.</li> <li>Residents Affected - Few as the prevent mistreatment, neglect, or abuse of residents of the facility failed to operationali abuse policies and proceedures in the areas of intervening when physical abuse was wineaschi, immediately assessing a resident, immediately assessing a resident, immediately assessing other residents could be unpermented, identification (immediate) wassessing a resident, immediately assessing a resident intervence or immediately report, Immediate jopardy) to ensure monitoring systems put into place are effective related to resident of the facility guidelines for investigating allegations of resident abuse, neglect or diple allegation with potential for a the area department of social services/adult protective services. The policy stated, the facility guidelines for investigating allegations of resident abuse, neglect or diple related to resident the facility abuse policy revealed.</li> <li>Review of the facility guidelines for investigating allegations of resident abuse, neglect or dipperiations. Review of the facility, a the protect of Nursing immediately.</li> <li>Call Director of Operations, in regards to the notification of DSSI/PS (Department of Social Service/Adult Protective Service).</li> <li>Notify the Administrator and Director of Nursing immediately.</li> <li>Call Director of Operations, in regards to the notification of DSSI/PS (Department of Social Service/Adult Protective S</li></ul>		residents that the two accused CN from 1-1-16 to 1-7-16. No injurie The Social Worker, Admissions ( being interviewed if they had eve- the ones that were cared for by ac- interviewed denied feeling mistre The credible allegation was verified different types of abuse, what to c observed and/or suspected.	As (NA # 1 and # 3) were assigned and perform s of unknown origin were found. Coordinator, Director of Nursing and Clinical r felt mistreated by a staff member of the faci- scused CNA 's (NA # 1 and # 3) that were na ated by any member of the staff. All intervieved and 1/13/16 at 3:00 PM as evidenced by stat ho if a resident displayed aggressive behaviors	bormed care on. These skin audits were completed 1 Supervisors asked all residents capable of lity, this included all residents including med in the abuse allegation. All residents ws were completed on 1-6-16 at 8pm. ff interviews on abuse policy and procedures, s and actions to be taken if abuse was	
<ul> <li>resideni property.</li> <li>resideni property.</li> <li>resideni property.</li> <li>residents Affected - Few</li> <li>Based on staff interviews, resident interview and record review it was determined that the facility finited to operationalit and the policies and proceedures in the areas of intervening when physical abases was winesed, immediately reporting order residents could have been affected, reporting (nonifying law enforcement). The abase policy did not empower any person to notify law enforcement for 1 of residents (#1).</li> <li>Immediate jogardy began on 1227/15 when Resident #1 was slaped by two nursing assistants and study with postelible allogation was provided. The facility remains ont at a lower scope and severity of D (solated with no acceptable cerebile allogation provided. The facility remains ont at a lower scope and severity of D (solated with no acceptable cerebile allogation provided. The facility remains ont at a lower scope and severity of D (solated with no acceptable cerebile allogation provided. The facility remains ont at a lower scope and severity of D (solated with no acceptable cerebile allogation of property included the following instructions (undated). Notify the appropriate State agencies as required. Call Director of Operations. In regards to the notification of back partner of social services abult protective services. The policy includes the following.</li> <li>Notify the Administration and Director of Narsing immediately.</li> <li>Call Director of Ops. (Operations), in regards to the notification of DSS/APS (Department of Social Service/Adult Protective Service/Ad</li></ul>		housekeeping, dietary, maintenan	ce, transportation, administrative staff, activit	ties, social worker) had been in-serviced	
