STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	12/13/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family interview and staff interviews the facility failed to notify the Responsible Party (RP) for 1 of 3 residents (Resident #2) of an injury. Findings included: Resident #2 was admitted to the facility on [DATE]. The Minimum Data Set ((MDS) dated [DATE] revealed the resident was severely cognitively impaired. A record review of an incident report dated 11/20/17 revealed the nurse was called to the resident ' s room by the nursing assistant due to a knot noted with bruising to Resident #2 ' s right forehead. The note indicated the resident stated she fell this morning, tonight and 3 months ago. A record review of the nursing notes on 11/20/17 revealed there was no documentation stating the RP was notified of the injury to Resident #2 ' s forehead. An interview was conducted with the RP on 12/12/17 at 11:59 pm. The RP indicated the resident sustained [REDACTED]. The RP stated that no one from the facility notified the RP of the injury. An interview was conducted with Nurse #3 on 12/12/17 at 3:59 pm. Nurse #3 stated that she did not notify the RP. Nurse #4 stated she reported the incident to the physician and the Director of Nursing (DON). Nurse #4 stated she would usually notify the RP of a change in condition during her shift, but when she notified the DON, the DON reported she would handle it. Nurse #4 assumed when the DON indicated she would handle it, then she would notify the RP. An interview was conducted with the DON on 12/13/17 at 8:28 am. The DON reported she assessed Resident #2 for the injury to her forehead but she did not speak to the RP until later in the afternoon on 11/21/17. The DON indicated when the RP was informed he was upset that he was not notified. The DON reported the RP should have been notified by the nurse during the shift that the injury occurred. The DON reported her expectation of the nurses was to notify the RP whenever there was a change of condition on a resident during their shift and to document in the nursing notes when the RP was notified.
F 0583 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, family, staff and law enforcement interviews the facility failed to maintain privacy for one of three sampled residents (Resident #1) when a staff member utilized a cell phone to video record physical abuse by another staff member who placed a pillow on Resident #1 ' s face and attempted to force Resident #1 to remain in place by grabbing his arm while he called out for help. The video was discovered by a non-employee of the facility which resulted in a violation of Resident #1 ' s privacy. Findings included: Resident #1 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident was severely cognitively impaired. A record review of the daily shift assignment for Saturday, 11/25/17, for the 3-11 shift and 11-7 shift revealed NA (Nursing Assistant) #1 was assigned to Resident #1. NA #2 was assigned on 11/25/17 for the 3-11 shift only and worked on a different hall. An interview was conducted with the Responsible Party (RP #1) of Resident #1 on 12/10/17 at 2:51 pm via phone. RP #1 revealed she was out of town the weekend of 11/25/17. RP #1 stated she was informed by another family member of Resident #1 that a female person in the community who was a family member (FM #1) of NA #2 and NA #3 sent a video to RP #1 of Resident #1 being abused by NA #1 and was informed NA #2 videotaped the incident. RP #1 reported the video showed NA #1 was putting a pillow over Resident #1 ' s face, she had her hand around his throat, and her knee was in between the resident ' s legs and she was unbuckling his pants. RP #1 reported she saw this video on 11/26/17 and called 911. RP #1 stated she spoke with Detective #1 at the local County Sherriff ' s Department and shared the video she had on her phone with Detective #1. RP #1 indicated she notified the Administrator with Detective #1 via phone. RP #1 stated Detective #1 went to the facility and interviewed NA #1, NA #2, and NA #3. RP #1 reported that NA #2 and FM #1 who shared the video with Resident #1 ' s RP, shared a cell phone and that was how FM #1 of NA #2 and NA #3 became aware of the incident. An interview was conducted with the Administrator on 12/11/17 at 4:40 pm. The Administrator reported what had happened. The Administrator reported on 11/26/17 at 7:00 pm, RP #1 called and made the facility Administrative Assistant (AA) aware she had received a video of Resident #1 being abused. The Administrator reported on 11/26/17 at 7:16 pm, she made the Director of Nursing (DON) aware of the call received from the AA in regards to RP #1 having a video of Resident #1 being abused. The Administrator reported on 11/26/17 at 7:20 pm, RP #1 called her so she could speak to Detective #1 at the local County Sherriff ' s Department via phone. Detective #1 made the Administrator aware of a video showing NA #1 abusing Resident #1. The Administrator reported on 11/26/17 at 7:30 pm, she arrived at the facility to meet with Detective #1 and interview NA #1 in regards to the video. Once she arrived at the facility, Detective #1 allowed her to view the video. The Administrator stated she observed NA #1 placing a pillow over Resident #1 ' s face and then grabbing Resident #1 ' s arm and pulling the resident back in the bed. The Administrator reported on 11/26/17 at 7:30 pm, she interviewed NA #1 in regards to the video showing NA #1 placing a pillow over Resident #1 ' s face and grabbing his arm and pulling him back in bed. The Administrator stated NA #1 started to deny the abuse until she told NA #1 there was a video. NA #1 stated that she and Resident #1 were joking and laughing and Resident #1 stated he yelled help, help, call the police. NA #1 stated at this time she started giggling and placed a pillow on Resident #1 ' s face not to suffocate or harm Resident #1. NA #1 stated she was not aware at the time of the incident that NA #2 had videoed the incident until after the incident had taken place. NA #1 made the Administrator aware that NA #3 and NA #4 were aware of the video in regards to NA #1 placing a pillow on Resident #1 ' s face. A review of a written statement from NA #1 written on 11/26/17 revealed: NA #2 took the video without my knowledge of it. I did not know until after the fact. But we, me and Resident #1 were laughing and joking like always and he started yelling help, help, somebody call the police. I started giggling and took the pillow and placed it on his face, not to suffocate or harm him. NA #2 showed NA #3 and NA #4 the video. Those are the only two of my knowledge that knows. On 12/13/17 at 11:15 am attempted to interview NA #1 via phone. NA #1 was unavailable for an interview. The Administrator reported on 11/26/17 at 8:30 pm she interviewed NA #2 regarding the video of NA #1 placing a pillow on Resident #1 ' s face. NA #2 stated she did not take a video of NA #1 abusing Resident #1.

