STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115394	A. BUILDING _____ B. WING _____	03/28/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH - PEAKE	6190 PEAKE ROAD MACON, GA 31220

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 0166 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Try to resolve each resident's complaints quickly.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the policy titled, Grievances, resident and staff interviews, the facility failed to ensure prompt efforts to resolve a grievance related to missing personal items for one of 44 sampled residents (R) (R#47). Findings included: Review of the policy titled, Grievances revised 11/21/16 documented: It is the policy to follow an established process whereby patients and/or other customers may have their grievances and complaints resolved in a prompt, reasonable and consistent manner. All partners should take an active part in efforts to resolve grievances and complaints. The policy further documented that in the event a patient expresses a grievance or complaint to a staff member one or more for the following: If the grievance is associated with a missing item, refer to the Missing Item Policy and associated forms. Review of the policy titled Missing Items Policy revised 5/4/16 documented: It is the policy to follow the established grievance process to resolve complaints in a prompt, reasonable and consistent manner. This policy applies to all partners employed by the facility. An interview with R#47 on 3/21/17 at 10:35 a.m. revealed she had received balloons on Valentine's Day and for her birthday (March 3rd). Someone removed the balloons from her room and she still does not know where her balloons are. R#47 called her husband and he called the facility to ask where the balloons were taken and why they were taken. The Licensed Practical Nurse (LPN) KK came in to speak to R#47 and told her that the State said that she cannot have her balloons in the room. The resident was observed to be very agitated and upset about the missing property and voiced that she wanted to know why other residents could have personal items in their rooms but she could not. Record review for R#47 revealed a Quarterly Minimum Data Set (MDS) assessment dated [DATE], which documented a Brief Interview for Mental Status (BIMS) summary score of 12, indicating moderate cognitive impairment. During an interview with the Senior Care Partner, the Interim Director of Nursing (DON), and the Social Services Director (SSD) on 3/27/17 at 3:44 p.m. they confirmed that they were not made aware that R#47 was missing her balloons that she received on Valentine's Day. An interview with the Certified Nursing Assistant (CNA) (CNA MM) on 3/28/17 at 2:26 p.m., confirmed that R#47 did mention to her when she returned from [MEDICAL TREATMENT] a few weeks ago that she was upset about her balloons being missing from her room. CNA MM stated that she did not know what happened to the balloons and confirmed that she did not report that the resident was upset about her missing balloons. During an interview with Licensed Practical Nurse (LPN) (LPN JJ) on 3/28/17 at 2:39 p.m. she stated that R#47 did tell her about her missing balloons when she came back to work after a few days off. LPN JJ stated that R#47 told her that when she left one morning to go to [MEDICAL TREATMENT], the balloons were in her room and that when she returned from [MEDICAL TREATMENT], her balloons were gone. She stated that the resident was really upset about the balloons being missing. LPN JJ further stated that R#47 told her that she believed that LPN KK threw her balloons away. LPN JJ asked R#47 did she report this to someone and R#47 told her yes. LPN JJ stated that she mentioned it to the Unit Manager Registered Nurse (RN) (RN NN), who only works PRN (as needed). RN NN told her she was aware of the residents' concerns. A review of the Grievance Log revealed that there was not any evidence or documentation that a grievance was filed for R#47 related to her missing balloons.
F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility policy titled Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of property, resident and staff interviews, the facility failed to ensure that three of 44 sampled residents (R) (R#112, R#80 and R A) were free from verbal and physical abuse by a Licensed Practical Nurse (LPN) (LPN KK). On March 23, 2017, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. The facility's former Administrator and former Director of Health Services (DHS) were informed of the immediate jeopardy on 3/23/17 at 6:50 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on 2/11/16. The immediate jeopardy continued through 3/27/17 and was removed on 3/28/17. The facility implemented a Credible Allegation of Compliance related to the immediate jeopardy on 3/25/17. The Immediate Jeopardy is outlined as follows: Review of the clinical record revealed that R#112 had reported to the facility on [DATE] that Licensed Practical Nurse (LPN) (LPN KK) had verbally abused her. The facility failed to thoroughly investigate, and failed to report, this allegation of abuse. The facility failed to follow their abuse policy and failed to protect other residents, from LPN KK. The facility continued to allow LPN KK to continue to work with R#112, and other residents, after the facility was aware of the abusive behavior on 2/11/16. The facility's failure to thoroughly investigate, and report, the allegations of abuse, and by continuing to allow LPN KK to continue to work in the facility R#112, and other residents, continued to be subjected to abusive behavior from LPN KK. The immediate jeopardy was related to the facility's noncompliance with the program requirements at 42 C.F.R. 483.12(a)(1) Free from Abuse/Involuntary Seclusion (F223 S/S: J), 483.12(a)(3)(4)(c)(1) Investigate/report allegations/individuals (F225 S/S: J), 483.12(b)(1)-(3) Develop/implement abuse/neglect etc. policies (F226 S/S: J), and 483.70 Effective Administration/resident wellbeing (F490 S/S: J) Additionally, Substandard Quality of Care was identified with requirements at 42 C.F.R. 42 C.F.R. 483.12(a)(1) Free from Abuse/Involuntary Seclusion (F223 S/S: J), 483.12(a)(3)(4)(c)(1) Investigate/report allegations/individuals (F225 S/S: J), 483.12(b)(1)-(3) Develop/implement abuse/neglect etc. policies (F226 S/S: J). In addition Harm was identified at 483.21(b)(3)(ii) Services by qualified persons/ per care plan 483.25(e)(1)-(3) and No catheter, prevent UTI, restore bladder (F315). A Credible Allegation of Compliance (AOC) was received on 3/25/17. Based on observations, record reviews, interviews and review of the facility's policies as outlined in the AOC, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 3/28/17. The facility remained out of compliance at a lower scope and severity at

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 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) F223 S/S: D, F225 S/S: D, F226 S/S: D and F490 S/S: D, while the facility continued management level staff oversight of the facility's abuse policy, recognizing allegations of abuse, investigating abuse, and reporting abuse. In-service materials and records were reviewed. Observation and interviews were conducted with staff to ensure they demonstrated knowledge of facility Policies and Procedures governing abuse. Findings include: Review of the facility policy titled Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property revised 11/21/16 documented: It is the policy of Pruitthealth and its affiliated entities (Collectively, the Organization) to actively preserve each patient's right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation, mistreatment and misappropriation of property, referred collectively in this policy as abuse, mistreatment and exploitation. The organization and its partners should assure that best efforts are made to prevent any occurrences of any form of abuse, neglect and exploitation. 1. Record review for R#112 revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE] which documented a Brief Interview for Mental Status (BIMS) summary score of 10, indicating moderate cognitive impairment. The MDS assessment revealed the resident did not exhibit hallucinations or delusions. Review of the resident's clinical record revealed [DIAGNOSES REDACTED]. During an interview with R#112 on 3/21/17 at 12:37 p.m. she alleged that a black nurse on first shift has a history of verbally and physically abusing her. The nurse yells and hollers at her and has also threatened to stick her with needles. She stated that she told the people over the facility and when she told the people over the facility the nurse went crazy, hit her across the back and shoved her. The resident stated she did not report when the nurse went crazy, hit her across the back and shoved her. Upon further interview with the resident on 3/21/17 at 12:37 p.m., the resident stated that she was afraid of this nurse. R#112 stated that this occurred about three weeks ago. R#112 could not provide details of an exact date or name of the nurse but she was able to describe the nurse, knew she worked during the day and administered her medications. R#112 stated that the nurse was not working today (3/21/17). Review of the Reportable Occurrence Log Form failed to reveal an allegation made by R#112 during the past several weeks. Further review of the Reportable Occurrence Log Form revealed an allegation was made by R#112 on 10/28/16. Review of the allegation dated 10/28/16, revealed that at approximately 5:00 p.m. during a internal facility survey process, the resident was interviewed and alleged that a heavy set female staff employee pushed her. During an interview with R#112 on 3/22/17 at 11:43 a.m., she stated that the nurse who abuses her was working today. R#112 stated it was the nurse who had administered her medications this morning. R#112 stated that the nurse came in today and said Get up! R#112 stated she tried to sit up. And the nurse said Get up! If you don't sit up, I'm going to give you a shot! I don't suppose to get shots so I just sat up! The Licensed Practical Nurse (LPN) (LPN KK) was observed at the medication cart outside of R#112's room, just after the interview with R#112. LPN KK confirmed that she was assigned to care for residents on this hall (300 hall, for which R#112 resides). LPN KK fit the description provided by R#112 as the alleged perpetrator. The facility former Administrator was informed of this incident by the surveyor at this time. During an interview with the former Administrator on 3/22/17 at 11:47 a.m., who is also the facility's abuse coordinator, revealed on 10/28/16 at 5:00 p.m. the Certified Nursing Assistant (CNA)/Central Supply Scheduler (CNA SS) reported to her that R#112 had made an allegation of abuse by staff. She stated that the resident alleged that she had been pushed by a heavy set woman, but could not communicate when this occurred or by whom. She stated that R#112 was unable to give any further description of the staff member. She stated that R#112's family member was in the room at time of the interview with CNA SS. The Administrator stated that a thorough investigation had been conducted and that the incident was reported to the State Agency. The former Administrator repeatedly stated R#112 had a BIMS score of seven and therefore the allegation was not credible and was unsubstantiated. The former Administrator provided an untitled document dated 11/3/16, which was addressed to the Georgia Department of Health - LTC- Complaint unit. The document stated that during a quarterly resident interview, R#112 answered yes when asked about ever being abused. R#112 did not know the name of their staff member, but reported that she was a very heavy woman. R#112 did not know the time or date of the occurrence. The former Administrator was not able to provide any additional relevant information that the allegation of abuse was investigated and only that the allegation was unsubstantiated (refer to F225). Review of the State Agency Complaint and Incident Tracking System during the survey revealed no evidence of an entity self-report related to this incident of 10/28/16. During an interview with LPN KK on 3/22/17 at 12:13 p.m., she revealed that she has worked at the facility for two years and has a set assignment on the 300 Hall (where R#112 resides). LPN KK stated that she was assigned to care for R#112. LPN KK stated she was not aware of any concerns R#112 may have had related to verbal abuse, physical abuse or mistreatment. During an interview with a family member of R#112 on 3/22/17 at 12:37 p.m., the family member stated that she was in the room when R#112 told staff that she was pushed by an employee at the facility. The family member stated R#112 said the person who pushed her was a large black woman. Review of the employee file for LPN KK, revealed a Grievance Complaint Form dated 2/11/16, which was stapled to a Record of Partner Corrective Action Form dated 2/15/16. Review of the grievance report revealed R#112 informed the Senior Care Partner (SCP) Registered Nurse (RN) that When I turn on my call light, LPN KK won't answer. When she comes in, she's always talking loudly and when I tell her that my leg hurts, she tells me to 'Shut up!' and there is nothing wrong with my leg. The way she talks to me hurts my feeling and nobody else here talks to me that way or hurt my feelings. The SCP RN noted that R#112 began to cry at this point during the conversation. The Record of Partner Corrective Action Form dated 2/15/16 indicated there was no investigation conducted and LPN KK received a written warning related to a violation of discourtesy to the patients/residents. Review in the State Agency Complaint and Incident Tracking System during the survey revealed no evidence of an entity self-report related to the 2/11/16 incident. An interview with the Interim Administrator on 3/28/17 at 4:15 p.m., who replaced the previous Administrator on 3/24/17, revealed the incident involving LPN KK and R#112, which was documented on the Grievance Complaint Form dated 2/11/16 and the Record of Partner Corrective Action Form dated 2/15/16, should have been investigated as an allegation of verbal abuse. An interview with the Senior Care Partner (SCP) on 3/28/17 at 4:24 p.m., confirmed that she filled out the Grievance Complaint Form dated 2/11/16 at 5:50 p.m. The SCP reviewed the form and confirmed that R#112 began to cry during the interview. The SCP stated that she reported this to the Administrator because the nature of the grievance was an allegation of abuse. She stated that she was not sure what the former Administrator did after she reported it to her. 2. During an interview with R#80 on 3/24/17 at 1:18 p.m., (who resided on the 300 hall) he stated that a nurse comes around and curses him and makes him mad. This same nurse threatened to beat the hell out of him. R#80 stated that she has shoved him in the past and that he was sort of afraid of her R#80 did not know the name of the nurse but described her as a black female nurse weighing about 250 pounds. He stated that he could identify her if he saw her but he had not seen her today. R#80 further stated that he did not report this and did not know who the abuse coordinator was. Record review for R#80 revealed a quarterly MDS assessment dated [DATE], which documented a BIMS summary score of four, indicating severe cognitive impairment. [DIAGNOSES REDACTED]. The MDS revealed the resident did not exhibit hallucinations or delusions. Despite a BIMS score of four, the resident was able to accurately describe his nurse and knew that he had not seen LPN KK on the day of his interview on 3/24/17. (Although R#80 had a BIMS score of four, on 3/24/16 at 1:16 p.m., LPN XXX included R#80 on a list of residents who, were in her professional opinion candidates for resident interviews.) 3. During an Interview on 3/24/17 at 2:00 p.m., with R A(who resided on the 300 hall), R A reported a nurse would make her wait for her medications. R A stated the nurse was overly aggressive with words and always had an attitude when speaking to her. R A was fearful to name the nurse initially, but stated the nurse wore green and worked on Tuesday (3/21/17). R A eventually named the nurse as LPN KK and was visibly upset when talking about her. R A had never reported this to the facility. R A was crying throughout the interview and was afraid that she would be retaliated against if others knew that she was telling about the treatment from LPN KK. Record review for R A revealed an annual MDS assessment dated [DATE] which documented a BIMS summary score of 15, indicating no cognitive impairment. The resident was not assesed to have exhibited behaviors of hallucinations or delusions. A post survey interview with the Interim Administrator was conducted, via the telephone, on 4/7/17 at 10:04 a.m. The interview revealed that LPN KK was terminated on 3/27/17 and was reported to the Nursing Board on 3/29/17 by the Interim DHS.