<ul> <li>Level of harm - Immediate         <sup>++</sup>NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**         Based on staff interview, resident interview and record review it was determined that the facility failed to operationalit         abuse policies and procedures in the areas of intervening when physical abuse awas vinesed, immediately reporting p         terview, resident interview and record review it was determined that the facility reporting p         terview. The terview is a determined that the facility reporting p         terview of the facility remains out a 1 overs scope and P was nempeoted on 17/16 when an acceptable credible allegation w         provided. The facility remains out at a lower scope and eventy of D (solated with an actual harm with potential for         than minimal harm, that is not inmediate jopandy was removed on 17/16 when an acceptable credible allegation w         provided. The facility guidelines for investigating allegations of resident abuse, neglect or misappropriation of property         included the following instructions (undeta). Notify the appropriate State agencies as required. Call Director of         Operations, in regards to the notification of the department of social services/adult protective services. The policy         stated, Notification of Law Enforcement Agencies requires the approval of the Director of Operations.         Review of the facility aguidelines or investigating immediately.         • Notify the Administrator and Director or Nursing immediately.         • Notify the Administrator and Director or Nursing immediately         • Notify the Administrator and Director or Nursing immediately         • Notify the Administrator and Director or Nursing immediately         • Notify the Administrator and Director or Nursing immediately         • Notify the Administrator and Director or Nursing immediately         • Notify the Administrator and Director or Nursing immediately         • Notify the Administrator and Director or Nursing im</li></ul>	F 0226		istreatment, neglect, or abuse of residents o	or theft of	
Residents Affected - Few abuses so that protection could be implemented, identification (immediately assessing a resident, immediately assessing of did not empower an person to notify law enforcement for 1 of 1 residents (#1). Immediate jopanty began on 12/27/13 when Resident + 1 was slapped by two nursing assistants and staff witness did provided. The facility remains out at a lower scope and severity of D (stolated with no actual harm with potential for n that minimal harm, that is not immediate jopanty) to norsure monitoring systems put into place are effective related to resident rights to be free from abuse and abuse policies are operationalized. Findings included: Review of the facility guidelines for investigating allegations of resident abuse, neglect or misappropriation of property included the following instructions (unded). Notify the appropriate State agencies as required. Call Director of Operations, in regards of the policy includes the following. Review of the facility guidelines for investigation of property or injuries of unknown origin must be investigated thoro and timely. The investigation place of the policy includes the following. Notify the Administrator and Director of Noresty or injuries of unknown origin must be investigated thoro and timely. The investigation place of the policy includes the following. Notify the Administrator and Director of Noresty or injuries of unknown origin must be investigated thoro and timely. The investigation place of the policy includes the following. Notify the Administrator and Director of Nores. The facility policy included miscellaneous points to remember. This portion of the policy stated, if abuse or potential abuse has not been reported timely to the facility. Takes tas assesses if abuse could bave occurred in the building elsewhre Review, conduct, and document resident physical assessments as necessary (one hall, or enitre facility), as appropriat decided a pod displaying upysical basels of the prophysical assessmy of a singlay systate, state, in ca		**NOTE- TERMS IN BRACKET Based on staff interviews, resident	t interview and record review it was determine	ed that the facility failed to operationalize	
<ul> <li>person to notify law enforcement for 1 of 1 residents (#1).</li> <li>Immediate jeopardy began on 12.2715 when Resident #1 was slapped by two nursing assistants and staff witness did intervene or immediate/popardy los ensure monitoring systems put into place are effective related to resident rights to be free from abuse and abuse policies are operationalized.</li> <li>Review of the facility guidelines for investigating allegations of resident abuse, neglect or misappropriation of property included the following instructions (unduel). Notify the appropriate State agencies are requestioned. Call Director of Operations, in regards to the notification of the department of social services/adult protective services. The policy stated, Notification of Law Enforcement Agencies requires the approval of the Director of Operations. Review of the facility abuse policy revealed:</li> <li>Notification of Law Enforcement Agencies requires the approval of the Director of Operations. Review of the facility abuse policy revealed:</li> <li>Notification of Law Enforcement Agencies requires the approval of the Director of Operations. Review of the facility abuse of the policy includes the following.