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

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F 0583 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) A review of a written statement written on 11/26/17 revealed, in part, NA #2 never recorded NA #1 in the room with Resident #1. On 12/13/17 at 11:17 am attempted to interview NA #3 via phone. NA #3 was unavailable for an interview. On 12/13/17 at 11:48 am attempted to interview NA #2 via phone. NA #2 was unavailable for an interview. The medication aide/NA #4 who was working on the 11-7 shift from 11/25 – 11/26/17 morning was suspended pending an investigation for Resident #1 and was unable to be interviewed. A review of the video was conducted. The video revealed NA #1 standing in front of Resident #1 ' s bed. Resident #1 was sitting upright in the bed with his feet on the floor. Resident #1 was fully dressed and shoes were on his feet. NA #1 had one knee up on the bed between Resident #1 ' s legs. NA #1 was observed pulling Resident #1 ' s right arm as he attempted to move away from NA #1. Resident #1 was observed yelling, Help, help, somebody call the police! NA #1 was observed placing a pillow over Resident #1 ' s face. An interview was conducted with Detective #2 on 12/11/17 at 3:49 pm. Detective #2 stated Detective #1 did the initial interview with NA #1 and NA #2 on 11/26/17. Detective #2 stated on 11/26/17 when Detective #1 interviewed NA #2, she denied she took the video of NA #1. Detective #2 stated during her interview with NA #2, she admitted she took the video of NA #1. Detective #2 stated during an interview with FM #1, she stated that FM #1 and NA #2 shared a phone and while FM #1 was at church services on 11/26/17, she saw the video of the abuse on the shared cell phone. FM #1 stated she sent the video to RP #1. The corrective action for non-compliance dated 11/26/17 was as follows: 1. A thorough investigation was initiated on 11/26/17 to ascertain the root cause was failure of NA #2 to follow the electronic communications device policy by utilizing a cell phone to video tape Resident #1 being abused by NA #1. On Sunday, 11/26/17 at 7:14 pm, it was reported to the Administrator that Resident #1 was hit in the face and had a pillow put over his face by one of the staff. The family reported to the local Sherriff ' s Department they had a video of a staff member at the facility mistreating Resident #1. The Administrator received a phone call from RP #1 of Resident #1 who placed Detective #1 on the phone. Detective #1 stated we have a video of Resident #1 being mistreated by one of your staff members at the facility. Detective #1 met the Administrator at the facility on 11/26/17. An interview was conducted with Detective #2 on 12/11/17 at 3:49 pm. Detective #2 stated Detective #1 did the initial interview with NA #1 and NA #2 on 11/26/17. Detective #2 stated on 11/26/17 when Detective #1 interviewed NA #2, she denied she took the video of NA #1. Detective #2 stated during her interview with NA #2, she admitted she took the video of NA #1. Detective #2 stated during an interview with FM #1, she stated that FM #1 and NA #2 shared a phone and while FM #1 was at church services on 11/26/17, she saw the video of the abuse on the shared cell phone. FM #1 stated she sent the video to RP #1. The DON provided statements from staff that were working on 11/25/17 and 11/26/17, skin assessment audits of all the residents, in services and education provided to all staff regarding abuse policy and procedures, HIPAA regulations, and the use of electronic devices in the facility. The DON reported the in-services and audits were put in place on 11/26/17. The DON reported the initial 24 hour report was sent indicating injury of unknown origin, however it was amended once the video was discovered of NA #1 abusing Resident #1 and was faxed to the Health Care Investigations. 2. The facility created a QI (Quality Improvement) team to direct and implement this plan of correction. The team was formed and met for the first time on 11/28/17. Team members included the Nursing Home Administrator, DON, Medical Director, QI Nurse, Patient Care Coordinator, Staff Facilitator and the MDS nurses. Additional members can be added at the discretion of the Facility Administrator as/if needed. This QI team collaborated to create the in-service, the schedule for in-servicing all staff, the Quality Assurance (QA) tool (15 minute checks QA Monitoring Tool) for monitoring and the review of Resident #1. To address this issue and to prevent future similar issues: The facility created a QI team including the Nursing Home Administrator, DON, QI Nurse, Patient Care Coordinator, Staff Facilitator and the MDS nurses on 11/26/17 to continuously review and monitor the interventions put into place specific to the plan of correction. The facility QI team members including the Nursing Home Administrator, DON, QI Nurse, Patient Care Coordinator, Staff Facilitator and the MDS nurses initiated 100% in-services with all staff in the facility on 11/26/17 at 9:00 pm regarding the electronic communications device policy to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, Administrator, DON, administrative assistant, admissions coordinator, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler and resident care coordinator to be completed by 11/28/17. No staff will be allowed to work until staff has been in-serviced in regards to use of electronic communications devices. 3. 25% of all staff to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator will complete a staff questionnaire to ensure that staff are adhering to the electronic communications device policy. Questionnaires will occur weekly X 8 weeks and monthly X 1 month. The Administrator will review and sign the staff questionnaires for completion and that any areas of concern were addressed appropriately. 