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F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) The facility implemented the following actions to remove the Immediate Jeopardy: What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? Nurse in question was immediately suspended pending the investigation on March 22 2017, Administrator is conducting an internal investigation related to this event Investigation was started on March 22 , 2017 and is on-going. 24 hour report was completed and submitted to state on March 22, 2017. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? On March 22, 2017 the Nurse Management and Senior Care Partner interviewed 11 residents with a BIMS score of 10 or above on the unit where the accused nurse worked (this was 100% of residents on this unit with a BIMS of 10 or above). On March 24, 2016 the center expanded our sample to an additional 46 residents with a BIMS score of 10 or above (this was 100% of all residents in the center with a BIMS of 10 or above). The center performed a 100% body audit of all residents with a BIMS score of 9 or below with no adverse findings on 3/26/2017. Staff has also been in-serviced on the identification of injuries or events that are suspicious and may constitute abuse in patients of all levels of cognition. Based on our interviews the following allegations were reported. On March 22, 2017 we had one allegation (of abuse) which was reported for an allegation on a CNA. This was reported and the CNA was suspended. On March 27, 2017 interviews revealed we had one additional allegation (of abuse) which was reported from a resident on an unnamed CNA which was stated to have happened twice over the last 8 months. This allegation was also reported to the state. On additional interviews with this patient she stated that CNA doesn't work here any longer. We had two allegations (of abuse) brought to us by the survey team regarding the nurse in the original complaint, These two alllegations were also reported to the state agency. We have filed a police report based on the allegations against the LPN. We have had 3 total allegations against the LPN, The investigation on the LPN will be completed resulting in the termination of the LPN. We have had a total of 7 [MEDICATION NAME] (3 from the survey team; 2 from interviews; 2 presented to staff). Of the four [MEDICATION NAME] (self reports) submitted by the center 3 had a BIMS of 10 or greater and 1 had a BIMS of 99, During this time frame we have suspended 7 staff members. What measures will be put in place or systematic changes will be made to ensure that the deficient practice will not reoccur? Education began on March 22, 2017 for all staff (to include Nursing, CNAs, Housekeeping, Dietary, Laundry, Maintenance, Administrative, Therapy and Respiratory Therapy) conducted by the Clinical Competency Coordinator, on abuse and reporting abuse per policy. The in-service included types of abuse that must be reported, how and who to report to, and the time frame for reporting. The center has 90% staff in-service completed as of 3/25/17. Any staff not receiving the in-service after 3/26/2017 related to FMLA, PRN status, or paid time off will be educated before the next schedule shift for that staff member. Education on abuse is reviewed in new partner orientation by the Clinical Competency Coordinator. Any staff members not receiving the in-service will be unable to return to work until they have completed the in-service. On March 24, 2017 the Administrator met with Resident Council to review abuse and reporting of abuse. There were no allegations reported during resident council. The resident council was educated on who to report to and will continue to be reassured that they can report without fear of retaliation. On 3/27/2017 the Administrator posted his personal contact information in the front lobby and at both nursing stations. In addition, the Administrator distributed the reporting phone numbers for the Ombudsman, Department of Community Health reporting, and the Pruitt Health Customer Service Hot Line to all residents with a BIMS score of 10 or above. These numbers are also posted in common areas for all visitors and families to see. How will the corrective action be monitored to assure that the deficient practice will not reoccur? Administrator will notify the Area Vice President immediately of any alleged reports of abuse or neglect. The center will continue to follow new hire policy and procedure which includes checking the applicant's background, licensure/certification, and two reference checks. The center will also begin checking all licensed and certified staff on a quarterly bases. All RNs, LPNs, CNAs, and therapist have been completed with no other findings. (Other than the one LPN who was terminated on 3/28/2017) Administrator and Area Vice President will review all allegations of abuse and neglect. To ensure accurate and thorough investigations were completed and reporting is completed per current policy. Abuse policy is reviewed yearly by the compliance officer at the corporate office and was updated on [DATE] to include the new requirements of participation. The State survey agency validated the implementation of the facility's Credible Allegation of Jeopardy Removal (CAJR) as follows: Review of Records revealed a Notice dated 3/26/17 documented the following: LPN KK was suspended 3/22/17. As of 3/26/17 employee is still suspended pending investigation. Continued record review revealed a Separation Notice dated 3/27/17 for LPN KK documenting that LPN KK was terminated from employment on 3/27/17. Reason for separation documented to be: Serious Rule Violation - Resident Abuse. Record review revealed that investigation conducted and incident reported. Record review revealed forms titled, Resident Interview Question Alleged Abuse Investigation which revealed on 3/22/17 10 residents with BIMs greater than 10 were interviewed with no adverse findings noted. Further review revealed that on 3/24/17 46 residents with BIMS 10 or greater were interviewed. Alleged Abuse Investigation forms for the 10 residents interviewed on 3/22/17 and for the 46 residents interviewed on 3/24/17 revealed the following questions were investigated: Have you ever been treated roughly by staff? Have staff injured you on purpose? Have you ever had an injury that you did not know how it happened? Do you ever feel afraid because of the way you or some other resident is treated? All forms reviewed for each resident. Record review revealed Body audit forms were reviewed for all residents with BIMS score less than 9. No adverse findings documented. Review of In-service Program Attendance Record Form dated 3/22/17 for Abuse revealed 113 staff members signed in for attendance. Review of Resident Interview Question Alleged Abuse Investigation revealed the following questions documented on the questionnaire: Have you ever been treated roughly by staff? Have staff injured you on purpose Have you ever had an injury that you did know how it happened? Do you ever fee afraid because of the way your or some other resident is treated? Review of Staff list compared to In-service sign in sheets educated revealed 140 staff members signed in for and attended the Abuse in-service. Review of the facility self reports and investigations revealed allegations were investigated and reported. Review of Resident Council Minutes/Report Form dated 3/24/17 and 3/26/17 revealed that Resident Council meeting was called The Resident Council president (BIMS 15) and 11 other residents. Information discussed included Abuse. Any allegations, suspicion, or identified occurrence is identified involving patient abuse, neglect, exploitation, mistreatment and misappropriation of property, reported. Area Vice President informed the residents that he will be the administrator at this time, and you need anything to let him know. Residents said they would. 3/25/17 Resident Council meeting - Discussed retaliation. - The provider will provide emotional support and assurance to patients and their families or representatives following the reporting of discovery. AVP explained to the residents that if any staff mistreated, including talked ugly to , abuse of any kind, mistreat them, to report it as soon as possible to the Charge Nurse, Administrator, nurse or anyone you see. Please report if you, or you anyone abuses you, neglects you, mistreats you or anyone you know. We are here to keep you all safe.

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F 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) Multidisciplinary staff members were interviewed. All staff stated they had attended in-services related to abuse on 3/22/17. The staff were able to define abuse and the types of abuse, how to recognize and report abuse to their supervisor and/or the abuse coordinator and were able to identify that the Administrator was the abuse coordinator for the facility. Abuse in-services were provided by the DHS, Clinical Competency Coordinator, RN Restorative Nurse on Abuse, types of abuse, how and when to report abuse, recognition of abuse for non-cognitive, or non-communicative residents. Further interview, with staff, revealed that if a confused or non-cognitive resident stated that someone hurt them then they would report that as well. Continued interview revealed that some residents that may not be able to communicate can show outward signs or behaviors of abuse such as jerking, facial expressions, shutting down and not responding anymore, that if a resident showed those kinds of behaviors that they would report it to the nurse and Abuse Coordinator. Further interview revealed that if they reported the abuse to the Charge Nurse and the Administrator and did not seem to get a response or the issue was not addressed then they would continue to report the abuse until it was addressed. Continued interview revealed that each staff member revealed that they knew how to contact the Ombudsman and HFRD to report abuse themselves. The following staff members were interviewed: 11:00 p.m. to 7:00 a.m., shift: On 3/26/17 at 12:46 p.m., with Housekeeper BBB, on 3/26/17 at 12:49 p.m., with Activities Director/CNA, 3/26/17 at 12:56 p.m., with CNAZZZ, 3/26/17 at 1:07 p.m. with CNA YYY (Restorative), 3/26/17 at 1:13 p.m. with CNA XXX, 3/26/17 at 1:47 p.m. with CNA WWW, 3/26/17 at 1:53 p.m. with CNA VVV, Interview on 3/27/17 at 6:47 a.m., with CNA UUU, On 3/27/17 at 7:00 a.m., with CNA TTT, On 3/27/17 at 7:10 a.m., with CNA SSS, On 3/27/17 at 7:15 a.m., with CNA RRR, On 3/27/17 at 7:20 a.m. with CNA QQQ, On 3/28/17 at 9:30 a.m. with CNA PPP, On 3/28/17 at 9:41 a.m. with CNA PP On 3/28/17 at 10:04 a.m., with CNA OOO, On 3/28/17 at 10:35 a.m., with CNA NNN, On 3/28/17 at 10:45 a.m., with CNA MMM, On 3/28/17 at 10:55 a.m., with CNA SS, Central Supply, CNA scheduler, On 3/28/17 at 11:03 a.m. with CNA LLL, 3:00 p.m. to 11 p.m. shift 3/26/17 at 3:24 p.m., with CNA KKK, 3/26/17 at 4:20 p.m. with CNA JJJ, On 3/26/17 at 4:53 p.m. LPN JJ, 7pm - 7AM On 3/27/17 at 6:55 a.m. (11p.m. - 7 a.m.) LPN III, 3/27/17 at 6:57 a.m., with LPN HHH, 3/27/17 at 7:03 a.m., with LPN GGG, 3/28/17 at 9:25 a.m. with RN EE (Infection control, Restorative nurse), 3/28/17 at 10:52 a.m. with LPN FFF, 3/26/17 at 12:52 p.m., with Maintenance Director EEE, 3/28/17 at 3:15 p.m., with Housekeeping DDD Interviews with the following residents revealed: Interview 3/26/17 at 1:27 p.m. with R#1, the Resident Council President, on 3/26/17 at 12:45 p.m., with R#77, on 3/28/17 at 10:50 a.m., with R87, on 3/28/17 at 11:00 a.m,, with R#88, on 3/28/17 at 11:13 a.m., R#73, on 3/28/17 at 11:20 a.m., with R#120, on 3/28/17 at 11:28 a.m., with R#66 revealed that the Area Vice President (AVP), that is currently the Interim Administrator, called a Resident Council meeting Friday night (3/24/17) and spoke with the Resident Council members and staff regarding abuse. That the residents were instructed to tell the staff CNA, Charge Nurse, any staff, and the Administrator and tell them if they have any problems. Residents were educated that they can call the Ombudsman and how to call the Ombudsman. Residents able to verbalize who they would report abuse to, who was the Abuse Coordinator, and how to report abuse themselves. Residents revealed that the AVP and Interim DHS have encouraged them to report abuse to them. Residents revealed that they (AVP and Interim DHS) want us to tell them if we have any concerns. R#1 revealed that the Ombudsman comes to facility pretty frequently and that the facility announces the resident rights over the loud speaker every morning. Information sheets were given to cognitive residents and included the phone number to the Ombudsman, HFRD, and the facility's corporate office. Review of Abuse Policy's revealed: revealed all seven components addressed. Review of the facility self reports and investigations revealed allegations were reviewed by the AVP, were investigated by the AVP, Interim DHS and were reported by the AVP. Interventions of QAPI for abuse are documented to be: All allegations of abuse will be reported to the Administrator or DHS immediately. The Administrator or DHS will report the allegation to the state agency within a 2 hour time frame. The Ombudsman will be notified. Law enforcement will be notified if deemed appropriate. A complete investigation will be completed. Staff will be in-serviced related to the abuse allegations. Review of notice regarding QAPI meeting on 3/26/17 revealed the following: On 3/26/17 the AVP educated all department heads on QAPI process, policy and procedures, their roles and responsibilities, current action plans, and how write Performance Improvement plans. AVP discussed QAPI review with Medical Director on 3/26/17. Medical Director signature observed to be on 5th page as reviewed and dated 3/26/17.
F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility policy titled, Reporting, Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, review of the policy titled, Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, resident and staff interviews, the facility failed to immediately report to the State Survey Agency and thoroughly investigate allegations of staff to resident abuse for one of 44 sampled residents (R#112). Refer F223 and F226: On 2/11/16 R#112 reported to the facility that LPN KK had been verbally and mentally abusing her. Additionally, on 10/28/16 R#112 reported that a heavyset woman, who provided her care, had been verbally, mentally, and physically abusive. In an interview with R#112 on 3/21/17 at 12:37 p.m., she stated that she had reported this to the people over the facility. R#112 could not name the nurse, but could describe her appearance, knew that she worked during the day and administered her medications. R#112 stated that she was afraid of this nurse and that the nurse was not working today (3/21/17). Additional interviews were conducted on 3/24/17 with residents who reside on the 300 hall. On 3/24/17 at 1:18 p.m., R#80 stated he was sort of afraid of a nurse, who he was unable to name and who worked on the 300 hall and provided his care. In addition, on 3/24/17 at 2:00 p.m., R A alleged verbal and physical abuse by LPN KK, however, she did not report the allegation to the facility. R A stated she was afraid of LPN KK and afraid of retaliation for telling on her. This failure to thoroughly investigate the alleged incidents reported on 2/11/16 and 10/28/16 by R#112 contributed to the increased likelihood of abuse to other residents in care of LPN KK. The facility suspended LPN KK on 3/22/17 during the survey and she was officially terminated on 3/27/17. The facility's failure to immediately report to the State Survey Agency and thoroughly investigate allegations of abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 3/23/17 and determined to have existed on 2/11/16. The facility's former Administrator and former Director of Health Services (DHS) were informed of the Immediate Jeopardy on 3/23/17 at 6:50 p.m. An acceptable Allegation of Compliance (AoC) was received on 3/25/17 and the State Survey Agency validated the Immediate Jeopardy which was removed on 3/28/17 as alleged. The Scope and Severity was lowered to a D while the facility developed and implemented the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The facility's Administrator and Director of Health Services (DHS) were informed of the immediate jeopardy on 3/23/17 at 6:50 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on 2/11/16. The immediate jeopardy continued through 3/27/17 and was removed on 3/28/17. The facility implemented a Credible Allegation of Compliance related to the immediate jeopardy on 3/25/17. Findings include: Review of the facility policy titled Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property revised 2/24/17 documented; Any allegation, suspicion, or identified occurrence is identified involving patient abuse, neglect, exploitation, mistreatment, and misappropriation of property, including injuries of unknown source, should immediately be reported to the Administrator of the provider entity. In accordance with applicable laws and regulations, the Administrator or his or her designee should notify the appropriate state agency (or agencies), the patient's attending physician, and the patient's designated representative of any allegation or incident described above and of the pending investigation. Review of the facility policy titled Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and