</li> <li>Notification of Law Enforcement Agencies requires the approval of the Director of Ops. The facility policy included miscellaneous points to remember. This portion of the policy stated, if abuse or potential abuse has not been reported timely to the facility.</li> <li>Notification of IAW Enforcement Agencies requires the approval of the Director of Ops. The facility policy included miscellaneous points to remember. This portion of the policy stated, if abuse or potential abuse has not been reported timely to the facility.</li> <li>Take steps to assess if abuse could have occurred in the building elsewhere</li> <li>Review, conduct, and document resident physical abscheats. The resident abs probeing with mesongian and motioning cognitively at the mornine streament writhen on 12/27/15 whi</li></ul>	Residents Affected - Few	abuse so that protection could be	implemented, identification (immediately ass	sessing a resident, immediately assessing if	
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<ul> <li>Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set Åssessmet revealed that the resident was understood and understood others. The resident was coded as having a score of 3 on the Brief Interview of Mental Status (BIMS). BIMS is a brief snapshot of how well a resident is functioning cognitively at the moment. A BIMS score of three indicates that the resident had problems with memory and recall of events. The reside coded as not displaying physical behavioral symptoms. He was coded as displaying verbal behavior such as threatening screaming during the past 1-3 days.</li> <li>Medical record review revealed a care plan goal 12/17/15 which stated will have 1 or less combative/verbal abuse beha through next review. Interventions included, approach resident warmly and positively, talk with resident in calm voice behavior is disruptive.</li> <li>Review of the statement written on 12/27/15 by nursing assistant (NA) #1 revealed, I (NA #1), went into (Resident #1 'a room around 9:30am-10 am. (Resident #1) was already fussy this morning before proceeding into his room. I went intu room to perform ADL (activity of daily living) care. (Resident #1) started to fuss at me. As I went to go get him dresse Resident #1 was sin the room but did not proceed getting him ready. NA #3 dressed him since he was more calme moment. NA #2 helped but morely observed. Once finished, he was pushed down to activities and I did report to (nurs supervisor) about the situation that had occurred.</li> <li>During interview with (NA) #1 at 4:20 pm on 12/31/15 she stated, Resident #1 was agitated during breakfast. As I was ready to do activity of daily living care, he hit me in my face. NA #1 reported that she went be first attempted to give hit moring care. She stated, It was 14 reported that Resident #1 was agitated during breakfast. As I was ready to do activity of daily living care, he hit me in my face. NA #1 reported that she went to get the nures and asked two other NAs to come help her. NA #1</li></ul>		The facility policy included miscellaneous points to remember. This portion of the policy stated, if abuse or potential abuse has not been reported timely to the facility: • Take steps to assess if abuse could have occurred in the building elsewhere			
<ul> <li>Interview of Mental Status (BIMS). BIMS is a brief snapshot of how well a resident is functioning cognitively at the moment. A BIMS score of three indicates that the resident had problems with memory and recall of events. The reside coded as not displaying physical behavioral symptoms. He was coded as displaying verbal behavior such as threatening screaming during the past 1-3 days.</li> <li>Medical record review revealed a care plan goal 12/17/15 which stated will have 1 or less combative/verbal abuse beha through next review. Interventions included, approach resident warmly and positively, talk with resident in calm voice behavior is disruptive.</li> <li>Review of the statement written on 12/27/15 by nursing assistant (NA) #1 revealed, I (NA #1), went into (Resident #1 ' room around 9:30am-10 am. (Resident #1) was already fussy this morning before proceeding into his room. I went into room to perform ADL (activity of daily living) care. (Resident #1) started to fuss at me. As I went to go get him dresse Resident #1 was still fussing calling me pathetic and all other names. He then raised his hand and slapped me across th face. I then proceeded to go get my nurse but she was on break. The statement revealed that she requested that 2 other nursing assistants help her get the resident ready. The statement continued, Once inside the room, (Resident #1) contin to be combative. I was in the room but did not proceed geting him ready. NA #3 dressed him since he was more calme moment. NA #2 helped but morely observed. Once finished, he was pushed down to activities and I did report to (nurs supervisor) about the situation that had occurred.</li> <li>During interview with (NA) #1 at 4:20 pm on 12/31/15 she stated. Resident #1 was bagitated that the resident calmed down and that there was no abuse. NA #1 reported that she went to get the nurse and asked two other NAs to come help her. NA #1 reported that Resident #1 was bacing your care by NA #3 when they return room. She staid, No one touched him but NA #3 whe</li></ul>		Resident #1 was admitted on [DA' revealed	TE] with [DIAGNOSES REDACTED]. Revi	iew of the Minimum Data Set Assessment 10/22/15	