25% of all staff will be audited by the Staff Facilitator, QI Nurse, MDS Nurses and the patient care coordinator utilizing a staff interaction tool to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, Administrator, DON, administrative assistant, admissions coordinator, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator weekly X 8 weeks and monthly X 1 month. The DON will review and initial all staff interaction tools to ensure completion and that any areas of concern are addressed appropriately. The Administrator will forward the results the use of electronic communications device questionnaires and the staff interaction tool to the Executive QI committee monthly X 3 months. The Executive QI committee will meet monthly X 3 months and review the results the use of electronic communications device questionnaires and the staff interaction tool questionnaires to determine trends and or issues that may need further interventions put into place and to determine the need for further and or frequency of monitoring. 4. The QI team met on 11/28/17 and have met daily since 11/28/17. They plan to meet again on 12/19/17. The purpose of these QI meetings being to gauge the plan of correction progress and to ensure ongoing compliance. The QI team will meet at least monthly for the next 12 months. The Administrator will be responsible for chairing this QI team in addition to assign new members, changes or updates to the plan of correction and the responsibility of ensuring monitoring of the electronic communications device policy interventions. As part of the validation process on 12/11/17 through 12/13/17, the plan of correction was reviewed and included the in-services and questionnaires in regards to the use of electronic communications device policy. The facility alleges full compliance with this plan of correction effective 11/28/17.
F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, family, staff and law enforcement interviews the facility failed to protect one of three sampled residents (Resident #1) from being physically abused by a staff member who applied baby oil to Resident #1 ' s feet with intent for Resident #1 to fall and placed a pillow on Resident #1 ' s face and attempted to force Resident #1 to remain in place by grabbing his arm while he called out for help. Findings included: Resident #1 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident was severely cognitively impaired. Resident #1 required limited assistance with the assistance of one staff member with bed mobility and transfers, extensive

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F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) assist with the assistance of one staff member with toileting, hygiene, and dressing, and supervision with set up only with ambulating in the room. He had no impairments and used a walker. Resident #1 was frequently incontinent of bowel and bladder. Resident #1 was coded as having one fall with no injury and one fall with injury during this look back period. Resident #1 was not coded as having any behaviors or resistance to care. A review of Resident #1 ' s care plan revealed a plan of care updated on 9/1/17 for a problematic manner in which resident had inappropriate behavior; including urinating in inappropriate places. Interventions included to document episodes of urinating in inappropriate places and monitor resident ' s room daily including trash can. A plan of care dated 9/1/17 was in place for at risk for falls characterized by history of falls/actual falls, injury, and multiple risk factors related to the disease process including Alzheimer ' s disease, hearing deficit, impaired cognition, impaired mobility, unsteady gait and wandering. Interventions included fall risk protocol, commonly used articles within easy reach, assistive ambulation device within reach, personal bed alarm, wearing proper and non-slip footwear. The fall care plan was updated on 11/26/17 to include anti-slip strips on the floor at bedside and padded bed rails. A record review of the daily shift assignment for Saturday, 11/25/17, for the 3-11 shift and 11-7 shift revealed NA (Nursing Assistant) #1 was assigned to Resident #1. NA #2 was assigned on 11/25/17 for the 3-11 shift only and worked on a different hall. An interview was conducted with the Responsible Party (RP #1) of Resident #1 on 12/10/17 at 2:51 pm via phone. RP #1 revealed she was out of town the weekend of 11/25/17. RP #1 stated she was informed by another family member of Resident #1 that a female person in the community who was a family member (FM #1) of NA #2 and NA #3 sent a video to RP #1 of Resident #1 being abused by NA #1 and was informed NA #2 videotaped the incident. RP #1 reported the video showed NA #1 was putting a pillow over Resident #1 ' s face, she had her hand around his throat, and her knee was in between the resident ' s legs and she was unbuckling his pants. RP #1 reported she saw this video on 11/26/17 and called 911. RP #1 stated she spoke with Detective #1 at the local County Sherriff ' s Department and shared the video she had on her phone with Detective #1. RP #1 indicated she notified the Administrator with Detective #1 via phone. RP #1 stated Detective #1 went to the facility and interviewed NA #1, NA #2 and NA #3. RP #1 reported that NA #2 and FM #1 who shared the video with Resident #1 ' s RP, shared a cell phone and that was how the FM #1 of NA #2 and NA #3 became aware of the incident. A review of the video was conducted. The video revealed NA #1 standing in front of Resident #1 ' s bed. Resident #1 was sitting upright in the bed with his feet on the floor. Resident #1 was fully dressed and shoes were on his feet. NA #1 had one knee up on the bed between Resident #1 ' s legs. NA #1 was observed pulling Resident #1 ' s right arm as he attempted to move away from NA #1. Resident #1 was observed yelling, Help, help, somebody call the police! NA #1 was observed placing a pillow over Resident #1 ' s face. A record review of incident reports were reviewed for Resident #1. The record revealed Resident #1 had an injury of unknown origin on 11/26/17. A review of the incident report for injury of unknown origin on 11/26/17 at 6:45 am revealed Nurse #1 was called to Resident #1 ' s room. Resident #1 was observed sitting in a recliner with a skin tear noted on the right elbow and an abrasion on the right side of his face. The resident was alert, however he was unable to determine the cause of injury. The resident was checked for other injuries. Resident #1 was noted to have good range of motion and had no complaints or signs or symptoms of pain. The skin tear was cleansed with normal saline and foam dressing was applied. The abrasion to Resident #1 ' s face was cleansed. The report indicated padded side rails were placed on the bed and the physician, RP and Administrator were notified. The report indicated predisposing physiological factors included, decreased functional status, decreased safety awareness, fragile skin, cognitive status, incontinence, Alzheimer ' s disease and noncompliance. An interview was conducted with Nurse #1 on 12/12/17 at 6:00 am. Nurse #1 revealed on 11/26/17 at 6:45 am, she was called to go to Resident #1 ' s room from the on-coming nurse (Nurse #2) because she was needed. Nurse #1 stated NA #1 told her he had a skin tear. Nurse #1 stated NA #1 did not say anything about Resident #1 having a fall. Upon arrival to Resident #1 ' s room, Nurse #1 stated she noted the resident had a skin tear to his right elbow and an abrasion to the right side of his face and he was sitting on the recliner with both feet on the floor. The nurse did not remember if he had socks or shoes on his feet. The nurse reported she asked the resident what happened, but he was unable to give a clear statement due to his cognitive status. Nurse #1 stated by the time she finished the treatment on Resident #1, NA #1 had already left the facility. Nurse #1 stated she did not notice if the floor was wet or slippery. Nurse #1 stated she notified the DON, RP #1, and physician of the injury. Nurse #1 stated the staff padded the bed rails on his bed as an intervention. An interview was conducted with Detective #2 on 12/11/17 at 3:49 pm. Detective #2 stated Detective #1 did the initial interview with NA #1 and NA #2 on 11/26/17. Detective #2 stated on 11/26/17 when Detective #1 interviewed NA #2, she denied she took the video of NA #1. Detective #2 stated during her interview with NA #2, she admitted she took the video of NA #1 and also stated NA #1 told her she put baby oil on Resident #1 ' s feet so he would not get up, and if he did, he would fall. Detective #2 stated during an interview with FM #1 she stated that FM #1 and NA #2 shared a phone and while she was at church services on 11/26/17, she saw the video of the abuse on the shared cell phone. FM #1 stated she sent the video to RP #1. FM #1 also reported to Detective #2 during this interview that NA #2 stated NA #1 said she puts baby oil on Resident #1 ' s feet and she messed up one night because he fell . FM #1 stated she spoke with NA #4 and NA #4 stated that NA #1 only put baby oil on the resident ' s feet once. Detective #2 stated she interviewed NA #1 on 11/27/17. Detective #2 stated NA #1 stated she never hit Resident #1 or put her hands on him. She stated Resident #1 got up a lot at night and would fall. NA #1 confirmed NA #1 put baby oil on his feet but stated he did not have a fall as a result of this. NA #1 stated she put baby oil on his feet the night of 11/26/17. NA #1 admitted to putting baby oil on the residents ' feet to cause him to fall, but she had nothing to say about the video recording of her hitting the resident and putting a pillow over his face. NA #1 stated she did not think putting baby oil on the resident ' s feet was considered abuse and confirmed that he did actually fall from the baby oil. NA #1 was charged with felony of patient abuse and neglect as well as misdemeanor assault on a handicapped person. An interview was conducted with Detective #1 on 12/13/17 at 1:11 pm. Detective #1 reported he responded to a 911 call by Resident #1 ' s FM on 11/26/17. Detective #1 reported he arrived to their home and was informed about concerns the FM had regarding falls and abuse at the facility. Detective #1 stated while he was at the FM ' s home a video was presented without sound of NA #1 pushing and shoving Resident #1 and putting a pillow over his face. Detective #1 stated he notified the facility and made the Administrator aware. Detective #1 stated when he arrived at the facility, he interviewed NA #1. Detective #1 stated NA #1 admitted she was aware of the video and said it look bad, like she was being aggressive. NA #1 stated her and the resident were just joking around. NA #1 said she was getting the resident ready for bed and he was not complying so she put the pillow on his head and pushed him back just joking around. Detective #1 stated NA #1 reported one time she put baby oil on her finger and ran it on the bottom of his foot so he would not be able to get out of bed because she did not like to have falls on her assigned floor. NA #1 stated she told NA #4 and NA #4 stated you can ' t do that and after that night she did not do it anymore. During the interview with Detective #1, he reported while interviewing NA #1, the family of Resident #1 arrived to the facility. Detective #1 stated he informed the family NA #1 had been terminated. At this time, Detective #1 was shown the video of NA #1 abusing Resident #1 but this time with sound by the FM. The detective reported that during these interview questions, NA #1 spoke of the incident on 11/25 and stated she was doing rounds and getting ready to change Resident #1. When she arrived to the room, the bed alarm was going off and Resident #1 was standing in the corner of the room, urinating. NA #1 stated she advised Resident #1 to get back in bed, he turned and walked toward her. NA #1 stated he was not steady and looked aggressive, she was concerned he would hurt her so