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F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 4) Misappropriation of Property revised 11/21/16 documented: The Administrator of the provider is responsible for assuring that an accurate and timely investigation is completed. If there is an occurrence of or allegation involving patients abuse (including injuries of unknown source), neglect, exploitation, mistreatment or misappropriation of patient property, the following investigation and reporting procedures will be followed: Documentation of the investigation should include, but not limited to; names of accused and any witnesses, any physical evidence and description of emotional state of patient(s), signed statements from pertinent parties, cognitive status of victim and patients who are witnesses (whether they are alert, oriented, and able to answer questions appropriately, information gathered from the investigation, action taken by the provider (safeguarding the patient and preventing a reoccurrence). Information gathering should include, but not limited to; written signed statements from any involved parties: the suspect, the person(s) making accusation(s), the patient(s) involved, reliable witnesses and any other person who may have information. All investigative information should be kept on file in a secured location. An interview with R#112 on 3/21/17 at 12:37 p.m., revealed that a heavy set, black nurse on first shift has a history of verbally, mentally and physically abusing her. She stated that the nurse has also threatened to stick her with needles. R#112 stated that she told the people over the facility. Upon further interview with the resident on 3/21/17 at 12:37 p.m., the resident stated that she was afraid of this nurse. R#112 stated that this occurred about three weeks ago. R#112 could not provide details of an exact date or name of the nurse but she was able to describe the nurse, knew she worked during the day and administered her medications. R#112 stated that the nurse was not working today (3/21/17). Record review for R#112 revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE] which documented a Brief Interview for Mental Status (BIMS) summary score of 11, indicating moderate cognitive impairment. A quarterly MDS assessment dated [DATE] documented a BIMS summary score of seven, indicating severe cognitive impairment. A quarterly MDS assessment dated [DATE] documented a BIMS summary score of 10, indicating moderate cognitive impairment. All three MDS assessments indicated that R#112 did not exhibit behaviors of hallucinations or delusions (section E). Review of the Reportable Occurrence Log Form revealed an allegation of abuse-physical reported by R#112 on 10/28/16. Further review of the Reportable Occurrence Log Form failed to reveal any additional allegation of abuse reported by R#112. During a second interview with R#112 on 3/22/17 at 11:43 a.m., she stated that the nurse who abused her was working today. R#112 stated it was the nurse who had administered her medications this morning. R#112 stated that the nurse came in today and said Get up! R#112 stated she tried to sit up. and the nurse said Get up! If you don't sit up, I'm going to give you a shot! I don't suppose to get shots so I just sat up! The Licensed Practical Nurse (LPN KK) was observed at the medication cart outside of R#112's room. LPN KK confirmed that she was assigned to care for residents on this hall (300 hall, on which R#112 resides). LPN KK fit the description provided by R#112 as the alleged perpetrator. The facility's former Administrator was immediately informed of this incident by the surveyor. During an interview with the former Administrator on 3/22/17 at 11:47 a.m., she confirmed that she was the facility abuse coordinator. The former Administrator stated that on 10/28/16 at 5:00 p.m., CNA/Central Supply Scheduler (CNA SS) reported to her that R#112 had made an allegation of abuse by staff. The resident alleged that she had been pushed by a heavy set woman but could not communicate when this occurred or by whom. The former Administrator stated that the family was in the room at the time CNA SS was interviewing R#112 about the abuse. The former Administrator stated that a thorough investigation was conducted. She stated the investigation did include speaking with other staff that cared for R#112 and speaking with R#112 about the incident. The former Administrator stated she did not interview all staff that fit the resident's description of the perpetrator. The former Administrator repeatedly stated that R#112 had a BIM score of seven, and therefore, was not credible. The former Administrator stated that she did report the incident to the State Survey Agency and provided a fax cover sheet dated 10/28/16, but no fax confirmation. The former Administrator confirmed that she did not have any evidence or documentation of the information gathered for this investigation. The former Administrator provided the documents she had on file for the incident of 10/28/16. Review of documents provided revealed a plain white paper with no letterhead, dated 11/3/16, addressed to: Georgia Department of Health-LTC-Complaint unit. The document stated that during a quarterly resident interview, R#112 answered yes when asked about ever being abused. R#112 did not know the name but that she was a very heavy woman. R#112 did not know the time or date of the occurrence. The section titled The immediate protection revealed an initiation of immediate investigation. The investigation documented the resident's diagnoses, her BIMS score of seven, and that R#112 reported that she was pushed by a very heavy set woman but did not know who she was. The daughter was present in the room and was not aware of an incident of her mom being pushed. The findings documented that based on the investigation, there was not any supporting evidence that this incident occurred. The conclusion stated that after a thorough investigation, the exact nature of the allegation was unfounded and unsubstantiated. The Administrator was unable to provide any gathered investigative documents to support that a thorough investigation had been conducted or to support the conclusion. The second document was a Facility Incident Report Form dated 10/28/16 which documented staff to resident and physical abuse. No injury, no treatment required. The physician was not notified, the police were not notified and other agencies involved were not notified. Review in the State Survey Agency Complaint and Incident Tracking System during the survey revealed no evidence of an entity self-report related to this incident of 10/28/16. Review of the employee file for LPN KK, revealed a Grievance Complaint Form dated 2/11/16, which was stapled to a Record of Partner Corrective Action Form dated 2/15/16. The Grievance stated R#112 informed the Senior Care Partner (SCP) Registered Nurse (RN) that When I turn on my call light, LPN KK won't answer. When she comes in, she always talking loudly and when I tell her that my leg hurts, she tells me to Shut up! and there is nothing wrong with my leg. The way she talks to me hurts my feeling and nobody else here talks to me that way or hurt my feelings. The SCP RN noted that R#112 began to cry at this point during the conversation. Action Taken documented on 2/15/16 by the SCP; discussed findings with the Administrator. Nurse will be disciplined for poor deportment as reported by resident who is alert and oriented x 3 (People, Place and Time). The Record of Partner Corrective Action Form indicated no investigation conducted and that LPN KK received a written warning related to violation of discourtesy to the patients/residents and was allowed to continue working with the resident until she was suspended on 3/22/17 and officially terminated on 3/27/17. An interview with the Interim Administrator on 3/28/17 at 4:15 p.m. revealed the incident involving LPN KK and R#112 documented on the Performance Corrective Action dated 2/15/16 should have been investigated as an allegation of verbal abuse. During an interview with the Senior Care Partner on 3/28/17 at 4:24 p.m., she confirmed that R#112 began to cry during the interview for the grievance of 2/11/16. She stated that she reported this to the former Administrator because the nature of the grievance was an allegation of abuse. She stated that she was not sure what the former Administrator did after she reported the allegation of abuse to her. Review of the State Survey Agency Complaint and Incident Tracking System during the survey revealed no evidence of an entity self-report related to this incident of 2/11/16. The facility implemented the following actions to remove the Immediate Jeopardy: What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? Nurse in question was immediately suspended pending the investigation on March 22 2017, Administrator is conducting an internal investigation related to this event Investigation was started on March 22 , 2017 and is on-going. 24 hour report was completed and submitted to state on March 22, 2017. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? On March 22, 2017 the Nurse Management and Senior Care Partner interviewed 11 residents with a BIMS score of 10 or above on the unit where the accused nurse worked (this was 100% of residents on this unit with a BIMS of 10 or above). On March 24, 2016 the center expanded our sample to an additional 46 residents with a BIMS score of 10 or above (this was 100% of all residents in the center with a BIMS of 10 or above). The center performed a 100% body audit of all residents with a BIMS score of 9 or below with no adverse findings on 3/26/2017. Staff has also been in-serviced on the identification of injuries or events that are suspicious and may constitute abuse in patients of all levels of cognition. Based on our interviews the following allegations were reported. On March 22, 2017 we had one allegation (of abuse) which

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) was reported for an allegation on a CNA. This was reported and the CNA was suspended. On March 27, 2017 interviews revealed we had one additional allegation (of abuse) which was reported from a resident on an unnamed CNA which was stated to have happened twice over the last 8 months. This allegation was also reported to the state. On additional interviews with this patient she stated that CNA doesn't work here any longer. We had two allegations (of abuse) brought to us by the survey team regarding the nurse in the original complaint, These two alllegations were also reported to the state agency. We have filed a police report based on the allegations against the LPN. We have had 3 total allegations against the LPN, The investigation on the LPN will be completed resulting in the termination of the LPN. We have had a total of 7 [MEDICATION NAME] (3 from the survey team; 2 from interviews; 2 presented to staff). Of the four [MEDICATION NAME] (self reports) submitted by the center 3 had a BIMS of 10 or greater and 1 had a BIMS of 99, During this time frame we have suspended 7 staff members. What measures will be put in place or systematic changes will be made to ensure that the deficient practice will not reoccur? Education began on March 22, 2017 for all staff (to include Nursing, CNAs, Housekeeping, Dietary, Laundry, Maintenance, Administrative, Therapy and Respiratory Therapy) conducted by the Clinical Competency Coordinator, on abuse and reporting abuse per policy. The in-service included types of abuse that must be reported, how and who to report to, and the time frame for reporting. The center has 90% staff in-service completed as of 3/25/17. Any staff not receiving the in-service after 3/26/2017 related to FMLA, PRN status, or paid time off will be educated before the next schedule shift for that staff member. Education on abuse is reviewed in new partner orientation by the Clinical Competency Coordinator. Any staff members not receiving the in-service will be unable to return to work until they have completed the in-service. On March 24, 2017 the Administrator met with Resident Council to review abuse and reporting of abuse. There were no allegations reported during resident council. The resident council was educated on who to report to and will continue to be reassured that they can report without fear of retaliation. On 3/27/2017 the Administrator posted his personal contact information in the front lobby and at both nursing stations. In addition, the Administrator distributed the reporting phone numbers for the Ombudsman, Department of Community Health reporting, and the Pruitt Health Customer Service Hot Line to all residents with a BIMS score of 10 or above. These numbers are also posted in common areas for all visitors and families to see. How will the corrective action be monitored to assure that the deficient practice will not reoccur? Administrator will notify the Area Vice President immediately of any alleged reports of abuse or neglect. The center will continue to follow new hire policy and procedure which includes checking the applicant's background, licensure/certification, and two reference checks. The center will also begin checking all licensed and certified staff on a quarterly bases. All RNs, LPNs, CNAs, and therapist have been completed with no other findings. (Other than the one LPN who was terminated on 3/28/2017) Administrator and Area Vice President will review all allegations of abuse and neglect. To ensure accurate and thorough investigations were completed and reporting is completed per current policy. Abuse policy is reviewed yearly by the compliance officer at the corporate office and was updated on [DATE] to include the new requirements of participation. The State survey agency validated the implementation of the facility's Credible Allegation of Jeopardy Removal (CAJR) as follows: Review of Records revealed a Notice dated 3/26/17 documented the following: LPN KK was suspended 3/22/17. As of 3/26/17 employee is still suspended pending investigation. Continued record review revealed a Separation Notice dated 3/27/17 for LPN KK documenting that LPN KK was terminated from employment on 3/27/17. Reason for separation documented to be: Serious Rule Violation - Resident Abuse. Record review revealed that investigation conducted and incident reported. Record review revealed forms titled, Resident Interview Question Alleged Abuse Investigation which revealed on 3/22/17 10 residents with BIMs greater than 10 were interviewed with no adverse findings noted. Further review revealed that on 3/24/17 46 residents with BIMS 10 or greater were interviewed. Alleged Abuse Investigation forms for the 10 residents interviewed on 3/22/17 and for the 46 residents interviewed on 3/24/17 revealed the following questions were investigated: Have you ever been treated roughly by staff? Have staff injured you on purpose? Have you ever had an injury that you did not know how it happened? Do you ever feel afraid because of the way you or some other resident is treated? All forms reviewed for each resident. Record review revealed Body audit forms were reviewed for all residents with BIMS score less than 9. No adverse findings documented. Review of In-service Program Attendance Record Form dated 3/22/17 for Abuse revealed 113 staff members signed in for attendance. Review of Resident Interview Question Alleged Abuse Investigation revealed the following questions documented on the questionnaire: Have you ever been treated roughly by staff? Have staff injured you on purpose Have you ever had an injury that you did know how it happened? Do you ever fee afraid because of the way your or some other resident is treated? Review of Staff list compared to In-service sign in sheets educated revealed 140 staff members signed in for and attended the Abuse in-service. Review of the facility self reports and investigations revealed allegations were investigated and reported. Review of Resident Council Minutes/Report Form dated 3/24/17 and 3/26/17 revealed that Resident Council meeting was called The Resident Council president (BIMS 15) and 11 other residents. Information discussed included Abuse. Any allegations, suspicion, or identified occurrence is identified involving patient abuse, neglect, exploitation, mistreatment and misappropriation of property, reported. Area Vice President informed the residents that he will be the administrator at this time, and you need anything to let him know. Residents said they would. 3/25/17 Resident Council meeting - Discussed retaliation. - The provider will provide emotional support and assurance to patients and their families or representatives following the reporting of discovery. AVP explained to the residents that if any staff mistreated, including talked ugly to , abuse of any kind, mistreat them, to report it as soon as possible to the Charge Nurse, Administrator, nurse or anyone you see. Please report if you, or you anyone abuses you, neglects you, mistreats you or anyone you know. We are here to keep you all safe. Multidisciplinary staff members were interviewed. All staff stated they had attended in-services related to abuse on 3/22/17. The staff were able to define abuse and the types of abuse, how to recognize and report abuse to their supervisor and/or the abuse coordinator and were able to identify that the Administrator was the abuse coordinator for the facility. Abuse in-services were provided by the DHS, Clinical Competency Coordinator, RN Restorative Nurse on Abuse, types of abuse, how and when to report abuse, recognition of abuse for non-cognitive, or non-communicative residents. Further interview, with staff, revealed that if a confused or non-cognitive resident stated that someone hurt them then they would report that as well. Continued interview revealed that some residents that may not be able to communicate can show outward signs or behaviors of abuse such as jerking, facial expressions, shutting down and not responding anymore, that if a resident showed those kinds of behaviors that they would report it to the nurse and Abuse Coordinator. Further interview revealed that if they reported the abuse to the Charge Nurse and the Administrator and did not seem to get a response or the issue was not addressed then they would continue to report the abuse until it was addressed. Continued interview revealed that each staff member revealed that they knew how to contact the Ombudsman and HFRD to report abuse themselves. The following staff members were interviewed: 11:00 p.m. to 7:00 a.m., shift: On 3/26/17 at 12:46 p.m., with Housekeeper BBB, on 3/26/17 at 12:49 p.m., with Activities Director/CNA, 3/26/17 at 12:56 p.m., with CNAZZZ, 3/26/17 at 1:07 p.m. with CNA YYY (Restorative), 3/26/17 at 1:13 p.m. with CNA XXX, 3/26/17 at 1:47 p.m. with CNA WWW, 3/26/17 at 1:53 p.m. with CNA VVV, Interview on 3/27/17 at 6:47 a.m., with CNA UUU, On 3/27/17 at 7:00 a.m., with CNA TTT, On 3/27/17 at 7:10 a.m., with CNA SSS, On 3/27/17 at 7:15 a.m., with CNA RRR, On 3/27/17 at 7:20 a.m. with CNA QQQ, On 3/28/17 at 9:30 a.m. with CNA PPP, On

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F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 6) 3/28/17 at 9:41 a.m. with CNA PP On 3/28/17 at 10:04 a.m., with CNA OOO, On 3/28/17 at 10:35 a.m., with CNA NNN, On 3/28/17 at 10:45 a.m., with CNA MMM, On 3/28/17 at 10:55 a.m., with CNA SS, Central Supply, CNA scheduler, On 3/28/17 at 11:03 a.m. with CNA LLL, 3:00 p.m. to 11 p.m. shift 3/26/17 at 3:24 p.m., with CNA KKK, 3/26/17 at 4:20 p.m. with CNA JJJ, On 3/26/17 at 4:53 p.m. LPN JJ, 7pm - 7AM On 3/27/17 at 6:55 a.m. (11p.m. - 7 a.m.) LPN III, 3/27/17 at 6:57 a.m., with LPN HHH, 3/27/17 at 7:03 a.m., with LPN GGG, 3/28/17 at 9:25 a.m. with RN EE (Infection control, Restorative nurse), 3/28/17 at 10:52 a.m. with LPN FFF, 3/26/17 at 12:52 p.m., with Maintenance Director EEE, 3/28/17 at 3:15 p.m., with Housekeeping DDD Interviews with the following residents revealed: Interview 3/26/17 at 1:27 p.m. with R#1, the Resident Council President, on 3/26/17 at 12:45 p.m., with R#77, on 3/28/17 at 10:50 a.m., with R87, on 3/28/17 at 11:00 a.m,, with R#88, on 3/28/17 at 11:13 a.m., R#73, on 3/28/17 at 11:20 a.m., with R#120, on 3/28/17 at 11:28 a.m., with R#66 revealed that the Area Vice President (AVP), that is currently the Interim Administrator, called a Resident Council meeting Friday night (3/24/17) and spoke with the Resident Council members and staff regarding abuse. That the residents were instructed to tell the staff CNA, Charge Nurse, any staff, and the Administrator and tell them if they have any problems. Residents were educated that they can call the Ombudsman and how to call the Ombudsman. Residents able to verbalize who they would report abuse to, who was the Abuse Coordinator, and how to report abuse themselves. Residents revealed that the AVP and Interim DHS have encouraged them to report abuse to them. Residents revealed that they (AVP and Interim DHS) want us to tell them if we have any concerns. R#1 revealed that the Ombudsman comes to facility pretty frequently and that the facility announces the resident rights over the loud speaker every morning. Information sheets were given to cognitive residents and included the phone number to the Ombudsman, HFRD, and the facility's corporate office. Review of Abuse Policy's revealed: revealed all seven components addressed. Review of the facility self reports and investigations revealed allegations were reviewed by the AVP, were investigated by the AVP, Interim DHS and were reported by the AVP. Interventions of QAPI for abuse are documented to be: All allegations of abuse will be reported to the Administrator or DHS immediately. The Administrator or DHS will report the allegation to the state agency within a 2 hour time frame. The Ombudsman will be notified. Law enforcement will be notified if deemed appropriate. A complete investigation will be completed. Staff will be in-serviced related to the abuse allegations. Review of notice regarding QAPI meeting on 3/26/17 revealed the following: On 3/26/17 the AVP educated all department heads on QAPI process, policy and procedures, their roles and responsibilities, current action plans, and how write Performance Improvement plans. AVP discussed QAPI review with Medical Director on 3/26/17. Medical Director signature observed to be on 5th page as reviewed and dated 3/26/17.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy titled No Retaliation for Good Faith Reporting of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, staff and resident interviews, the facility failed to implement and follow its policy related to employee training, identifying abuse, conducting thorough investigations of alleged abuse, immediately reporting suspected abuse to the State Survey Agency, and providing protection from staff to resident abuse for one of 44 sampled residents (R#112). This failure increased the likelihood of staff to resident abuse of all residents in care of the alleged perpetrator, Licensed Practical Nurse (LPN KK). LPN KK continued to work in the facility for over one year after it was first reported by R#112 on 2/11/16, that she was abusive. Refer F223 and F225 The facility's failure to implement its policies related to allegations of abuse, has caused or is likely to cause serious injury, harm, impairment or death to residents. Immediate Jeopardy was identified on 3/23/17 and determined to have existed on 2/11/16. The facility's former Administrator and former Director of Health Services (DHS) were informed of the Immediate Jeopardy on 3/23/17 at 6:50 p.m. An acceptable Allegation of Compliance (AoC) was received on 3/24/17 and the State Survey Agency validated the Immediate Jeopardy which was removed on 3/28/17, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. Findings include: Review of the policy titled No Retaliation for Good Faith Reporting of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property revised 11/21/16 documented: It is the policy of PruittHealth and its affiliated providers (collectively, the Organization) that there should be no retaliation against PruittHealth partners, patients, patients' families, or others for good faith reporting of occurrences or allegations of patient abuse, neglect, exploitation, mistreatment, or misappropriation of patient property. Any suspicion of abuse, neglect, exploitation, mistreatment or misappropriation of patient property, a suspected partner should not have direct care contact with the patient at issue until the investigation is completed and the issue resolved. For example, a partner suspected of committing any such act should be suspended without pay pending the outcome of the investigation. 1. During an interview with R#112 on 3/21/17 at 12:37 p.m., she alleged that a heavy set black nurse on first shift has a history of verbally and physically abusing her. R#112 stated that a few weeks ago, she reported to the facility that her nurse was hollering at her and threatening to stick her with needles. R#112 stated that after she reported it, the nurse went crazy and hit her across the back and shoved her. The resident did not report this incident to the facility. R#112 stated that she was afraid of this nurse. R#112 could not provide details of an exact date or name of the nurse but she was able to describe the nurse, knew she worked during the day and administered her medications. R#112 stated that the nurse was not working today. In a subsequent interview with R#112 on 3/22/17 at 11:43 a.m., she stated that the nurse who abused her was working today (3/22/17). R#112 stated it was the nurse who had administered her medications this morning (3/22/17). R#112 stated that the nurse came in today and said Get up! R#112 stated she tried to sit up. And the nurse said Get up! If you don't sit up, I'm going to give you a shot! I don't suppose to get shots so I just sat up! R#112's eyes were open very wide as she described this incident and she was visibly frightened. LPN KK was observed at the medication cart outside of R#112's room, just after the interview with R#112. LPN KK confirmed that she was assigned to care for residents on this hall (300 Hall, on which R#112 resides). The former facility Administrator was immediately informed of this incident by the surveyor. Record review for R#112 revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE] which documented a Brief Interview for Mental Status (BIMS) summary score of 11, indicating moderate cognitive impairment. A quarterly MDS assessment dated [DATE] documented a BIMS summary score of seven, indicating severe cognitive impairment. A quarterly MDS assessment dated [DATE] documented a BIMS summary score of 10, indicating moderate cognitive impairment. All three MDS assessments indicated that R#112 did not exhibit behaviors of hallucinations or delusions (section E). During an interview with the former Administrator on 3/22/17 at 11:47 a.m., she stated that she is the abuse coordinator. On 10/28/16 at 5:00 p.m., the Certified Nursing Assistant (CNA) Central Supply Scheduler (CNA SS) reported to her that R#112 made an allegation of abuse by staff. She stated that the resident alleged that she had been pushed by a heavy set woman but could not communicate when this occurred or by whom. The former Administrator stated that she had not interviewed all staff that fit R#112's description. She stated that R#112's family member was in the room at time of the interview with CNA SS. The Administrator stated that a thorough investigation had been conducted and that the incident was reported to the State Survey Agency. The former Administrator repeatedly stated R#112 had a BIMS score of seven and therefore the allegation was not credible and was unsubstantiated. The former Administrator provided a plain white paper with no letterhead, dated 11/3/16, addressed to: Georgia Department of Health-LTC-Complaint unit. The document stated that R#112 had reported that a very heavy set woman pushed her but she did not know who she was or the date or time of the occurrence. The section titled Immediate protection implemented indicated initiation of immediate investigation. The conclusion stated that after a thorough investigation, the exact nature of the allegation was unfounded and unsubstantiated. The former Administrator was unable to provide any gathered investigative