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<ul> <li>towards both of them saying they were mean girls. NA #1 hit (Resident #1) in the face on his right side, then he swung again and NA #3 hit him in the face on his left side. I helped put his pants and shoes on and made sure he was in his ch then I left the room.</li> <li>Interview with NA #2 at 3:25 pm on 12/31/15 revealed that she saw NA #1 coming down the hall. NA #1 was upset ab (Resident #1). I said what's wrong? She said (Resident #1) is getting on my damn nerves. NA #2 said she told NA #1 ti would help and went down the hall with her. NA #2 reported that (Resident #1) was sitting on the side of the bed with</li> </ul>		morning care. She stated, It wasn' Review of the written statement by saving she was gonna clock out a nerves. We was at nursing station on the side of the bed. NA #1 and	't even a purposeful hit. He was already in a ra y NA #2 revealed the following, NA #1 was c nd go home. I asked her what was wrong. She then NA#3 came up and we all went to (Resi #3 were antagonizing him (Resident #1) vert	ant, his hand came up and I left the room. coming down from 200 Hall towards nursing statio e said that (Resident #1) was getting on her damn ident #1)'s room. He was very agitated sitting bally. NA#1 was on the right side of (Resident	
(Resident #1). I said what's wrong? She said (Resident #1) is getting on my damn nerves. NA #2 said she told NA #1 the would help and went down the hall with her. NA #2 reported that (Resident #1) was sitting on the side of the bed with		towards both of them saying they again and NA #3 hit him in the fa then I left the room.	were mean girls. NA #1 hit (Resident #1) in the on his left side. I helped put his pants and the pants and the pants and the pants and the pants are part of the pants and the pants are part of the pants are pants are pan	the face on his right side, then he swung shoes on and made sure he was in his chair	
on the other side. She stated that she helped (Resident #1) stand up and put on his shoes and went out of the room. NA reported that NA#1 and #3 were saying a bunch of curse words. NA #2 said that she did not know the other two nursin		(Resident #1). I said what's wrong would help and went down the ha on one side and NA #3 on the oth on the other side. She stated that s reported that NA#1 and #3 were s	g? She said (Resident #1) is getting on my dar ill with her. NA #2 reported that (Resident #1 er side. NA #2 said she saw NA #1 swing and she helped (Resident #1) stand up and put on 1	mn nerves. NA #2 said she told NA #1 that she ) was sitting on the side of the bed with NA #1 d hit (Resident #1) in the face. Then NA #3 swung his shoes and went out of the room. NA #2	
assistants outside of the facility. During follow up telephone interview with NA #2 on 1/5/16 at 8:45 pm she stated that she was standing right in front o (Resident #1) in the room. She said NA #1 was on her left side and NA #3 was on her right side. She stated that NA #1 (Resident #1) in the face and NA#3 was in a boxing stance when she hit the resident. NA #2 reported that (Resident #1 swinging but she did not see him hit either NA #1 or #3. NA #2 said that she told NA #1 and #2 to stop. NA #2 said		assistants outside of the facility. During follow up telephone interv (Resident #1) in the room. She sa (Resident #1) in the face and NA#	iew with NA #2 on 1/5/16 at 8:45 pm she stat id NA #1 was on her left side and NA #3 was #3 was in a boxing stance when she hit the res	ted that she was standing right in front of s on her right side. She stated that NA #1 hit sident. NA #2 reported that (Resident #1) was	

ENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED:5/27/2016 FORM APPROVED OMB NO. 0938-0391
ATEMENT OF EFICIENCIES ND PLAN OF DRRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2016
JKKEC HON	345370		
ME OF PROVIDER OF SU		STREET ADD	RESS, CITY, STATE, ZIP
NEHURST HEALTHCAR	E & REHAB	300 BLAKE B PINEHURST,	
r information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state su	
X4) ID PREFIX TAG		DEFICIENCIES (EACH DEFICIENCY MUST B	E PRECEDED BY FULL REGULATORY
F 0226	OR LSC IDENTIFYING INFORM (continued from page 3)	MATION)	
	reported the incident to the nurse		0:00am another CNA (cortified pursing