she put her arms and hands out to stop him, he bumped her hands and turned back toward the chair. NA #1 stated he did not fall. NA #1 stated she left the room to go take care of another resident and when she returned he was on the floor. Detective #1 reported NA #1 then changed her story and said when she went to stop him, he turned around and fell and she got scared and she left to change someone else. When she came back he was back in bed and he was bleeding on his head. NA #1 stated she got the nurse and she treated it. A record review of an investigation report written by the Administrator on 11/26/17 was reviewed. The report stated On Sunday, 11/26/17, it was reported to the Administrator that Resident #1 was hit in the face and had a pillow put over his face by one of the staff. RP #1 reported to the local Sherriff ' s Department they had a video of a staff member at the facility mistreating Resident #1. The Administrator received a phone call from RP #1 of Resident #1 who placed Detective #1 on the phone. Detective #1 stated we have a video of Resident #1 being mistreated by one of your staff members at the facility. Detective #1 met the Administrator at the facility on 11/26/17. NA #1 was immediately removed from the hall and

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) questioned. The Administrator and the DON interviewed NA #1 and she reported that NA #1 and Resident #1, were laughing and joking like always and Resident #1 started yelling help, help, somebody call the police. NA #1 stated she then placed the pillow on his face, not to suffocate or harm him. The police escorted NA #1 out of the facility. The investigation report indicated based on the facility investigation, it was determined abuse did occur. NA #1 was terminated. The report stated the Sherriff ' s Department had an on-going investigation to determine if any criminal charges would be filed against NA #1. An interview was conducted with the Administrator on 12/11/17 at 4:40 pm. The Administrator reported what had happened on the evening of 11/26/17 as follows: The Administrator reported on the morning of 11/26/17 when she learned of an injury of unknown origin on Resident #1 she came to the facility with the DON to assess the resident. She reported there was a laceration on his face and a skin tear to his right arm. The Administrator stated the floor was not noted to be wet or slick or slippery. The Administrator stated the first time she heard of anything having to do with baby oil on Resident #1 ' s feet was when RP #1 reported it. The Administrator reported on 11/26/17 at 7:30 pm, she arrived at the facility to meet with Detective #1 and interview NA #1 in regards to the video. Once she arrived at the facility, Detective #1 allowed her to view the video. The Administrator stated she observed NA #1 placing a pillow over Resident #1 ' s face and then grabbing Resident #1 ' s arm and pulling the resident back in the bed. The Administrator reported on 11/26/17 at 7:30 pm, she interviewed NA #1 in regards to the video showing NA #1 placing a pillow over Resident #1 ' s face and grabbing his arm and pulling him back in bed. The Administrator stated NA #1 started to deny the abuse until she told NA #1 there was a video. NA #1 stated that she and Resident #1 were joking and laughing and Resident #1 stated he yelled help, help, call the police. NA #1 stated at this time she started giggling and placed a pillow on Resident #1 ' s face not to suffocate or harm Resident #1. NA #1 stated she was not aware at the time of the incident that NA #2 had videoed the incident until after the incident had taken place. The Administrator reported NA #1 was terminated on 11/26/17 due to abuse substantiated on 11/25/17 and the local county Sherriff ' s Department had an on-going investigation to determine if any criminal charges will be filed against NA #1 for allegation of abuse. A review of a written statement from NA #1 written on 11/26/17 revealed: NA #2 took the video without my knowledge of it. I did not know until after the fact. But we, me and Resident #1 were laughing and joking like always and he started yelling help, help, somebody call the police. I started giggling and took the pillow and placed it on his face, not to suffocate or harm him. On 12/13/17 at 11:15 am attempted to interview NA #1 via phone. NA #1 was unavailable for an interview. A review of a written statement from NA #3 revealed in part: As far as the video, I have not seen the video but my mother (FM #1) told me FM #1 recorded NA #1 abuse Resident #1. Also, NA #1 told NA #3 NA #1 hated coming in Resident #1 ' s room because he got up too much and urinates on the floor, which was why NA #1 put baby oil on his feet so he can fall when he gets up. On 12/13/17 at 11:17 am attempted to interview NA #3 via phone. NA #3 was unavailable for an interview. The medication aide/NA #4 who was working on the 11-7 shift from 11/25 – 11/26/17 morning was suspended pending an investigation for Resident #1 and was unable to be interviewed. An observation of Resident #1 on 12/11/17 at 11:15 am revealed the resident was in a private room. Resident #1 was alert but not oriented. He was lying in bed. He was fully clothed with a hat on his head and well groomed. He was not noted to have any bruising to face or arms. His lower body was covered with blankets. The bed was in low position, there were 3 anti-slip strips next to his bed on the floor with a call light on his lap. There were pads noted on bilateral side rails and a wheeled seating walker was noted to be in the room near the resident ' s bed. The room was clean and free of clutter. On 12/13/17 at 3:00 pm an interview was conducted with the Administrator. The Administrator stated she had initiated in services for all staff regarding abuse and put a plan of correction in place. The corrective action for non-compliance dated 11/26/17 was as follows: 1. A thorough investigation was initiated on 11/26/17 to ascertain