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) documents to support that a thorough investigation had been conducted or to support the conclusion. There was no documentation that any staff caring for R#112, who fit the description, had been removed from her care until the investigation was completed. The second document was a Facility Incident Report Form dated 10/28/16 which documented: staff to resident physical abuse. No injury, no treatment required. The physician was not notified, the police were not notified and other agencies involved were not notified. The following interviews with direct care staff revealed they were not able to identify the facility's Abuse Coordinator: On 3/22/17 at 6:29 p.m., CNA PP revealed that she has worked in the facility four years. CNA PP was not able to identify the facility Abuse Coordinator. On 3/22/17 at 6:37 p.m., CNA DDD revealed she has worked in the facility one year. CNA DDD was not able to identify the facility Abuse Coordinator. On 3/22/17 at 6:55 p.m., CNA EEE revealed she has worked in the facility for 8 months. CNA EEE was not able to identify the facility Abuse Coordinator. An interview with the Resident Council President on 3/24/17 at 10:14 a.m., revealed she did not know who the facility's Abuse Coordinator was. During an interview with the Clinical Competency Coordinator (CCC) on 3/24/17 at 11:00 a.m., she stated that she was responsible for staff education under the direction of the former Director of Health Services (DHS). She stated that the most recent in-house training on abuse was 2/23/17 with only 26 employees signed as attending this in-service. The CCC stated that the in-services related to abuse are targeted for all employees of the facility. She was trying to do abuse in-services monthly because she was having difficulty getting staff to attend and was not getting cooperation from the DHS. The CCC stated she did not know why all staff did not attended the abuse in-service. Review of the in-service dated 11/3/16 titled Abuse Prevention revealed a signature indicating LPN KK was in attendance. Review of the in-service dated 2/23/17 titled Hand in Hand 2 Abuse revealed no signature indicating attendance by LPN KK. Further review of the in-service revealed only 26 employee signatures were in attendance. Review of the employee file for LPN KK, revealed a Grievance Complaint Form dated 2/11/16 which was stapled to a Record of Partner Corrective Action Form dated 2/15/16. The Grievance stated R#112 informed the Senior Care Partner (SCP) Registered Nurse (RN) that When I turn on my call light, LPN KK won't answer. When she comes in, she always talking loudly and when I tell her that my leg hurts, she tells me to Shut up! and there is nothing wrong with my leg. The way she talks to me hurts my feeling and nobody else here talks to me that way or hurt my feelings. The SCP RN noted that R#112 began to cry at this point during the conversation. Action Taken documented on 2/15/16 by the SCP; discussed findings with the Administrator. Nurse will be disciplined for poor deportment as reported by resident who is alert and oriented x 3 (People, Place and Time). The Record of Partner Corrective Action Form indicated no investigation conducted and that LPN KK received a written warning related to violation of discourtesy to the patients/residents. There was no evidence or documentation that LPN KK had been removed from resident care or that an investigation had been conducted. Review of the nursing license for LPN KK revealed it was due to expire on 3/31/17. Additional interviews were conducted on 3/24/17 with residents who reside on the 300 hall. In an interview with R#80 on 3/24/17 at 1:18 p.m., he expressed that he was sort of afraid of the nurse and she had threatened to beat the hell out of him. R#80 was not able to name the nurse but described her as a black female nurse weighing about 250 pounds. R#80 further stated that the nurse curses at him and makes him mad. In addition, on 3/24/17 at 2:00 p.m., an interview with R A (who wished to remain anonymous) revealed that she had been verbally abused by a nurse. R A was hesitant to name the nurse that verbally abused her, but stated the nurse was overly aggressive with words and always had an attitude when speaking to her. R A did finally identify the nurse as LPN KK. The resident was crying as she spoke about LPN KK. R A alleged verbal and physical abuse by LPN KK; however, she did not report the allegation to the facility. R A stated she was afraid of LPN KK and afraid of retaliation for telling on her. Record review for R#80 revealed a quarterly MDS assessment dated [DATE], which documented a BIMS summary score of four, indicating severe cognitive impairment. [DIAGNOSES REDACTED]. The resident did not exhibit hallucinations or delusions. Despite a BIMS score of four, the resident was able to accurately describe his nurse and knew that he had not seen LPN KK on the day of his interview on 3/24/17. (Although R#80 had a BIMS score of four, on 3/24/16 at 1:16 p.m., LPN XXX included R#80 on a list of residents who, were in her professional opinion candidates for resident interviews.) During an interview with the Interim Administrator on 3/28/17 at 4:15 p.m., he stated the incident involving LPN KK and R#112 that was documented on a Grievance Complaint Form dated 2/11/16 and the Record of Partner Corrective Action Form dated 2/15/16, should have been investigated as an allegation of verbal abuse. During an interview with the Registered Nurse (RN) Senior Care Partner (SCP) on 3/28/17 at 4:24 p.m., she confirmed that she had filled out the Grievance Complaint Form dated 2/11/16 at 5:50 p.m. The RN SCP stated that she reported this to the former Administrator and the nature of the grievance was that of abuse and that R#112 was crying during the interview. A post survey interview with the Interim Administrator was conducted, via the telephone, on 4/7/17 at 10:04 a.m. The interview revealed that LPN KK was terminated on 3/27/17 and was reported to the Nursing Board on 3/29/17 by the Interim DHS. A telephone interview conducted 3/28/17 at 3:54 p.m., with a representative of the Georgia State Board of Licensing, revealed LPN KK was on probation status and that any additional questions needed to be directed in an e-mail to the Licensing Board. On 3/29/17 at 9:56 a.m., a representative for the State Board of Licensing called the surveyor and stated that LPN KK had failed to comply with Board recommendation to provide a copy to her employer of her probationary status and provide quarterly reports by her employer. The representative further stated LPN KK's license was on the calendar for review. Review of the Georgia Secretary of State public website dated 8/31/16 under Findings of Fact revealed on or about September of 2011, the Respondent (LPN KK) had signed out 59 narcotics and failed to enter documentation on the medication administration records. On or about July 2012, the Board issued a Confidential Order for Mental/Physical Examination (MPE 2012). The results of the July MPE revealed the Respondent had been receiving treatment for [REDACTED]. On or about August 2014, the Board issued a second Order for Mental/Physical examination (2014 MPE) in order to determine Respondent's [DIAGNOSES REDACTED]. The 2014 MPE results contained a [DIAGNOSES REDACTED]. On or about June 19, 2015, after finding that the 2014 examination did not comply with the Board's 2014 MPE, because it was not performed by a licensed physician who is Board Certified in Addiction Medicine or Addiction Psychiatry, the Board entered a third Confidential Expedited Order for Mental/Physical Examination (2015 MPE). The results of the 2015 MPE included an Opioid Use Disorder, controlled with [MEDICATION NAME]. The 2015 MPE recommended that Respondent enter a treatment program and gradually be tapered off the [MEDICATION NAME]; that she enters a nurses' recovery group; and undergo random drug screens. The former Administrator had been terminated from the facility after the Immediate Jeopardy was called on 3/23/17. The surveyor was unable to attain an interview related to whether she was aware of LPN KK's probationary status and restrictions on her license. The facility implemented the following actions to remove the Immediate Jeopardy: What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? Nurse in question was immediately suspended pending the investigation on March 22 2017, Administrator is conducting an internal investigation related to this event Investigation was started on March 22 , 2017 and is on-going. 24 hour report was completed and submitted to state on March 22, 2017. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? On March 22, 2017 the Nurse Management and Senior Care Partner interviewed 11 residents with a BIMS score of 10 or above on the unit where the accused nurse worked (this was 100% of residents on this unit with a BIMS of 10 or above). On March 24, 2016 the center expanded our sample to an additional 46 residents with a BIMS score of 10 or above (this was 100% of all residents in the center with a BIMS of 10 or above). The center performed a 100% body audit of all residents with a BIMS score of 9 or below with no adverse findings on 3/26/2017. Staff has also been in-serviced on the identification of injuries or events that are suspicious and may constitute abuse in

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) patients of all levels of cognition. Based on our interviews the following allegations were reported. On March 22, 2017 we had one allegation (of abuse) which was reported for an allegation on a CNA. This was reported and the CNA was suspended. On March 27, 2017 interviews revealed we had one additional allegation (of abuse) which was reported from a resident on an unnamed CNA which was stated to have happened twice over the last 8 months. This allegation was also reported to the state. On additional interviews with this patient she stated that CNA doesn't work here any longer. We had two allegations (of abuse) brought to us by the survey team regarding the nurse in the original complaint, These two alllegations were also reported to the state agency. We have filed a police report based on the allegations against the LPN. We have had 3 total allegations against the LPN, The investigation on the LPN will be completed resulting in the termination of the LPN. We have had a total of 7 [MEDICATION NAME] (3 from the survey team; 2 from interviews; 2 presented to staff). Of the four [MEDICATION NAME] (self reports) submitted by the center 3 had a BIMS of 10 or greater and 1 had a BIMS of 99, During this time frame we have suspended 7 staff members. What measures will be put in place or systematic changes will be made to ensure that the deficient practice will not reoccur? Education began on March 22, 2017 for all staff (to include Nursing, CNAs, Housekeeping, Dietary, Laundry, Maintenance, Administrative, Therapy and Respiratory Therapy) conducted by the Clinical Competency Coordinator, on abuse and reporting abuse per policy. The in-service included types of abuse that must be reported, how and who to report to, and the time frame for reporting. The center has 90% staff in-service completed as of 3/25/17. Any staff not receiving the in-service after 3/26/2017 related to FMLA, PRN status, or paid time off will be educated before the next schedule shift for that staff member. Education on abuse is reviewed in new partner orientation by the Clinical Competency Coordinator. Any staff members not receiving the in-service will be unable to return to work until they have completed the in-service. On March 24, 2017 the Administrator met with Resident Council to review abuse and reporting of abuse. There were no allegations reported during resident council. The resident council was educated on who to report to and will continue to be reassured that they can report without fear of retaliation. On 3/27/2017 the Administrator posted his personal contact information in the front lobby and at both nursing stations. In addition, the Administrator distributed the reporting phone numbers for the Ombudsman, Department of Community Health reporting, and the Pruitt Health Customer Service Hot Line to all residents with a BIMS score of 10 or above. These numbers are also posted in common areas for all visitors and families to see. How will the corrective action be monitored to assure that the deficient practice will not reoccur? Administrator will notify the Area Vice President immediately of any alleged reports of abuse or neglect. The center will continue to follow new hire policy and procedure which includes checking the applicant's background, licensure/certification, and two reference checks. The center will also begin checking all licensed and certified staff on a quarterly bases. All RNs, LPNs, CNAs, and therapist have been completed with no other findings. (Other than the one LPN who was terminated on 3/28/2017) Administrator and Area Vice President will review all allegations of abuse and neglect. To ensure accurate and thorough investigations were completed and reporting is completed per current policy. Abuse policy is reviewed yearly by the compliance officer at the corporate office and was updated on [DATE] to include the new requirements of participation. The State survey agency validated the implementation of the facility's Credible Allegation of Jeopardy Removal (CAJR) as follows: Review of Records revealed a Notice dated 3/26/17 documented the following: LPN KK was suspended 3/22/17. As of 3/26/17 employee is still suspended pending investigation. Continued record review revealed a Separation Notice dated 3/27/17 for LPN KK documenting that LPN KK was terminated from employment on 3/27/17. Reason for separation documented to be: Serious Rule Violation - Resident Abuse. Record review revealed that investigation conducted and incident reported. Record review revealed forms titled, Resident Interview Question Alleged Abuse Investigation which revealed on 3/22/17 10 residents with BIMs greater than 10 were interviewed with no adverse findings noted. Further review revealed that on 3/24/17 46 residents with BIMS 10 or greater were interviewed. Alleged Abuse Investigation forms for the 10 residents interviewed on 3/22/17 and for the 46 residents interviewed on 3/24/17 revealed the following questions were investigated: Have you ever been treated roughly by staff? Have staff injured you on purpose? Have you ever had an injury that you did not know how it happened? Do you ever feel afraid because of the way you or some other resident is treated? All forms reviewed for each resident. Record review revealed Body audit forms were reviewed for all residents with BIMS score less than 9. No adverse findings documented. Review of In-service Program Attendance Record Form dated 3/22/17 for Abuse revealed 113 staff members signed in for attendance. Review of Resident Interview Question Alleged Abuse Investigation revealed the following questions documented on the questionnaire: Have you ever been treated roughly by staff? Have staff injured you on purpose Have you ever had an injury that you did know how it happened? Do you ever fee afraid because of the way your or some other resident is treated? Review of Staff list compared to In-service sign in sheets educated revealed 140 staff members signed in for and attended the Abuse in-service. Review of the facility self reports and investigations revealed allegations were investigated and reported. Review of Resident Council Minutes/Report Form dated 3/24/17 and 3/26/17 revealed that Resident Council meeting was called The Resident Council president (BIMS 15) and 11 other residents. Information discussed included Abuse. Any allegations, suspicion, or identified occurrence is identified involving patient abuse, neglect, exploitation, mistreatment and misappropriation of property, reported. Area Vice President informed the residents that he will be the administrator at this time, and you need anything to let him know. Residents said they would. 3/25/17 Resident Council meeting - Discussed retaliation. - The provider will provide emotional support and assurance to patients and their families or representatives following the reporting of discovery. AVP explained to the residents that if any staff mistreated, including talked ugly to , abuse of any kind, mistreat them, to report it as soon as possible to the Charge Nurse, Administrator, nurse or anyone you see. Please report if you, or you anyone abuses you, neglects you, mistreats you or anyone you know. We are here to keep you all safe. Multidisciplinary staff members were interviewed. All staff stated they had attended in-services related to abuse on 3/22/17. The staff were able to define abuse and the types of abuse, how to recognize and report abuse to their supervisor and/or the abuse coordinator and were able to identify that the Administrator was the abuse coordinator for the facility. Abuse in-services were provided by the DHS, Clinical Competency Coordinator, RN Restorative Nurse on Abuse, types of abuse, how and when to report abuse, recognition of abuse for non-cognitive, or non-communicative residents. Further interview, with staff, revealed that if a confused or non-cognitive resident stated that someone hurt them then they would report that as well. Continued interview revealed that some residents that may not be able to communicate can show outward signs or behaviors of abuse such as jerking, facial expressions, shutting down and not responding anymore, that if a resident showed those kinds of behaviors that they would report it to the nurse and Abuse Coordinator. Further interview revealed that if they reported the abuse to the Charge Nurse and the Administrator and did not seem to get a response or the issue was not addressed then they would continue to report the abuse until it was addressed. Continued interview revealed that each staff member revealed that they knew how to contact the Ombudsman and HFRD to report abuse themselves. The following staff members were interviewed: 11:00 p.m. to 7:00 a.m., shift: On 3/26/17 at 12:46 p.m., with Housekeeper BBB, on 3/26/17 at 12:49 p.m., with Activities Director/CNA, 3/26/17 at 12:56 p.m., with CNAZZZ, 3/26/17 at 1:07 p.m. with CNA YYY (Restorative), 3/26/17 at 1:13 p.m. with CNA XXX, 3/26/17 at 1:47 p.m. with CNA WWW, 3/26/17 at 1:53 p.m. with CNA VVV,