Level of harm - Immediate eopardy Residents Affected - Few	assistant) (NA) came to me which into (Resident #1 ' s) room. Upon (Resident #1) was swearing, swin stepped in and started talking to (	en by nurse aide # 3 revealed: At or around 8:30, h was (NA#1) and asked for help. (NA #2) was st e netering (Resident #1 ' s) room (Resident #1) alr iging and kicking at (NA #1), so she stepped back Resident #1). At first he started swinging and kic	anding in the hallway and followed NÅ #1 and eady was being loud and combative. c. NA #2 was just standing at the door. I king again. I put my hands up and told
	(Resident #1) looked at me and sa okay. I began to put his pants on, had gotten (Resident #1) calm and	havior would not be tolerated. And told him he w aid yes. I then told (Resident #1 to let's finish ge (NA #1) was still in the room, but just standing t d putting his clothes on. Once (Resident #1) was to the nurse that he was being combative.	tting his clothes on and he said here. (NA#2) then tried to help once I
	During interview on 12/31/15 at 3 better come down and stated that He was waving his hands. I took clothes on and get dressed for the reported that no one helped her dr	(Resident #1) was being combative. So provide that on Sunday (Resident #1) was being combative. Soon as we ' his hands in mine and said you need to calm dow day. I said will you do that for me? He calmed d ress him. I told them (NA#1 and #2) to just let me hands up and called his name several times. She s	walked to the door he was already combative. n. I told him that he needed to put his own, I put his clothes on. NA #3 e do it. The NA stated that when the
	before and he can get a little rowd (Resident #1) was sitting on the s for no reason.	dy. NA $#3$ reported that NA $#1$ was standing behi ide of the bed when they were all in the room. Sh	ind her, NA #2 was at the door and the reported that the resident was upset
	#2 reported to me (Nurse #1) that help with (Resident #1). NA #2 si above stood on either side of the	y Nurse #1 (nurse assigned to the resident's hall of this morning around 9:45-10:15 am another CNA tated while she was in (Resident #1) room with (1 resident as she was assisting place his pants on hi NA#3) slapped him as well. NA #2 also stated bo	A (certified nursing assistant) asked her to NA #1 and NA #3), the two cna's listed m, one CNA (NA#1) slapped resident in
	more agitated and combative. I sp them back, then he pointed to NA marks at that time.	booke with resident and he said two women were in \$\$\#2\$ saying she was there, but she was the one that \$\$2 pm on 1/5/16 with the Nurse #1 (nurse assigned)	n his room and they hit him, but that he hit at helped me. Resident did not have any
	medication. She said that his face supervisor. Nurse #1 reported tha wheelchair in the hallway when s	e did not know about the incident when she went was a little red at that time but was not red at all it Resident # 1 was a very confused resident. She the asked him if someone hit him. Nurse #1 repor	when she went in with the nurse said she saw Resident #1 up in his ted that Resident #1 said Yeah, there were
	two of them but she helped me an with the nurse supervisor he was During telephone interview with t	nd pointed to NA #2. The nurse further stated that	when she went to talk to the resident around 3:30
	shift change. The supervisor said	I he said no. The supervisor said that the girl who that she has not known the resident to have any I is supervisor reported that she has worked with the tstanding.	ucid moments and that he talks stuff
	that 2 CNA's (Certified Nursing A arrived at facility on Monday Dec	(DON) statement revealed, It was reported to me Assistant) slapped a resident during morning ADI cember 28, 2015 I went and did a skin assessment aarks noted on resident. I also asked the resident i	(activity of daily living care). When I t on resident at 9:30 am. There was no
	and the resident did not have any yesterday that you need to tell me	rses (DON) on 12/31/15 at 3:09 pm revealed that redness or bruising. The DON said that she asked e about? The resident said no. Interview with the l	d the resident, Did anything happen DON revealed that NA #1 and #3 were
	was observed working on 12/31/1 mistreatment during the abuse inv Telephone interview with the Dire	investigation. Per the DON, NA #1 was terminate 15 at 2:30 pm). The DON reported that no other re- vestigation. ector of Nurses on 1/6/16 at 10:51 am revealed the hat sometimes in the mornings the resident is mor-	esidents had been interviewed regarding at the resident was alert and oriented to
	were not notified of the allegation During interview with Resident # that he hit them back. The resider	In a some of the more more more than the more than a some more than a som	meone hit him on the hand 2-3 times and who she was) doesn't belong here or
	During telephone interview with t contact with the DON and the reg	the facility administrator on 1/6/16 at 10:55 am th gistered nurse (RN) supervisor. The RN superviso rved the resident with no markings and he did no	e administrator reported that he was in or could not find any markings on the