the root cause was failure of NA #1 to follow the abuse/neglect policy. On Sunday, 11/26/17 at 7:14 pm, it was reported to the Administrator that Resident #1 was hit in the face and had a pillow put over his face by one of the staff. The family reported to the local Sherriff ' s Department they had a video of a staff member at the facility mistreating Resident #1. The Administrator received a phone call from a FM of Resident #1 who placed Detective #1 on the phone. Detective #1 stated we have a video of Resident #1 being mistreated by one of your staff members at the facility. Detective #1 met the Administrator at the facility on 11/26/17. NA #1 was immediately removed from the hall and questioned. The Administrator and the DON interviewed NA #1 and she reported that her and Resident #1 were laughing and joking like always and Resident #1 started yelling help, help, somebody call the police. NA #1 stated she then placed the pillow on his face, not to suffocate or harm him. The police escorted NA #1 out of the facility. The investigation report indicated based on the facility investigation, it was determined abuse did occur. NA #1 was terminated. The report stated the Sherriff ' s Department had an on-going investigation to determine if any criminal charges would be filed against NA #1. The DON provided statements from staff that were working on 11/25/17 and 11/26/17, skin assessment audits of all the residents, in services and education provided to all staff regarding abuse policy and procedures, HIPPA regulations, and the use of electronic devices in the facility. The DON reported the in services and audits were put in place on 11/26/17. The DON reported the initial 24 hour report was sent indicating injury of unknown origin, however it was amended once the video was discovered of NA #1 abusing Resident #1 and was faxed to the Health Care Investigations. 2. The facility created a QI (Quality Improvement) team to direct and implement this plan of correction. The team was formed and met for the first time on 11/28/17. Team members included the Nursing Home Administrator, DON, Medical Director, QI Nurse, Patient Care Coordinator, Staff Facilitator and the MDS nurses. Additional members can be added at the discretion of the Facility Administrator as/if needed. This QI team collaborated to create the in service, the schedule for in servicing all staff, the QA tool (15 minute checks QA Monitoring Tool) for monitoring and the review Resident #1. To address this issue and to prevent future similar issues: The facility initiated a 100% skin assessments of all residents to include Resident #1 which were completed on 11/26/17 by the Staff Facilitator, Patient Care Coordinator and facility staff nurses. No other abnormalities were noted at this time. The facility created a QI team including the Nursing Home Administrator, DON, QI Nurse, Patient Care Coordinator, Staff Facilitator and the MDS nurses on 11/26/17 to continuously review and monitor the interventions put into place specific to the plan of correction. The facility QI team including the Nursing Home Administrator, DON, QI Nurse, Patient Care Coordinator, Staff Facilitator and the MDS nurses initiated on 11/26/17 to create an improved system of implementation and follow up on all accident and incident reports and skin assessments. The facility QI team members including the Nursing Home Administrator, DON, QI Nurse, Patient Care Coordinator, Staff Facilitator and the MDS nurses initiated 100% in services with all staff in the facility on 11/26/17 at 9:00 pm regarding the abuse policy to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, Administrator, DON, administrative assistant, admissions coordinator, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler and resident care coordinator to be completed by 11/28/17. No staff will be allowed to work until staff has been in serviced in regards to abuse. The facility initiated abuse questionnaires with all staff in the facility on 11/26/17 at 9:00 pm by the DON to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler and resident care coordinator to be completed on 11/28/17 in regards to : 1. Have you ever observed any resident abuse? If so, did you report the abuse? 2. Has anyone ever talked to you or have you ever heard of anyone talking about a resident being abused? If so, did you report the abuse? 3. Do you know the process of how to and when to report abuse? Please explain. No staff will be allowed to work until abuse questionnaire is completed. Administrator reviewed and initiated all abuse

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) questionnaires. Any areas of concern were immediately addressed by the Administrator. No new areas of concerns identified. The facility initiated 100% of abuse quizzes with all staff in the facility at 9:00 pm on 11/26/17 by the DON and to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator to be completed by 11/28/17 in regards to: 1. Who should you report abuse to? 2. When should you report abuse? 3. Give 2 examples of abuse. 4. What is the first thing you do if you see or hear a resident being abused from a staff member, visitor or another resident? No staff would be allowed to work until abuse quizzes were completed. The DON will re-educate any employee who did not answer the quizzes at the time quiz was completed. No areas of concern identified during quizzes. The facility initiated interviews for 100% of alert and oriented residents on 11/26/17 by the Social Worker and completed on 11/27/17 in regards to: 1. Do you know what it means to be abused? 2. Are there any instances that you felt you were verbally or physically abused? 3. Do you know of any residents that have been verbally or physically abused? 