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) Interview on 3/27/17 at 6:47 a.m., with CNA UUU, On 3/27/17 at 7:00 a.m., with CNA TTT, On 3/27/17 at 7:10 a.m., with CNA SSS, On 3/27/17 at 7:15 a.m., with CNA RRR, On 3/27/17 at 7:20 a.m. with CNA QQQ, On 3/28/17 at 9:30 a.m. with CNA PPP, On 3/28/17 at 9:41 a.m. with CNA PP On 3/28/17 at 10:04 a.m., with CNA OOO, On 3/28/17 at 10:35 a.m., with CNA NNN, On 3/28/17 at 10:45 a.m., with CNA MMM, On 3/28/17 at 10:55 a.m., with CNA SS, Central Supply, CNA scheduler, On 3/28/17 at 11:03 a.m. with CNA LLL, 3:00 p.m. to 11 p.m. shift 3/26/17 at 3:24 p.m., with CNA KKK, 3/26/17 at 4:20 p.m. with CNA JJJ, On 3/26/17 at 4:53 p.m. LPN JJ, 7pm - 7AM On 3/27/17 at 6:55 a.m. (11p.m. - 7 a.m.) LPN III, 3/27/17 at 6:57 a.m., with LPN HHH, 3/27/17 at 7:03 a.m., with LPN GGG, 3/28/17 at 9:25 a.m. with RN EE (Infection control, Restorative nurse), 3/28/17 at 10:52 a.m. with LPN FFF, 3/26/17 at 12:52 p.m., with Maintenance Director EEE, 3/28/17 at 3:15 p.m., with Housekeeping DDD Interviews with the following residents revealed: Interview 3/26/17 at 1:27 p.m. with R#1, the Resident Council President, on 3/26/17 at 12:45 p.m., with R#77, on 3/28/17 at 10:50 a.m., with R87, on 3/28/17 at 11:00 a.m,, with R#88, on 3/28/17 at 11:13 a.m., R#73, on 3/28/17 at 11:20 a.m., with R#120, on 3/28/17 at 11:28 a.m., with R#66 revealed that the Area Vice President (AVP), that is currently the Interim Administrator, called a Resident Council meeting Friday night (3/24/17) and spoke with the Resident Council members and staff regarding abuse. That the residents were instructed to tell the staff CNA, Charge Nurse, any staff, and the Administrator and tell them if they have any problems. Residents were educated that they can call the Ombudsman and how to call the Ombudsman. Residents able to verbalize who they would report abuse to, who was the Abuse Coordinator, and how to report abuse themselves. Residents revealed that the AVP and Interim DHS have encouraged them to report abuse to them. Residents revealed that they (AVP and Interim DHS) want us to tell them if we have any concerns. R#1 revealed that the Ombudsman comes to facility pretty frequently and that the facility announces the resident rights over the loud speaker every morning. Information sheets were given to cognitive residents and included the phone number to the Ombudsman, HFRD, and the facility's corporate office. Review of Abuse Policy's revealed: revealed all seven components addressed. Review of the facility self reports and investigations revealed allegations were reviewed by the AVP, were investigated by the AVP, Interim DHS and were reported by the AVP. Interventions of QAPI for abuse are documented to be: All allegations of abuse will be reported to the Administrator or DHS immediately. The Administrator or DHS will report the allegation to the state agency within a 2 hour time frame. The Ombudsman will be notified. Law enforcement will be notified if deemed appropriate. A complete investigation will be completed. Staff will be in-serviced related to the abuse allegations. Review of notice regarding QAPI meeting on 3/26/17 revealed the following: On 3/26/17 the AVP educated all department heads on QAPI process, policy and procedures, their roles and responsibilities, current action plans, and how write Performance Improvement plans. AVP discussed QAPI review with Medical Director on 3/26/17. Medical Director signature observed to be on 5th page as reviewed and dated 3/26/17.
F 0247 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give notice to the resident before a room or roommate change.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility policy titled Room or Roommate Changes, resident and staff interviews, the facility failed to ensure that three residents (R) received prior notification of receiving a new roommate (R#28, R#95 and R#133) and failed to ensure prior notification for one resident that was transferred to a new room (R#73). The sample was 44 residents. Findings include: Review of the facility policy titled, Room or Roommate Changes revised 5/4/16 indicated: It is policy to inform residents in advance of any changes in room or roommate and allow residents the opportunity to have input in the decision. (1) The resident should be informed in advance of room or roommate changes and given the opportunity to have input on the decision. (2) Resident should be provided an explanation as to why the change is necessary. (3) The resident should be given the opportunity to tour the new room and be introduced to the new roommate if possible. (4) Notify the new roommate of the room/roommate change. (7) A progress note should be written in both of the roommates' medical records by the Social Worker or designee regarding the room change. 1. During an interview with R#28 on 3/21/17 at 9:17 a.m., she stated that a new roommate was moved into her room and she did not receive any notice. Record review for R#28 revealed an Annual Minimum Date Set (MDS) assessment dated [DATE] which documented a Brief Interview for Mental Status (BIMS) summary score of 15, indicating no cognitive impairment During an interview with the Business Office Manager (BOM) on 3/28/17 at 12:59 p.m. she confirmed that on 11/1/16, a roommate (R#10) was moved into R#28's room. Further record review for R#28 revealed no evidence of Social Services Progress Notes documenting that the resident was notified of the receiving a new roommate on 11/1/16. 2. During an interview with R#95 on 3/21/17 at 9:31 a.m., she stated that a new roommate was moved into her room and she did not receive any notice. During an interview with the BOM on 3/28/17 at 12:59 p.m. she confirmed that on 12/28/16, a roommate (R#172) was moved into R#95's room. Record review for R#95 revealed an Annual Minimum Date Set (MDS) assessment dated [DATE] which documented a BIMS summary score of 15, indicating no cognitive impairment Further record review for R#95 revealed no evidence of Social Services Progress Notes documenting that the resident was notified of the receiving a new roommate on 12/28/16. 3. During an interview with R#133 on 3/21/17 at 10:27 a.m., she stated that a new roommate was moved into her room and she did not receive any notice. During an interview with the BOM on 3/28/17 at 12:59 p.m. she confirmed that on 2/28/2016, a roommate (R#162) was moved into R#133's room. Record review for R#133 revealed an Annual Minimum Date Set (MDS) assessment dated [DATE] which documented a BIMS summary score of 15, indicating no cognitive impairment Further record review for R#133 revealed no evidence of Social Services Progress Notes documenting that the resident was notified of the receiving a new roommate on 2/28/16. 4. During an interview with R#73 on 3/21/17 at 11:59 a.m., he confirmed that he had been moved to a different room within the last nine months. He stated that the Social Services Director came to his room and said he would be moved to another room. He stated that two Certified Nursing Assistants removed his personal belongings out of his room and moved them to the other room. He stated that his family came to visit and went to the wrong room. He stated that neither he nor his family were provided notice prior to the room change. During an interview with the BOM on 3/28/17 at 12:59 p.m. she confirmed that on 8/24/16, R#73 was moved into his current room. Record review for R#73 revealed Quarterly Minimum Date Set (MDS) assessment dated [DATE] which documented a BIMS summary score of 15, indicating no cognitive impairment. Further record review for R#73 revealed a Social Services Progress Notes of prior notification to the resident or family that he would be moved to a different room, the resident's input, the opportunity to tour the new room or meet the new roommate On 3/28/17 at 12:01 p.m. an interview was conducted with the Social Services Director (SSD). She stated that she has only worked at the facility for one month but that the process is that when there is a room to room change in the facility, the Social Services department completes a Room Change Notification form for the resident who is moving and places a copy of the form in the resident's clinical record. She stated that she is not sure if it is the process to documents when a resident is receiving a roommate. The Room Change Notification form is used for in house room to room changes and only for the resident who is actually moving. She stated that the Nursing Home Administrator went over what her responsibilities are as the SSD and discussed with her the Room Change Notification form and the process for room change assignment when she was hired. During an interview with the Admissions Director 3/28/17 at 12:26 p.m. she stated that the nurse, SSD or herself will notify the existing resident that they will be receiving a new roommate. She stated that she does not do any documenting on the residents clinical record that this notification is being completed and that, to her knowledge, it is not documented

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	115394	A. BUILDING _____ B. WING _____	03/28/2017

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F 0247 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10) anywhere that notification is provided. During an interview with the Interim Director of Nursing on 3/28/17 at 12:42 p.m. she stated that when a room change assignment is made, the notification information of all parties should be documented on the Social Service Progress notes in the clinical record. She stated that the room change form is not part of the medical record and is just used a tool for internal communication.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff and resident interviews, the facility failed to revise the nutritional care plan to reflect an increase in an oral diet from once a day at lunch to twice a day at breakfast and lunch for one resident (R) (R#63), that received enteral feeding x 20 hours per day via Gastroenteral ([DEVICE]). The resident sample was 44. Refer F325 Findings include: Record review for R#68 revealed a care plan with an onset date of 3/14/17, which identified a potential for nutrition and hydration deficits related to [DEVICE] status. On 3/15/17, the care plan noted the resident receives one mechanical soft with meats meal per day at lunch and significant weight loss. Interventions include, but not limited; Speech Therapy as ordered, diet as ordered. Review of a physician telephone order for R#63 dated 3/21/17 revealed: Speech Language Pathologist (SLP) diet clarification: mechanical soft/ground meat diet with thin liquids x 2 meals per day at breakfast and lunch. Continue all other dietary restrictions. An interview on 3/23/17 at 1:20 p.m. with the SLP LL revealed she had been assisting R#63 with eating one meal a day at lunch since last week. SLP LL further stated that the resident's meals had been increased to two meals per day (breakfast and lunch) and the goal was to wean R#63 off of her gastrostomy-tube ([DEVICE]) feedings. Observation on 3/25/17 at 8:18 a.m. of the meal cart on 300 Hall revealed an untouched breakfast meal tray for R#63 sitting in the cart with numerous trays for residents who had already eaten. An interview conducted on 3/25/17 at 8:33 a.m. with Certified Nurse Aide (CNA) (CNA HH) revealed that she was not aware that R#63 ate food and was unsure as to why the kitchen continued to send a meal tray to the hallway. CNA HH opened the lid on the tray for R#63 and the food on the tray had not been touched. During an interview on 3/25/17 at 8:35 a.m. with the nurse providing care for R#63, Licensed Practical Nurse (LPN) (LPN JJ), she stated that there was no morning meeting held this morning with the CNA's to inform them that there was a new dietary order for R#63. LPN JJ further stated that when the order was originally written on 3/21/17 the information was shared with the CNA's who were working at that time and she assumed that the information had been passed on. In a subsequent interview on 3/25/17 at 8:42 a.m. with CNA HH revealed that it had not been reported to her from the previous CNA that R#63 eats breakfast now opposed to being tube feeding only. CNA HH stated that no information was provided by the charge nurse related to R#63 dietary order changes. During an interview on 3/25/17 9:58 a.m. with the Interim Director of Health Services (DHS), she provided documentation of the consumption record for R#63. Review of the Meal Percentage (CNA Role) revealed that there is no evidence or documentation that R#63 received breakfast on 3/22/17, 3/23/17, and 3/24/17 per the dietary order dated 3/21/17. The DHS further stated that the task for meals in the computer system was not activated and did not prompt the CNAs by turning red when a meal was not documented.
F 0282 **Level of harm** - Actual harm **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 record review and staff interview the facility failed to ensure that the care plan was followed to check proper positioning of the indwelling urinary catheter tubing for one (1) resident (R) (R#239) of four (4) residents with urinary catheters. This failure resulted in harm for R#239 who was hospitalized for [REDACTED].) coli Urinary Tract Infection [MEDICAL CONDITIONS] (MRSA) bacteremia . The sample was forty-four (44) residents. Findings include: 1. Review of the Comprehensive Care Plan for R#239 dated 9/21/16 revealed that the resident had a Foley catheter related to [MEDICAL CONDITION] due to Benign Prostate Hypertrophy ([MEDICAL CONDITION]) with a goal that he would have no complications related to the catheter in three (3) months. Interventions included nursing staff to check the catheter every shift for patency and proper position of the tubing and bag. Continued review of the Comprehensive Care Plan revealed that the resident was at risk for skin breakdown related to bowel incontinence, limited mobility and use of a Foley catheter with an intervention for nursing staff to perform skin assessments per facility protocol and as needed (PRN). Review of the medical record revealed that there was no indication that nursing staff checked the proper positioning of the Foley catheter tubing from the resident's admission on 8/25/16 to his discharge to the hospital on [DATE] with [DIAGNOSES REDACTED].) coli Urinary Tract Infection [MEDICAL CONDITIONS] bacteremia and placement of a suprapubic urinary catheter. Interview with the Regional Nurse Consultant/Interim Director of Health Services (DHS) on 3/27/17 at 11:30 a.m. revealed that she expected licensed nursing staff to monitor a resident's intake and output (I/O) if ordered, to monitor the color/clarity of the urine and to monitor for any complications such as breakdown. Continued interview revealed that she expected licensed nursing staff to document any abnormalities that they identified, with the resident, in the Nurses Notes. She stated that she expected the Certified Nursing Assistants (CNA'S) to provide catheter care daily and to notify the nurse of any breakdown related to the catheter. Cross refer to F315
F 0315 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Wound, Ostomy and Continence Nurses Society ' s Care and Management of Patients With Urinary Catheters: A Clinical Resource Guide and staff interviews, the facility failed to ensure that nursing staff monitored one (1) resident (R) (R#239) with an indwelling urinary catheter for possible complications related to the use of the catheter of four (4) residents reviewed for indwelling/suprapubic catheters . This failure resulted in harm for R#239 who was hospitalized for [REDACTED].) coli Urinary Tract Infection [MEDICAL CONDITIONS] bacteremia (bacterial infection, in the blood, that is resistant to many of the antibiotics used to treat ordinary staph infections) and R#239 had to get a suprapubic urinary catheter placed (a cut in the abdominal wall that allows a hollow tubing to be inserted into the bladder to drain urine). The sample size was 44 residents Findings include: Review of the Wound, Ostomy and Continence Nurses Society ' s Care and Management of Patients With Urinary Catheters: A Clinical Resource Guide (2016) (pages 29-30) revealed that irritation or skin breakdown may occur in the periurethral/perineal area and/or in areas where the catheter and drainage tubing are placed or secured. Causes and contributive factors to breakdown include positioning of the drainage tubing or catheter straps on the skin. Prevention of breakdown includes securing the catheter and drainage tubing in areas that will not cause pressure or tension when changing