	Review of a statement written by (facility). (Resident #1) was admi Resident is alert and oriented X 1 the east wing brought an incident slapping a resident in the face. Du assessment on the resident. Per th	the facility administrator (undated) revealed, (Res itted to our facility on 7/7/15. (Resident #1) suffer . Resident is able to make his needs know (know: to the charge nurse on 12-27-15 around 10am. To ue to the severity of this incident, the charge nurse is skin assessment and nurse statement, no bruisi arge nurse had the RN supervisor to perform a ski	rs from multiple [DIAGNOSES REDACTED]. n). A CNA (Certified Nursing Assistant) on his incident was accusing two CNAs of e went down and performed a skin ng or red marks were noted to the area
	resident and she asked resident if write a statement before they left combative and he hit them but the assessment on 12-28-2015 at 9:30 incident report. She performed an hitting him. Based on the informat	I marks to the areas noted in the incident report. T anyone had hit him today and (Resident #1) state and both CNAs denied hitting (Resident #1). The ey got help from another CNA to perform care on 0 am and was unable to locate any bruising or red interview with the resident and the resident did 1 ation provided by the accuser, the accused and the	ed no. The two accused CNAs were asked to ey did state that (Resident #1) was (Resident #1). The DON performed a skin areas to the locations noted in the not remember anyone being mean to him or e investigation that followed, the
	The administrator was notified of Credible Allegation To insure the safety of the identifi	d that there is not enough evidence to substantiate immediate jeopardy on 1/6/16 at 4:45 pm. ed resident, The Charge Nurse was informed of a e Nurse went to the identified resident 's room an	n abuse allegation on 12-27-15 around
	at 12:32 pm. This skin assessmen allegation. The Charge Nurse not Supervisor removed the CNAs (N RN supervisor went to the room a interview the RN supervisor ask t performed another skin assessme bruising. At this time the RN sup	tt showed some redness but no markings or bruisi ified the RN supervisor around 3:00 pm of the ab AA = 1 and $NA = 3$ from the building and suspen at 3 pm to perform an interview and skin assessm the identified resident if anyone had slapped him, nt on identified resident's facial area and was unai ervisor contacted the Director of Nursing. The Di	ng on the face area identified in the abuse use allegation at that time the RN ded them until investigation was completed. The ent on the identified resident, during the his comment was NO. The RN supervisor ble to identified any markings or rector of Nursing contacted the
	Director of Nursing performed an 9:45 am on 12-28-2015. During to on the facial area in the abuse allo	17-15. The Director of Nursing submitted a 24 hor i interview and a skin assessment to the facial are his interview the identified resident denied any at egation. The Responsible Party for the identified a concerning the abuse allegation. The Medical Director is a statement of the statement	a identified in the abuse allegation at buse and were no noted bruising or marks resident was notified by the Director

STATEMENT OF     (X1) PROVIDER / SUPPLIER     (X2) MULTIPLE CONSTRUCTION     (X3) DATE SURVEY       DEFICIENCIES     / CLIA     A. BUILDING     COMPLETED       AND PLAN OF     IDENNTIFICATION     B. WING     01/13/2016	DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:5/27/2016 FORM APPROVED OMB NO. 0938-0391
AME OF PROVIDER: OF SUPPLIER         FIFEER ADDRESS. CTY, STATE, 200           PREDUCT HEALTHEALTER ARE REHAB         INDEXER DOLLARS TO CITY, STATE, 200           PREDUCT HEALTHEALTER CARE & REHAB         INDEXER DOLLARS TO CITY, STATE, 200           PREDUCT HEALTHEALTER AND OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OK LS 200         INDEXES TO CITY, STATE, 200           (X4) DEPERIN TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OK LS 200         INDEXES (CTY, STATE, 200           F0226         ContinueL_from nge 4)         that identified exident regression to the durative and any durative sent on to the comparison of the start and the state analysis of the state the state	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	Ì CLIA IDENNTIFICATION NUMBER	À. BUILDING	TION	(X3) DATE SURVEY COMPLETED
PAPELIURENT ILBACTIVE-LET LEAR INTERPORT         Image: Control interport           C4:01 DPERENT TAG         INTERPORT         INTERPORT           C5:01 DPERENT TAG         INTERPORT         INTERPORT           Residents Afferded 1         INTERPORT         INTERPORT         INTERPORT           Residents Afferded 1         INTERPORT         INTERPORT         INTERPORT         INTERPORT           Residents Afferded 1         INTERPORT         <	NAME OF PROVIDER OF SU			STREET ADDRESS CITY S	STATE ZIP