4. Do you know who to report abuse to? No new allegations of abuse noted. The facility initiated 100% staff in services with all staff in the facility on 11/26/17 at 9:00 pm by the DON to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, accounts receivable, accounts payable, activities director, activities assistant, QI nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator in regards to burn out and to be completed on 11/28/17. No staff will be allowed to work until burn out in servicing completed. The facility initiated 100% staff in services with all staff in the facility on 11/26/17 at 9:00 pm by the DON to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator to be completed 11/28/17 in regards to: 1. Was care performed using correct procedure (Staff interacted in an appropriate manner? 2. If care performed incorrectly, Administrator/DON immediately notified? Interaction tool revised on 11/28/17: 1. Was care performed using correct procedure? (Staff interaction with resident in an appropriate manner (observed for any signs of abuse/neglect) 2. If care performed incorrectly, Administrator/DON immediately notified? All staff interactions completed after 11/28/17 will be completed on revised tool. Any areas of concern will be addressed during the interaction. No staff will be allowed to work until staff interactions completed. The facility initiated 100% review of incident reports to include Resident #1 for the last 30 days and was completed on 11/27/17 by the Facility Nurse Consultant for proper investigation and appropriate interventions of the incident. During the audit, it was determined that licensed nurses were not completing the incident report when an incident occurred and to include obtaining a witness statement and putting an intervention in place at time of the incident. 100% in service started with all licensed nurses by the DON/Staff Facilitator on 11/27/17 on the incident report process to include completing the incident report at the time of incident and obtain a witness statement and putting an intervention in place at the time of the incident to be completed by 11/28/17. The DON addressed all identified areas of concern. The facility initiated 100% of review of all residents to include Resident #1 ' s progress notes on 11/27/17 by the Facility Nurse Consultant to ensure that there was no other allegations of abuse noted in the progress notes without proper investigation to be completed on 11/28/17. The DON addressed all identified areas of concern. The facility initiated a Geriatric/Adult Mental health Specialty Group to come to the facility to in service staff to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator in regards to burn out and stress management. 3. 25% of all staff to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator will complete an abuse quiz weekly to ensure that staff are knowledgeable on the policy of abuse. Quizzes will occur weekly X 8 weeks and monthly X 1 month. The Administrator will review and sign the abuse quizzes for completion and that any areas of concern are addressed appropriately. 25% of all staff will be audited by the Staff Facilitator, QI Nurse, MDS Nurses and the patient care coordinator utilizing a staff interaction tool to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, Administrator, DON, administrative assistant, admissions coordinator, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator weekly X 8 weeks and monthly X 1 month. The DON will review and initial all staff interaction tools to ensure completion and that any areas of concern are addressed appropriately. The Social Worker will interview 100% of alert and oriented residents utilizing a resident abuse questionnaire for resident ' s understanding of abuse and if abuse has occurred to the resident weekly X 8 weeks and monthly X 1. The Administrator will forward the results of the staff abuse questionnaires, abuse quizzes, resident abuse questionnaires, staff interaction tool and QI tool Abuse/injury of unknown origin to the Executive QI committee monthly X 3 months. The Executive QI committee will meet monthly X 3 months and review the staff abuse questionnaires, abuse quizzes, resident abuse questionnaires and the QI tool/Injury of Unknown Origin to determine trends and or issues that may need further interventions put into place and to determine the need for further and or frequency of monitoring. 4. The QI team met on 11/28/17 and have met daily since 11/28/17. They plan to meet again on 12/19/17. The purpose of these QI meetings being to gauge the plan of correction progress and to ensure ongoing compliance. The QI team will meet at least monthly for the next 12 months. The Administrator will be responsible for chairing this QI team in addition to assign new members, changes or updates to the plan of correction and the responsibility of ensuring monitoring of the abuse interventions. As part of the validation process on 12/11/17 through 12/13/17, the plan of correction was reviewed and included the in services, questionnaires and quizzes in regards to abuse, staff burn out and staff interaction for all staff members, questionnaires regarding abuse for all alert and oriented residents and the skin assessments and incident report audits for all residents. The Abuse Prohibition Review was completed. The licensed staff, nursing assistants, supervisors who interact with residents and alert and oriented residents that were interviewed were aware of to whom and how to report allegations, incidents, and or complaints. Five direct care staff representing all three shifts were interviewed to determine whether each staff member was trained in and knowledgeable about, how to appropriately intervene in situations involving residents who have aggressive or catastrophic reactions and knowledgeable regarding what, when, and to who to report according to the facility policies. A review of an ongoing log revealed Resident #1 was being observed by nursing staff every 15 minutes since 11/26/17 as well as an observation for one hour revealing Resident #1 was being observed by nursing every 15 minutes. The facility alleges full compliance with this plan of correction effective 11/28/17.