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F 0315 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 11) position. Continued review revealed that documentation of catheter care can be completed using a checklist or hand written progress notes. Complete, accurate, and timely documentation is essential to evaluate the clinical effectiveness of nursing interventions. Routine documentation should include the type/location of anchoring device and the presence/absence of problems. Review of the medical record for R#239 (a closed record) revealed that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating that he was alert and oriented; required the assistance of two staff for bed mobility and transfer; had an indwelling urinary catheter; was frequently incontinent of bowel; had an admission weight of 247 pounds; and had no skin breakdown on admission. Review of the resident's Admission Interim Care Plan dated 8/26/16 revealed that the resident had a urinary catheter related to [MEDICAL CONDITION] with a goal that the resident would not develop any complications associated with catheter usage within the next thirty (30) days. Interventions included nursing staff to provide catheter care per policy, keep catheter tubing free of kinks, keep drainage bag below level of the bladder and prevent tension on the urinary meatus from the catheter. Review of the Comprehensive Care Plan dated 9/21/16 revealed that the resident had a Foley catheter related to [MEDICAL CONDITION] due to Benign Prostate Hypertrophy ([MEDICAL CONDITION]) with a goal that he would have no complications related to the catheter in three (3) months. Interventions included nursing staff to check the catheter every shift for patency and proper position of the tubing and bag. Continued review of the Comprehensive Care Plan revealed that the resident was at risk for skin breakdown related to bowel incontinence, limited mobility, and use of a Foley catheter with an intervention for nursing staff to perform skin assessments per facility protocol and as needed (PRN). Review of the medical record for R#239 revealed that the resident was admitted to the facility on [DATE] for skilled therapy after hospitalization for cervical spinal surgery. Continued review revealed that the resident had [MEDICAL CONDITION] while hospitalized and was admitted to the facility with a Foley catheter. The resident had a physician's orders [REDACTED].) for [MEDICAL CONDITION] and for staff to provide catheter care nightly and PRN and to change the catheter PRN for leakage/occlusions/sediment. Review of the Admission/Nursing Observation Form dated 8/25/16 revealed that the resident had a Foley catheter and no skin breakdown. Review of the Braden Scale For Predicting Pressure Sore Risk dated 8/25/16 revealed that the resident scored 14 indicating that he was at moderate risk for pressure sore development. Review of the Skilled Daily Nurses Notes dated 9/1/16 on the 7:00 a.m. to 7:00 p.m. shift and the 7:00 p.m. to 7:00 a.m. shift revealed that staff failed to document that the resident had a catheter and failed to document the color and consistency of the resident's urine. Review of the SBAR Communication Form dated 9/2/16 at 6:20 p.m. revealed that the resident's urine was very concentrated and a dark yellowish-orange in color and he complained of feeling bad. Continued review revealed he verbalized his pain as a 7 on a scale of 1 to 10 and that he was grimacing. His vital signs were within normal limits. Review of the Skin Evaluation section of the form revealed that the resident did not have any skin tears, ulcers or wounds. Continued review revealed that the resident's family wanted staff to send him to the hospital. The physician was notified and the resident was sent to the emergency room (ER) on 9/2/16 at 7:30 p.m. Review of the Hospital Discharge Summary dated 9/7/16 revealed that the resident's Foley catheter had been changed during his admission to the hospital 9/2/16 to 9/7/16 but did not specify the actual date. Continued review revealed final diagnoses, for the resident being admitted to the hospital on [DATE], was Escherichia (E) coli Urinary Tract Infection [MEDICAL CONDITIONS] and acute kidney injury. There was no indication in the Hospital History and Physical dated 9/2/16 or the Hospital Discharge Summary dated 9/7/16 that the resident had any skin breakdown related to the catheter. Review of the Admission/Nursing Observation Form dated 9/7/16 revealed that the resident was readmitted to the facility without any skin breakdown. The resident was readmitted with a physician's orders [REDACTED]. Review of the medical record revealed that the resident had a follow-up appointment with the Urologist on 9/15/16. Review of the Urologist Progress Note dated 9/15/16 revealed that the resident was in a wheelchair and was unable to transfer. Continued review revealed that the Urologist was unable to place the resident on a stretcher in order to change his Foley catheter at that time. Continued review revealed that a physical examination of the resident's genitals was deferred so there was no documentation that the resident had breakdown. Further review revealed that the Urologist ordered facility nursing staff to change the resident's Foley catheter in two weeks (9/29/16) and then change every four weeks afterwards. Although the resident had a care plan intervention for staff to check the catheter every shift for proper position of the tubing, there was no indication in his medical record that staff had checked the position of the catheter tubing to ensure that it was positioned properly to prevent skin breakdown and erosion of the resident's penis. Continued review of the Skilled Daily Nurses Notes revealed that licensed nursing staff did not assess the resident's urine on 9/10/16, 9/13/16, 9/20/16, and 9/28/16. Review of the Skilled Daily Nurses Note dated 9/28/16 at 1:20 a.m. revealed that the resident had confusion and was yelling at times. However, there was no indication that licensed nursing staff assessed the resident's Foley catheter or the color and consistency of his urine on 9/28/16 on the 7:00 a.m. to 7:00 p.m. shift or the 7:00 p.m. to 7:00 a.m. shift. Review of the SBAR dated 9/29/16 revealed that the Licensed Practical Nurse (LPN) was to change the resident's Foley catheter as ordered by the Urologist and noted an open area on the underside of his penis. Continued review revealed that LPN WW inserted a new Foley catheter, notified the Unit Manager who notified the physician of the open area at 4:30 p.m. The physician ordered staff to send the resident to the emergency room (ER). Continued review of the SBAR revealed that the resident had increased confusion, appeared to have discomfort, verbalized the intensity of his pain as a 7 on a scale of 1 to 10 and had dark urine. Further review revealed that the LPN had administered pain medication to the resident at 2:30 p.m. for complaints of pain to his back and to the Foley insertion site. Review of the Hospital Discharge Summary dated 10/6/16 revealed that the resident presented with pelvic discomfort and was found to have traumatic [DIAGNOSES REDACTED] secondary to mucosal erosion from the Foley catheter, scrotal [MEDICAL CONDITION], E. coli UTI, [MEDICAL CONDITION]-resistant Staphylococcus aureus (MRSA) bacteremia and placement of suprapubic urinary catheter. The resident did not return to the facility after discharge from the hospital. Although the resident had a care plan intervention for nursing staff to perform skin assessments per facility policy and as needed (PRN) there was no indication that the Treatment Nurse had identified any slits or open areas on the resident's penis on the Admission Nursing Observation Form dated 8/25/16 and on his readmission from the hospital on [DATE]. Review of the Body Audits performed by Licensed Nursing Staff on 8/25/16, 8/30/16, 9/7/16, 9/13/16, 9/21/16 and 9/27/16 revealed no indication that staff had identified any breakdown related to the resident's Foley catheter at those times. Review of the Medication Administration Records (MARS) revealed that the resident received [MEDICATION NAME] twice in 8/2016 for throat pain, one time in 9/2016 for generalized pain and one time in 9/2016 for tooth pain. There was no indication that the resident requested or received pain medication for genital or groin pain. Interview with the previous Director of Health Services (DHS) on 3/23/17 at 12:25 p.m. revealed that the resident had a penile abscess that had burst during his hospitalization prior to his admission to the facility. Continued interview revealed that he was admitted with two slits on the head of his penis related to the abscess. The DHS was unable to provide Hospital documentation regarding the abscess or any facility documentation that the resident was admitted with the slits. Interview with LPN VV on 3/23/17 at 1:45 p.m. revealed that she had performed a skin assessment for the resident on 9/27/16 on the 7:00 p.m. to 7:00 a.m. shift, two days prior to his hospitalization for traumatic [DIAGNOSES REDACTED] and had not seen any open areas or slits on his penis. Continued interview with LPN VV revealed that she would have lifted up the resident's penis and scrotum to assess for any breakdown on his genitals. Further interview revealed that she would have ensured the catheter tubing was secured to his leg to prevent tension. Interview with the previous DHS on 3/23/17 at 4:50 p.m. revealed that the resident was obese and would frequently push his genitals between his thighs possibly causing pressure on his genitals instead of allowing his genitals to rest on top of his thighs as encouraged by staff. However, the DHS was unable to provide any documentation of the resident's behavior. There was no indication that staff had developed a plan of care to address the resident's behaviors. During a telephone interview on 3/23/17 at 4:56 p.m. with LPN WW who was the nurse who assessed R#239 with an open area on his penis on 9/29/16, revealed that the resident was admitted to the facility with two slits on his penis. However, LPN WW was unable to provide documentation that the resident had slits on his penis on admission to the facility or at any time

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F 0315 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 12) prior to 9/29/16 when she assessed him with an open area. Continued interview revealed that when she had removed the old Foley catheter to replace it with a new one on 9/29/16, the slits had worsened and were larger. She stated that the open area was noted prior to the insertion of the new Foley catheter. Continued interview revealed that there was no bleeding, swelling or redness from the open area. Further interview revealed that she did not remember if the resident complained of pain at the insertion site but, that she would have assessed the catheter to see if the tubing was secured to his leg and not pulling on his penis. Interview with LPN WW on 3/26/17 at 11:50 a.m. revealed that when she lifted up the resident's penis to change his Foley catheter on 9/29/16, that the catheter tubing was coming out of the bottom of his penis about mid-shaft. Continued interview revealed that the resident complained of pain during his stay at the facility related to his surgical site but, she did not remember that he complained of groin pain or pain at the insertion site until 9/29/16. Interview with Registered Nurse (RN) Nurse Manager (RN XX) on 3/26/17 at 12:25 p.m. revealed that LPN WW had notified her on 9/29/16 of the open area on the resident's penis. Continued interview revealed that she found that the physician had not been notified of any open area prior to LPN WW identifying the area on 9/29/16. Continued interview revealed that she notified the physician who ordered staff to send the resident to the hospital. Continued interview revealed that she did not assess the open area on the resident's penis at that time. Further interview revealed that she interviewed the CNAs who cared for the resident and CNA AAA told her that he was aware of an open area on the resident's penis prior to 9/29/16 but did not know when he first noticed the area. She stated that she did not know if he had notified the nurse. Further interview revealed that she had spoken with the treatment nurses who told her that they had not been notified about the open area. Interview with CNA YY on 3/26/17 at 12:35 p.m. revealed that she was aware of a slit under the resident's penis that was about ½ inch long but could not remember the date that she noticed it. She stated that she notified the nurse who no longer works at the facility. Continued interview revealed that when the resident was readmitted from the hospital (on 9/7/16) the slit was longer and extended about 1/3 the length of the resident's penis. Continued interview revealed that she notified the nurse at that time but, she could not remember who. Continued interview revealed that she provided catheter care for the resident every day during the provision of bowel incontinence care and the resident did not complain of genital pain at those times. Further interview revealed that she did not document her assessment of the slit and its deterioration or the supervisory nursing staff she notified. Interviews with LPN/Treatment Nurse ZZ and RN/Treatment Nurse OO on 3/26/17 at 12:55 p.m. revealed that they had not been notified of slits or open areas on the resident's penis. Continued interview revealed that if staff had notified them they would have notified the physician for treatment orders, treated the area and documented their treatments and assessment of the wound. LPN/Treatment Nurse ZZ stated at that time that she performed a head to toe skin assessment on the resident when he was readmitted from the hospital on [DATE] and that the resident did not have any slits/open areas on his penis at that time. Further interview with LPN/Treatment Nurse ZZ revealed that the resident did not complain of pain at that time but, expressed discomfort at having to spread his legs apart during the assessment because he was so obese. During a telephone interview with CNA AAA on 3/26/17 at 1:23 p.m., he stated that he provided catheter care for the resident but was not aware of any slits or open areas on the resident's penis. Continued interview revealed that the resident's family notified him one afternoon that they had pulled on the resident's catheter while repositioning the resident in the bed. Continued interview revealed that the resident's catheter was intact and the tubing secured with a leg strap. Continued interview revealed that the resident complained of pain in his private area at that time and he notified the nurse. However, he was unable to say who he notified. Further interview with CNA AAA revealed that he provided catheter care for the resident after this incident and the resident did not have any slits or open areas. Interview with the resident's attending physician on 3/26/17 at 5:15 p.m. revealed that he was not aware of any abscess on the resident's penis that had ruptured prior to his admission to the facility on [DATE]. He stated that if the resident had a ruptured abscess, he would have been notified by hospital staff and would have monitored the abscess during his stay at the facility. Continued interview revealed that he was not aware of any slits or open areas on the resident's penis until 9/29/16 when he ordered the resident sent to the hospital. Continued interview revealed that he expected nursing staff to notify him promptly of any slits or open areas or other breakdown so that he could assess the area and possibly order an antibiotic to prevent infection. He stated that he expected staff to notify him if the area had deteriorated. Continued interview revealed that he expected nursing staff to monitor a resident's indwelling urinary catheter for any complications, monitor the resident's genitals for breakdown and thoroughly document their assessments in the Nurse Notes every shift. Further interview revealed that he had expressed concerns to the previous DHS and Administrator about some nursing staff's failure to notify him that laboratory tests had not been done as ordered and the lack of thorough documentation by nursing staff. During a telephone interview with the family of R#239 on 3/27/17 at 10:44 a.m., she stated that staff had not notified the family of any abscess or slits in the resident's penis during his stay at the facility. Further interview revealed that the family were not aware of the [DIAGNOSES REDACTED] until 9/29/16 when the emergency room physician notified them. Although interviews with several nursing staff revealed that R#239 was admitted with several slits at the head of his penis, there was no indication in his medical record that the slits were assessed, that the physician was notified of the slits for possible treatment to prevent infection and that the slits were monitored for deterioration. Although nursing staff documented that daily catheter care was provided for R#239, there was no indication that nursing staff monitored the resident's catheter insertion site for breakdown and for the consistent proper positioning of the catheter tubing. There was no indication that nursing staff monitored the resident for possible complications related to the use of the Foley catheter until 9/29/16 when LPN WW identified an open area on the resident's penis and the resident was admitted to the hospital with [REDACTED]. During the Quality Assurance process, additional interviews and record reviews were conducted as follows: A post telephone interview was conducted with the attending physician on 4/3/17 at 12:20 p.m. The physician stated that although he is not an expert in the field of penile [DIAGNOSES REDACTED], this is a condition most commonly present from childhood and a younger population. The attending physician stated that he could not say based on the [DIAGNOSES REDACTED]. The physician stated that this [DIAGNOSES REDACTED]. Typically this develops over several months as opposed to several weeks. Chronic catheter use causes small micro trauma. Repeated trauma turns to fibrosis then to [DIAGNOSES REDACTED]. A post telephone interview with CNA RRR on 4/3/17 at 12:51 p.m. revealed he had cared for Resident #239 on a regular basis. CNA RRR stated that the resident wore a brief and he had never seen any discharge or blood in the residents brief. CNA RRR further stated that he performed catheter care for R#239 and never noticed any discharge or bleeding from his penis. A post telephone interview with CNA PP on 4/3/17 at 1:04 p.m. revealed that she had care for R#239 on several occasion. CNA PP stated that she had never seen a discharge or blood in the resident's brief and had never seen a discharge or blood form the resident's penis when she conducted catheter care. The resident had a catheter during the hospital stay prior to admission to the facility. Hospital records showed that he had a catheter inserted 8/15/16 which was removed on 8/22/16 and reinserted 8/24/16 due to [MEDICAL CONDITION]. During the hospital stay, it was noted on the GU consultation report dated 8/15/16 that R#239 complained of pain with the catheter the entire time he had a catheter. The resident was cognitively intact with a BIMS of 15 and never complained of any trauma or pain to his penis while in the nursing facility. Further review revealed that the resident was returned to the hospital on [DATE] with a UTI and the catheter was changed during that hospital stay of 9/2/16 - 9/7/16.
F 0325 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, the facility failed to follow the physician's dietary orders related to increasing the oral diet from one meal a day at lunch to two meals a day at breakfast and lunch for one resident (R) (R#63). The resident did not receive assistance with breakfast until 3/25/17, three days after an order was