Terr information on the mursing home types         constant the nursing home or the state survey agency.           CAU ID PREFIX Tod         EUMANY STATEMENT OF DEFECTENCE IG ACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DESTITY/NO INFORMATION).           F0226         Construction of the mursing home of the distance in the Medical Director performed the evaluation that norming around 9 that identified resoluted with the need of a physican output might good brinning to the final arcs. The origination of the mursing home of the mursing home of the submatrix of the submatrix of the submatrix of left shoulder pain. The Responsible Party stigned the resident vase samuled by some of the suff at the facility about week age. The physican output might also burbing and strain of 350 pm on 12-80-15 for accepting more y from a family member to wash the resident vase with facility is work age. The physican output might also all engines in about Higgs in the submatrix of the suff at the facility about week age. The physican output might also burbing and the submatrix of more and participation and the submatrix of the suff at the facility about a week age. The physican output might also burbing the submatrix of the suff at the facility about a week age. The physican output might also burbing the submatrix of the suff at the facility about a week age. The physican output might also burbing the submatrix of the submatrix of the submatrix of 12-80-15 for accepting more y from a family member to wash the resident's clubes and submatrix of the submatrix of the submatrix of the submatrix of the submatrix of the submatrix of the submatrix of the submatr				300 BLAKE BOULEVARD	
<ul> <li>UMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF DEPICEMENT MINING INFORMATION)</li> <li>F0226</li> <li>Continued, IDENTIFYION INFORMATION)</li> <li>The Medical Director noted of Ashn tears but did not note anything about bruising or markings to the facial area. The prophotone information of the medical Director noted of Ashn tears but did not note anything about bruising or markings to the facial area. The prophotone information of the medical director in the Medical Director noted of Ashn tears but did not note anything about bruising or markings to the facial area. The prophotone information of the medical and article at the compression of the staff at the facial part of the staff at the medical director period of the staff at the facial part of the staff at the facial part of the staff at the facial part of the staff at the theory of the staff at the facial part of the staff at the sta</li></ul>	For information on the nursing	home's plan to correct this deficien	icy please contact the pursing ho		
<ul> <li>F0226</li> <li>Cradinatez, I. from page, 4)</li> <li>The Medical Director noted of Asin tears but did not note anything about hursing or markings to the final arcs. The population of the model of physical examination. The Medical Director performed the evaluation that morning around 9</li> <li>Residents Affected - Few K</li> <li>Keisidents Affected - Few K</li> <li>For the population will adold a stay to Department of Social Services by 1-6-16. Social Services. The stew on a cut finature is note. The physical move is assigned to the isolation to day that the resident was assembled by zero. The or were no acute finature is note. The physical move isolation of the staff at the finature is note. The physical move isolation of the staff at the finature is note. The physical move isolation of the staff at the sta</li></ul>	ŭ	· · ·	•••		BY FULL REGULATORY
<ul> <li>that identified resident accided a physical examination. The Medical Director performed the evaluation that morning around 9 and 9</li></ul>	E 0226		MATION)		
the facility aload a week ago. The physician ordered 5-arys and fontified Department of Social Services. There were no acute fractures noted. The physician well send through a T-35 pm on 1-1-16 with no same changes. CNA 1 (NA + 1) that was involved in abase dilegation was terminated on A T-27 and T-270-15, she was no acute through a T-35 pm on 1-1-16 with no same changes. CNA 1 (NA + 2) was terminated on 1-0-16 previous and there ther	Level of harm - Immediate jeopardy	that identified resident needed a am. The Medical Director noted Responsible Party for the identifi of left shoulder pain. The Respor	old skin tears but did not note any ed resident requested that the resi nsible Party signed the resident ou	thing about bruising or marking dent be sent out to the emergen at and arrived at the emergency of	gs to the facial area. The cy room for complaints room at 3:59 pm on