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F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 13) received to begin an increase in her oral diet on 3/22/17. R#63 received enteral feeding x 20 hours/per day with a goal to wean off the enteral feeding. The resident sample was 44 residents. Findings include: Record review for R#63 revealed re-admission to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the last three Minimum Data Set (MDS) assessments for R#63 revealed a Quarterly assessments dated 9/4/16, 11/21/16, and 2/23/17 revealed that the resident had a Brief interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. These same MDS Assessments revealed that R#63 required either total dependence of staff for eating or extensive assistace with eating and No weight loss was indicated. Review of the care plan for R#63 with an onset date of 3/14/17, identified potential for nutrition and hydration deficits related to Gastrostomy ([DEVICE]) status. On 3/15/17 noted the resident receives one mechanical soft/ground meats meal per day at lunch to prevent significant weight loss. Interventions include, but not limited; Speech Therapy as ordered, diet as ordered. Review of the telephone physician orders [REDACTED]. Continue all other dietary restrictions. An interview on 3/23/17 at 1:20 p.m. with the SLP revealed she had been assisting R#63 with eating one meal a day at lunch since last week. The resident typically consumes 60% of her meal. The SLP further stated that the resident's meals had been increased to two meals per day (breakfast and lunch) and the goal was to wean R#63 off of her gastrostomy-tube ([DEVICE]) feedings. Observation on 3/25/17 at 8:18 a.m. of the meal cart on 300 Hall revealed an untouched meal tray for R#63 sitting in the cart with numerous trays for residents who had already eaten. An interview on 3/25/17 at 8:20 a.m. with R#63 revealed that she had not eaten breakfast this morning and was not aware that breakfast had been served. An interview conducted on 3/25/17 at 8:33 a.m. with Certified Nurse Aide (CNA) (CNA HH) revealed that she was not aware that R#63 had an oral diet and was unsure as to why the kitchen continued to send a meal tray to the hallway. CNA HH opened the lid on the tray for R#63 and the food on the tray had not been touched. An interview conducted on 3/25/17 at 8:35 a.m. with the nurse in care of R#63, Licensed Practical Nurse (LPN) (LPN JJ), revealed that ultimately it was her responsibility to assure that residents get their meal trays on the floor. LPN JJ stated that there was no morning meeting held this morning with the CNAs to inform them that there was a new dietary order for R#63. LPN JJ further stated that when the order was originally written on 3/21/17 the information was shared with the CNAs who were working at that time and she assumed that the information had been passed on. A subsequent interview on 3/25/17 at 8:42 a.m. with CNA HH revealed that it had not been reported to her from the previous CNA that R#63 eats breakfast now opposed to being tube feeding only. CNA HH stated that no information was provided by the charge nurse related to R#63 dietary order changes. An interview conducted on 3/25/17 at 8:57 a.m. with the Interim Administrator revealed that dietary orders should be followed as written but he was unsure of how staff communicate with one another regarding changes in the resident's regimen. Interview on 3/25/17 at 9:58 a.m. with the Interim Director of Health Services (DHS) related to R#63. The interim DHS provided documentation of the consumption record for R#63. The DHS further stated that the task for meals in the computer system was not activated and did not prompt the CNAs by turning red when a meal was not documented. Review of the Meal Percentage (CNA Role) revealed that there is no evidence or documentation that R#63 received breakfast on 3/22/17, 3/23/17, and 3/24/17 per the dietary order dated 3/21/17. Review of the Registered Dietician documentation dated 2/17/17 revealed an Email Faxed Recommendations form dated 2/17/17 revealed, in pertinent part, that the RD Recommendation was, change tube feeding to [MEDICATION NAME] 1.2 at 60ml/hr x 20 hours (off 10:00 a.m., on 2:00 p.m.) Review of the Nutrition Assessment dated 2/27/17 documented by the Registered Dietician revealed the R#63 was currently receiving [MEDICATION NAME] 1.2 at 60 ml/hr x 20 hours per day. The resident was not receiving an oral diet at this time. The resident's hospital return weight was 156 pounds reflecting a 7.4 pound gain which may be associated with IVF (Intravenous fluids), re-feeding. Current feeding is below nutritional needs for wound healing, recommend change back to Glucerna due to high protein content and promote BS (blood sugar) control with increase kcalories needed: Change to Glucerna 1.5 at 65ml/hr x 20 hours per day, will provide 1300ml/1950kcal, 107gm protein, 986ml water. Change water flush to 50ml/hr x 20 hours per day. Review of the Registered Dietician documentation dated 3/21/17 revealed Registered Dietican Recommendation documented, in pertinent part, comments: resident will be starting PO (by mouth) meals twice a day starting 3/22/17. Review of the Yearly Weight Record for R#63 revealed the last six months documented weights were as follows: 10/1/16= 160 pounds 11/1/16= 155 pounds 12/5/16= 158 pounds 1/1/17= 156 pounds 2/6/17= 149.8 pounds 2/16/17= 156.2 pounds 2/25/17= 148.6 pounds 3/5/17= 147 pounds 3/25/17= 151 pounds
F 0356 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information/data on a daily basis.** Based on observations and staff interviews, the facility failed to post the nurse staffing data at the beginning of the shift and failed to maintain record of the posted nurse staffing data for 18 months. The facility census was 113 residents. Findings Include: Observation on 3/23/17 at 8:32 a.m., in the facility's lobby revealed that the nurse staffing hours posted was dated 3/22/17. Observation on 3/28/17 at 8:10 a.m. and 10:37 a.m. in the facility lobby revealed the nurse staffing data posted was 3/27/17. Interview with the Scheduler SS on 3/28/17 at 4:13 p.m. revealed that she tries to post the nurse staffing each morning prior to the 9:30 a.m. morning meeting. Scheduler SS further stated that staff posting for the weekend is completed on Friday after consulting with the Admissions Director to see if there are any anticipated discharges or admissions. The form is then placed in the folder and the weekend receptionist is responsible for assuring that the correct form is displayed each day. It was further reported that if staffing changes occur throughout the shift the staffing form would be updated. In a subsequent interview on 3/28/17 at 7:02 p.m. with Scheduler SS revealed that she has all of the staff posting forms since she began this position in September 2016 but could not locate posted nursing hours prior to that.
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 record review, review of the facility policy titled Governing Body review of the Administrator Position Description, resident and staff interviews, the facility failed to ensure that it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable, physical, mental, and/or psychosocial wellbeing of each resident. The facility administration was aware on 2/11/16 that allegations had been reported by resident (R) #112 that Licensed Practical Nurse (LPN) KK was verbally and physically abusive. Additionally, on 10/28/16 R#112 reported that a heavyset woman, who provided her care, had been verbally, mentally, and physically abusive. The administration failed to thoroughly investigate the allegations of abuse and report the alleged abuse to the appropriate State Survey Agency in accordance with the facility's policies. During interviews with other residents that reside on the 300 Hall, for which LPN KK is regularly assigned, there was one resident (RA) that alleged she had been verbally abused by LPN KK. This failure had the potential to affect all residents in care of LPN KK. Refer F223, F225 and F226 The facility's failure to use its resources effectively and efficiently in accordance with the facility's policies related

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 14) to Governing Body and Abuse, has caused or is likely to cause serious injury, harm, impairment or death to residents. Immediate Jeopardy was identified on 3/23/17 and determined to exist on 2/11/16. The facility's former Administrator and Director of Health Services (DHS) were informed of the Immediate Jeopardy on 3/23/17 at 6:50 p.m. An acceptable Allegation of Compliance (AoC) was received on 3/24/17 and the State Survey Agency validated the Immediate Jeopardy which was removed on 3/28/17, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. Findings include: Review of the facility policy titled Governing Body revised 11/29/16 revealed that it is the policy of this healthcare center to have in place a governing body pursuant to 42 C.F.R 483.70. A designated group of people that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. The governing body of this healthcare center is the Administrator and Area Vice President. Review of the Administrator Position Description created 6/26/16 documented the Job Purpose- Directs the day to day functions of the nursing center in accordance with federal, state and local regulations that govern long term care centers, and as may be directed by the Area Vice President, to provide appropriate care for our patients/residents. Key Responsibilities include but not limited to; Ability to apply standards of professional practice to operations of nursing facility and to establish criteria to assure that care provided meets established standards of quality, Ability to develop and implement administrative policies and procedures, Demonstrates competency in the protection and promotion of residents' rights. During an interview with R#112 on 3/21/17 at 12:37 p.m., she stated that her nurse, who she described as a heavy set black woman, had a history of [REDACTED]. R#112 stated that the nurse hollers and yells at her and she was afraid of her. R#112 further stated that the nurse yells and hollers at her and has also threatened to stick her with needles. R#112 stated that when she told the people over the facility the nurse went crazy and hit her across her back and shoved her. In a subsequent interview on 3/22/17 at 11:43 a.m., R#112 stated that the nurse that abused her was her nurse that gave her medication this morning (3/22/17). R#112 stated that the nurse told her that if she didn't get up, she was going to give her a shot. R#112 sated that she doesn't get shots so she tried her best to sit up. Licensed Practical Nurse (LPN) KK was at the medication cart outside of R#112's room and confirmed that she was the nurse for the 300 hall for which R#112 resides. Review of the Reportable Occurrence Log Form revealed an allegation of abuse (physical) reported by R#112 on 10/28/16. In an interview with the former Administrator on 3/22/17 at 11:47 a.m., she stated that she had conducted a thorough investigation of the incident but was unable to provide evidence or documentation of the investigative information gathered to support that the incident was unfounded and unsubstantiated. The former Administrator further stated that the incident was reported to the State Survey Agency. The former Administrator provided a plain white piece of paper with no letterhead, dated 11/3/16, addressed to: Georgia Department of Health-LTC-Complaint unit. The document stated that R#112 had reported that a very heavy set woman had pushed her, but she did not know who she was or the date or time of the occurrence. The section titled Immediate protection implemented indicated initiation of immediate investigation. The conclusion stated that after a thorough investigation, the exact nature of the allegation was unfounded and unsubstantiated. The former Administrator stated that she conducted interviews with staff members but she could not remember who she spoke with. The former Administrator confirmed that the only documentation she had on file for this incident was the letter addressed to the Georgia Department of Health-LTC-Compliant Unit dated 10/28/16 and a Facility Incident Report Form dated 10/28/16, which documented staff to resident physical abuse, revealed no injury and no treatment required. The physician was not notified, the police were not notified and other agencies involved were not notified. Although the former Administrator claimed to have reported this incident to the State Survey Agency, the facility incident report form dated 10/28/16 reflected no such report was filed. In addition, review of the State Survey Agency Complaint and Incident Tracking System duing the survey revealed no evidence of an entity self-report related to the allegations of abuse made by R#112. The former Administrator repeatedly stated that R#112's Brief Interview of Mental Status (BIMS) score was a seven; therefore, she was not credible. Review of her employee file was conducted. The employee file revealed a previous Grievance Complaint Form dated 2/11/16 stapled to a Record of Partner Corrective Action Form dated 2/15/16, with a complaint made by R#112 indicated that LPN KK talks loudly to her and tells her to shut up. LPN KK received a written warning related to violation of discourtesy to the patients/residents. Additional interviews on the 300 hall revealed one resident (R A) alleged LPN KK had verbally and/or physically abused her. During an interview with R#80 on 3/24/17 at 1:18 p.m., (who resided on the 300 hall) he stated that a nurse comes around and curses him and makes him mad. This same nurse threatened to beat the hell out of him. R#80 stated that she has shoved him in the past and that he was sort of afraid of her R#80 did not know the name of the nurse but described her as a black female nurse weighing about 250 pounds. He stated that he could identify her if he saw her but he had not seen her today. R#80 further stated that he did not report this and did not know who the abuse coordinator was. Record review for R#80 revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE], which documented a BIMS summary score of four, indicating severe cognitive impairment. The resident was assessed as not having exhibited behaviors of hallucinations or delusions. Despite a BIMS score of four, the resident was able to accurately describe his nurse and knew that he had not seen LPN KK on the day of his interview on 3/24/17. (Although R#80 had a BIMS score of four, LPN XXX provided a list of residents (which included R#80) who were in her professional opinion candidates for resident interviews on 3/24/17 at 1:16 p.m.). During an interview on 3/24/17 at 2:00 p.m., with R A(who resided on the 300 hall), R A reported a nurse would make her wait for her medications. R A stated the nurse was overly aggressive with words and always had an attitude when speaking to her. R A was fearful to name the nurse initially, but stated the nurse wore green and worked on Tuesday (3/21/17). R A eventually named the nurse as LPN KK and was visibly upset when talking about her. R A had never reported this to the facility. R A was crying throughout the interview and was afraid that she would be retaliated against if others knew that she was telling about the treatment from LPN KK. Record review for R A revealed an Annual MDS assessment dated [DATE] which documented a BIMS summary score of 15, indicating no cognitive impairment. The MDS assessment revealed the resident did not exhibit behaviors of hallucinations or delusions. The former Administrator and DHS were terminated before an interview could be conducted regarding the Grievance Complaint Form dated 2/11/16 in LPN KK's employee file. An interview with the Interim Administrator on 3/28/17 at 4:15 p.m., revealed this incident should have been investigated as an allegation of verbal abuse. In an interview with the Senior Care Partner (SCP) Registered Nurse (RN) on 3/28/17 at 4:24 p.m., she confirmed that R#112 began to cry during the interview for the grievance of 2/11/16. She stated that she reported this to the former Administrator because the nature of the grievance was an allegation of abuse. She stated that she was not sure what the Administrator did after she reported it her. Review of the facility policy titled Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property revised 2/24/17 documented; Any allegation, suspicion, or identified occurrence is identified involving patient abuse, neglect, exploitation, mistreatment, and misappropriation of property, including injuries of unknown source, should immediately be reported to the Administrator of the provider entity. In accordance with applicable laws and regulations, the Administrator or his or her designee should notify the appropriate state agency (or agencies). Review of the policy titled No Retaliation for Good Faith Reporting of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property revised 11/21/16 documented: Any suspicion of abuse, neglect, exploitation, mistreatment or misappropriation of patient property, a suspected partner should not have direct care contact with the patient at issue until the investigation is completed and the issue resolved. For example, a partner suspected of committing any such act should be suspended without pay pending the outcome of the investigation. The facility implemented the following actions to remove the Immediate Jeopardy: What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? PruittHealth Peake will be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident. Based upon the alleged deficient practice cited on F 490. The Administrator of record during the survey is no longer at the facility. The Area Vice President is now the interim

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 15) administrator of the center. We are now in the process of securing a permanent administrator. The healthcare center conducted a Performance Improvement Committee meeting on March 24, 2017 to review the findings of the following: Regulatory survey tags cited - F223, F224, F225, F226, F281, F315, F490, F498, F520 Audit findings conducted as a result of the survey tags cited Reviewed in-servicing that was conducted relating to the survey tags cited which included: Abuse and Neglect How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Area Vice President is the acting administrator. If an allegation is brought forward the following procedure will be followed: Accused person will be suspended pending investigation per policy Reports will be filed to appropriate agency in the allotted time frame Investigation will be conducted by the Administrator and/or Director of Health Services The healthcare center's Performance Improvement Committee developed new performance improvement action plans on the areas noted during regulatory survey and other areas identified during monitoring/ audit findings. The healthcare center's Performance Improvement Committee was in-serviced on March 26, 2017 by the Area Vice President on the following: Action plan development related to abuse and catheter care. Action plan revision, utilizing monitoring/audit findings Action plan evaluation AVP educated Department heads on QAPI process and their roles and responsibilities on March 26, 2017. What measures will be put in place or systematic changes will be made to ensure that the deficient practice will not reoccur? For the abuse tag education began on March 22, 2017 for all staff (to include Nursing, CNAs, Housekeeping, Dietary, Laundry, Maintenance, Administrative, Therapy and 1 Respiratory Therapy) conducted by the Clinical Competency Coordinator, on abuse and reporting abuse per policy. The center has 90% staff in-service completed as of 3/25/17. Any staff not receiving the in-service by 3/26/2017 related to FMLA, PRN status, or paid time off will be educated before the next schedule shift. Education on abuse is reviewed in new partner orientation by the Clinical Competency Coordinator. Any staff members not receiving the in-service will be unable to return to work until they have completed the in-service. On March 24, 2017 Administrator met with Resident Council to review abuse and reporting of abuse. There were no allegations reported during resident council meeting. The healthcare center's Performance Improvement Committee will meet bi-monthly for three months, then monthly thereafter. The Performance Improvement Committee will review, but not be limited to the following, at each meeting: Action plan monitoring/auditing results Evaluation of current action plans Revisions of current action plans as a result of the audit findings submitted to the Performance Improvement Committee on a monthly basis Resolution of current action plans Development of new action plans The Administrator will monitor compliance to the Performance Improvement action plans bi-monthly for three months and monthly thereafter. If issues are discovered the plan will be re-assessed and new intervention put into place. How will the corrective action be monitored to assure that the deficient practice will not reoccur? Area Vice President will chair the initial Performance Improvement Committee meeting and will attend or review minutes thereafter. Any issues or identified deficiencies to be reviewed with full Performance Improvement team. Once an Administrator is secured for the building the following will occur: Area Vice President Monitoring; The AVP will monitor compliance to the following bi-monthly and document findings in a checklist report format: Review Job Description Review all allegations of abuse to ensure the policy was followed Review and/or observation of Performance Improvement Committee Team meetings/minutes The State survey agency validated the implementation of the facility's Credible Allegation of Jeopardy Removal (CAJR) as follows: Record review revealed the Administrator and the DHS were both terminated on 3/27/17. The Area Vice President is the acting Interim Administrator. Record review revealed that all areas of abuse and Administration were reviewed. Record review of the Quality Assessment and Assurance/QAPI Committee Meeting Attendance sheet for 3/25/17 at 5:30 p.m. revealed the Area Vice President, Interim DHS were in attendance, and reviewed all finding with the Medical Director on 3/26/17. Medical Director documented reviewed and signed on 3/26/17. The healthcare centers Performance Improvement Committee new Improvement Action Plans related to abuse and Administration. Action Plans included: Abuse: all allegations have to be investigated and reported, review of the types of abuse including: verbal abuse, sexual abuse, physical abuse, mental abuse, involuntary seclusion. Must report all allegations of abuse immediately - The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator of the facility. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. Screening: screen potential employees for a history of abuse, neglect or mistreating residents. Checking with previous employers, background checks, checking appropriate licensing boards and registries. How staff should report their knowledge related to allegations without fear of reprisal. Training: through orientation and on-going sessions related to abuse prohibition practices. Prevention: Provide families and staff information on how and to whom they can report concerns incidences and grievances without the fear of retribution; and provide feedback regarding the concerns that have been expressed. Identification - identify events, such as suspicious bruising, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation. Investigate different types of incidents and identify the staff member responsible for the initial investigation. Protect residents from harm during the investigation. Federal Regulations were reviewed with what requirements are to be met to meet the Federal Regulations related to each tag including Abuse: F223, F224, F225, F226, F490. Audit findings revealed 7 facility [MEDICATION NAME] that were investigated and reported. Education began on March 22, 2017 for all staff (to include Nursing, CNAs, Housekeeping, Dietary, Laundry, Maintenance, Administrative, Therapy and Respiratory Therapy) conducted by the Clinical Competency Coordinator, on abuse and reporting abuse per policy. On March 24, 2017 the Administrator met with Resident Council to review abuse and reporting of abuse. There were no allegations reported during resident council. The resident council was educated on who to report to and will continue to be reassured that they can report without fear of retaliation. On 3/27/2017 the Administrator posted his personal contact information in the front lobby and at both nursing stations. In addition, the Administrator distributed the reporting phone numbers for the Ombudsman, Department of Community Health reporting, and the(NAME)Health Customer Service Hot Line to all residents with a BIMS score of 10 or above. These numbers are also posted in common areas for all visitors and families to see. Multidisciplinary staff members were interviewed. All staff stated they had attended in-services related to abuse on 3/22/17. The staff were able to define abuse and the types of abuse, how to recognize and report abuse to their supervisor and/or the abuse coordinator and were able to identify that the Administrator was the abuse coordinator for the facility.

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	115394	A. BUILDING _____ B. WING _____	03/28/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH - PEAKE	6190 PEAKE ROAD MACON, GA 31220

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 16) Abuse in-services were provided by the DHS, Clinical Competency Coordinator, RN Restorative Nurse on Abuse, types of abuse, how and when to report abuse, recognition of abuse for non-cognitive, or non-communicative residents. Further interview, with staff, revealed that if a confused or non-cognitive resident stated that someone hurt them then they would report that as well. Continued interview revealed that some residents that may not be able to communicate can show outward signs or behaviors of abuse such as jerking, facial expressions, shutting down and not responding anymore, that if a resident showed those kinds of behaviors that they would report it to the nurse and Abuse Coordinator. Further interview revealed that if they reported the abuse to the Charge Nurse and the Administrator and did not seem to get a response or the issue was not addressed then they would continue to report the abuse until it was addressed. Continued interview revealed that each staff member revealed that they knew how to contact the Ombudsman and HFRD to report abuse themselves. The following staff members were interviewed: 11:00 p.m. to 7:00 a.m., shift: On 3/26/17 at 12:46 p.m., with Housekeeper BBB, on 3/26/17 at 12:49 p.m., with Activities Director/CNA, 3/26/17 at 12:56 p.m., with CNAZZZ, 3/26/17 at 1:07 p.m. with CNA YYY (Restorative), 3/26/17 at 1:13 p.m. with CNA XXX, 3/26/17 at 1:47 p.m. with CNA WWW, 3/26/17 at 1:53 p.m. with CNA VVV, Interview on 3/27/17 at 6:47 a.m., with CNA UUU, On 3/27/17 at 7:00 a.m., with CNA TTT, On 3/27/17 at 7:10 a.m., with CNA SSS, On 3/27/17 at 7:15 a.m., with CNA RRR, On 3/27/17 at 7:20 a.m. with CNA QQQ, On 3/28/17 at 9:30 a.m. with CNA PPP, On 3/28/17 at 9:41 a.m. with CNA PP On 3/28/17 at 10:04 a.m., with CNA OOO, On 3/28/17 at 10:35 a.m., with CNA NNN, On 3/28/17 at 10:45 a.m., with CNA MMM, On 3/28/17 at 10:55 a.m., with CNA SS, Central Supply, CNA scheduler, On 3/28/17 at 11:03 a.m. with CNA LLL, 3:00 p.m. to 11 p.m. shift 3/26/17 at 3:24 p.m., with CNA KKK, 3/26/17 at 4:20 p.m. with CNA JJJ, On 3/26/17 at 4:53 p.m. LPN JJ, 7pm - 7AM On 3/27/17 at 6:55 a.m. (11p.m. - 7 a.m.) LPN III, 3/27/17 at 6:57 a.m., with LPN HHH, 3/27/17 at 7:03 a.m., with LPN GGG, 3/28/17 at 9:25 a.m. with RN EE (Infection control, Restorative nurse), 3/28/17 at 10:52 a.m. with LPN FFF, 3/26/17 at 12:52 p.m., with Maintenance Director EEE, 3/28/17 at 3:15 p.m., with Housekeeping DDD Interview on 3/28/17 at 2:21 p.m., with the Senior Nurse Consultant revealed that the previous Director of Health Services (DHS) was terminated on 3/24/17 and that she is the Senior Nurse Consultant and she has stepped in as the Interim DHS and will be the Interim DHS until a new DHS is hired. The Interim DHS further revealed that the former DHS was not reporting what was occurring in the facility accurately and that there was a lack of follow up and that the former DHS was not following the facility's policies and procedures regarding abuse. The Interim DHS revealed that the facility has a System Checklist but that the checklist had not been completely correctly recently but she is going to ensure that the Systems Checklist is re-implemented and that the System Failure such as failure to assess, investigate, report are corrected. The Interim DHS revealed that they have vigorously started in-servicing the staff regarding abuse, neglect, recognizing abuse, investigating, and reporting abuse. She further revealed that they had found that the facility had a very hateful nurse but that nurse (LPN KK) had been terminated and that they have a zero tolerance for abuse of any kind. Interview on 3/28/17 at 3:49 p.m., with the facility's Area Vice President (AVP) revealed that he is the Interim Administrator until a new Administrator is hired. What he found was that the former Administrator did not report the instances of abuse, but that during their (his and the Interim DHS) investigation they substantiated the verbal abuse and that the nurse responsible (LPN KK) was terminated on 3/27/17 and that the former Administrator was terminated on 3/24/17 and the former DHS was terminated on 3/24/17. The AVP revealed that he will be responsible for reporting investigating and reporting all allegations of abuse. Interventions of QAPI for abuse are documented to be: All allegations of abuse will be reported to the Administrator or DHS immediately. The Administrator or DHS will report the allegation to the state agency within a 2 hour time frame. The Ombudsman will be notified. Law enforcement will be notified if deemed appropriate. A complete investigation will be completed. Staff will be in-serviced related to the abuse allegations. Review of notice regarding QAPI meeting on 3/26/17 revealed the following: On 3/26/17 the AVP educated all department heads on QAPI process, policy and procedures, their roles and responsibilities, current action plans, and how write Performance Improvement plans. AVP discussed QAPI review with Medical Director on 3/26/17. Medical Director Signature observed to be on 5th page as reviewed and dated 3/26/17.
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review it was determined that the facility failed to ensure accurate and complete documentation for one resident (R) (R#61) related to the administration of quetiapine on the Medication Administration Record [REDACTED]. The sample was 44 residents. Findings include: 1. Review of the Lippincott procedures titled, Oral Drug Administration revised 8/12/16, which the facility uses as their guidelines for their Medication Admnistration procedure indicated: If the patient/resident refuses medication, indicate on the paper Medication Administration Record [REDACTED]. Medication Notes are located on the back of the MAR. Resident R#61 had a physician's order for quetiapine 25 mg, ½ tablet 12.5 milligram (mg) of quetiapine by mouth twice daily at 6 a.m. and 8 p.m. A review of the Medication Administration Records (MAR's), revealed no evidence or documentation that the quetiapine was administered as ordered on [DATE] at 6:00 a.m., 12/3/16 at 6:00 a.m., 2/12/17 at 6:00 a.m., 2/21/17 at 6:00 a.m., 2/25/17 at 6:00 a.m., and 2/26/17 at 6:00 a.m. Interview on 3/28/17 at 10:34 a.m. with Licensed Practical Nurse (LPN) (LPN CCC) revealed she was not the nurse who completed the MAR for the 6:00 a.m. administration of quetiapine and she could not be sure if the medication had been administered on the identified dates. LPN CCC further stated that if the R#61 refused to take the medication the date should have been circled and an explanation should have been written on the back of the MAR. Interview on 3/28/17 at 11:05 a.m. with the Interim Unit Manager for the West Wing, confirmed that when a medication is missed or a resident refuses to take the medication the date should be circled and documented on the back of the MAR. The Interim Unit Manager further stated that she is currently doing an audit of all West Wing MARs and had identified some holes in the MAR. The missing documentation on the MARs was addressed with the nurses as it was identified. 2. Review of the Lippincott Procedures- Wound Observation and Assessment Documentaion undated page provided by the Administrator as policy for wound care documented the following: Implementaion: The anatomical location of existing wound should be documented. Determine the type of ulser or wound and the staging. Measaure wound in cm (centimeters) to determine length, width and depth. Measure for tunneling or undermining. Document undermining or tunneling in the narrative. Document signs and symptoms of infection in the narrative. Documentation: The wound observation and documentation form is completed with each dressing change. Wound assessment and documentation is completed weekly and when there is a significant change using the Documetation of Wound Observation and Assessment Form. Wound measurements are completed when there is significant change in wound status and weekly by the SIC RN. Review of the Quarterly Minimum Data Set (MDS) assessment for R#223, dated 12/30/16 documented in Section C- Cognitive Pattern a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Section G- Functional Status documented the resident required extensive assistance with Activities of Daily Living (ADL). Section M- Skin Assessment documented the resident had Stage I or higher pressure ulcer, is at risk for pressure ulcers and had two Stage II pressure ulcers present on admission. Record review for R#223 revealed the following Physician Orders for wound care treatment during the months of October 2016 and November 2016: 1.) Clean area of excoriation and ulcer to sacrum, blot dry and apply [MEDICATION NAME] dressing every three days and as needed (prn). Review of the Treatment Administration Record (TAR) for October 2016 indicated treatment was last administered on 10/29/16. There was no evidence or documentation that treatment had been administered and no evidence of a TAR for the month of November 2016. 2.) Cleanse ulcer to left heel with normal saline, blot dry, apply barrier film, allow to dry, apply 2 x 2 gauze with a dry dressing every three days and prn.). Review of the Treatment Administration Record (TAR) for October 2016 indicated treatment was last administered on 10/29/16. There was no evidence or documentation that treatment had been administered

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F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 17) and no evidence of a TAR for the month of November 2016. Review of the Wound Observation and Assessment Forms revealed an entry dated 10/24/16 which documented a Stage ll pressure ulcer of the sacrum measuring 0.5 x 0.4 x 0.1-stable. Further review revealed no evidence or documentation of pressure ulcer staging or measurements for the week of 10/31/16, 11/7/16 and 11/21/16. There were two forms dated 11/14/17 and 11/28/17 which documented resident refusal of treatment. Documentation resumed on 12/5/16 which documented a Stage ll pressure ulcer of the sacrum, measuring 0.5 x 0.3 x 0.1-improving. Review of the Wound Observation and Assessment Forms revealed an entry dated 10/24/16 which documented a Stage ll pressure ulcer of the left heel measuring 0.4 x 0.8 x 0.1-stable. Further review revealed no evidence or documentation of pressure ulcer staging or measurements for the week of 10/31/16, 11/7/16 and 11/21/16. There were two forms dated 11/14/17 and 11/28/17 which documented resident refusal of treatment. Documentation resumed on 12/5/16 which documented Stage ll pressure ulcer of the left heel, measuring 0.5 x 0.3 x 0.1-improving. Interview conducted on 3/27/16 at 2:22 p.m. with the Wound Care Registered Nurse (RN) (RN OO) confirmed there was no evidence of the Wound Observation and Assessment Forms or TAR in the residents clinical chart for the month of November, 2016. RN OO stated that she knew she had administered the treatment, completed the assessment forms and documented on a TAR for November 2016 but she does not know what happened to them.