	Kesidents Affected - Few	<ul> <li>the facility about a week ago. The fractures noted. The physician with facility at 7:45 pm on 1-1-16 with 12-30-15 for accepting money free and the set of t</li></ul>	e physician ordered x-rays and ne ill send all x-rays to Department of h no actue changes. CNA 1 (NA# f om a family member to wash the 5, she was not assigned to the ide identified resident. CNA 2 (NA ort was filed on 1-6-16 in regards reviewing all parties involved. Th of his investigation that concludec The 5 day investigation was com time and as needed staff were in s was seen by Nurse Psychiatrist of haviors. The interventions that she ident around the wrist, when ressi ill always have two people in the Kardex and care plan. All CNAs lentified resident will be continue ved in this abuse allegation have 1 lential to the affected by the same dents also have the right to be free lents of aggressive, sexual, or abu t. This must be reported immedia hecks on all potential employees 1 minal charge that could lead to abu e individual is never hired. The in-service covered the compar mediately when told or seen an o report, protect and prevent abus ty and Adfinistrator of the buildin to figure out what is making the r ng them combative or agitated. 3r ent, 4th always take your time an tesident's rights were included in 1 vice. Coordinator, Director of Nursing reft mistreated by a staff mema breused CNA's (NA # 1 and # 3) te ated by any member of the staff. s conducted Thursday, January 7, of abuse and how and who to repor responsible parties of residents tf s behaviors or physical signs re in addits for injuries of unknown of vAs (NA # 1 and # 3) were assign my behaviors or physical signs re in addits for injuries of unknown of vAs (NA # 1 and # 3) were assign the company abuse policy on hire e (NA # 2) was in serviced on 1-1 m 1-7-16. ed on 1/13/16 at 3:00PM as evide do if a resident displayed aggress of facility staff had been in-servi	tified Department of Social Ser of Social Services by 1-6-16. Re 4 1) that was involved in abuse 2 resident's clothes and she never nififed resident and was forbidd # 2) was terminated on 1-6-16 6 to this abuse allegation, a polic he Police Report number is . That there was not enough evidence pleted and submitted by Directt serviced on combative and agita in 1-7-16 to see if there are any recommended were to redirect dent is touched around the wrist room when care is being perfor- must go to the Kardex before e d to be monitored by the Nurse been terminated and are banned alleged deficient practice: sive behavior by one resident to tely to the supervisor and the re pefore hiring them. The Admini- use. If the background check rep -16 by the Nursing Consultant o olice immediately when notified -116 thru 1-6-16 by the Directo ry's abuse policy, what types of d how to identify signs and sym e in the facility. The in-service i ng must be informed immediate elder justice act and received a d Speak clearly and slowly to th the in-service on 1-6-16 that inc and Clinical Supervisors asked er of the facility, this included a hat were named in the abuse all All interviews were completed 2016. The residents will be ren rt it to. at cannot speak for themselves sible abuse on 1-6-15. These in used & performed care on. There ported by any of the responsible origin for 100% of residents, thi ed and performed care on. There date, at each alleged incident of -16, she admitted there was an 1 d due to breaking company abuse -16, she admitted there was an 1 d due to breaking company abuse -16, she admitted there was an 1 d due to breaking company abuse -16, she admitted there was an 1 d due to breaking company abuse -16, she admitted there was an 1 d due to breaking company abuse -16, she admitted there was an 1 d due to breaking company abuse -16, she admitted there was an 1 d due to breaking company abuse -16, she admitted there was an 1 d due to breaking company abuse -16, she admitted there was an 1 d due to breaking company a	vices. There were no acute sident returned to the illegation was terminated on returned to work. CNA 2 (NA en by the Director of ue to the abuse allegation e officer interviewed e police officer hand to rof Nursing on 12-30-15 at ted residents from 1-1-16 interventions to help resident if agitated area it can cause him to med. These interventions ach shift to see how to Psychiatrist. Both CNAs from coming on the or other mistreatment ward another resident sident must be protected strator reviews all backgrounds sorts any criminal items n the company abuse policy, d. rof Nursing, Clinical abuse, who to report the ptoms of abuse to nonverbal included that the ely when abuse is reported. to opy to review and keep with combative and can redirect the person, go get someone else e resident, and 5th luded the resident all residents including egation All residents on 1-6-16 at 8pm. hinded of their rights to be to inquire of any terviews included those were no concerns voiced by e parties is includes 100% of se skin audits were completed a buse or neglect and hour delay in telling her se policy and endangering the hour delay in telling her se policy and procedures, taken if abuse was