F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family, staff and law enforcement interviews the facility failed to follow the policy and procedure

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) for reporting abuse that occurred on one of three sampled residents (Resident #1). Staff were aware of physical abuse by a staff member who applied baby oil to Resident #1 ' s feet with intent for Resident #1 to fall, placed a pillow on Resident #1 ' s face, and attempted to force Resident #1 to remain in place by grabbing his arm while he called out for help. As a result of not reporting, there was a delay in law enforcement involvement and a delay in protection of all residents. Findings included: The policy and procedure for Resident Abuse/Neglect revised on 11/21/16 stated, in part, It is every employee ' s responsibility to immediately report any incident of resident abuse or suspected resident abuse to his or her supervisor. The supervisor and/or employee must then report immediately to the Administrator. Resident #1 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident was severely cognitively impaired. A record review of the daily shift assignment for Saturday, 11/25/17, for the 3-11 shift and 11-7 shift revealed NA (Nursing Assistant) #1 was assigned to Resident #1. NA #2 was assigned on 11/25/17 for the 3-11 shift only and worked on a different hall. An interview was conducted with the Responsible Party (RP #1) of Resident #1 on 12/10/17 at 2:51 pm via phone. RP #1 revealed she was out of town the weekend of 11/25/17. RP #1 stated she was informed by another family member of Resident #1 that a female person in the community who was a family member (FM #1) of NA #2 and NA #3 sent a video to RP #1 of Resident #1 being abused by NA #1 and was informed NA #2 videotaped the incident. RP #1 reported the video showed NA #1 was putting a pillow over Resident #1 ' s face, she had her hand around his throat, and her knee was in between the resident ' s legs and she was unbuckling his pants. RP #1 reported she saw this video on 11/26/17 and called 911. RP #1 stated she spoke with Detective #1 at the local County Sherriff ' s Department and shared the video she had on her phone with Detective #1. RP #1 indicated she notified the Administrator with Detective #1 via phone. RP #1 stated Detective #1 went to the facility and interviewed NA #1, NA #2 and NA #3. RP #1 reported that NA #2 and FM #1 who shared the video with Resident #1 ' s RP, shared a cell phone and that was how FM #1 of NA #2 and NA #3 became aware of the incident. An interview was conducted with the Administrator on 12/11/17 at 4:40 pm. The Administrator reported what had happened. The Administrator reported on the morning of 11/26/17 when she learned of an injury of unknown origin on Resident #1 she came to the facility with the DON to assess the resident. She reported there was a laceration on his face and a skin tear to his right arm. The Administrator stated the floor was not noted to be wet or slick or slippery. The Administrator stated the first time she heard of anything having to do with baby oil on Resident #1 ' s feet was when RP #1 reported it. The Administrator reported on 11/26/17 at 7:00 pm, RP #1 called and made the facility Administrative Assistant (AA) aware she had received a video of Resident #1 being abused. The Administrator reported on 11/26/17 at 7:16 pm, she made the Director of Nursing (DON) aware of the call received from the AA in regards to RP #1 having a video of Resident #1 being abused. The Administrator reported on 11/26/17 at 7:20 pm, RP #1 called her so she could speak to Detective #1 at the local County Sherriff ' s Department via phone. Detective #1 made the Administrator aware of a video showing NA #1 abusing Resident #1. The Administrator reported on 11/26/17 at 7:25 pm, she called the DON at the facility and made the DON aware of a video that showed NA #1 was abusing Resident #1. The DON immediately removed NA #1 from the hall. The Administrator reported on 11/26/17 at 7:30 pm, she arrived at the facility to meet with Detective #1 and interview NA #1 in regards to the video. Once she arrived at the facility, Detective #1 allowed her to view the video. The Administrator stated she observed NA #1 placing a pillow over Resident #1 ' s face and then grabbing Resident #1 ' s arm and pulling the resident back in the bed. The Administrator reported on 11/26/17 at 7:30 pm, she interviewed NA #1 in regards to the video showing NA #1 placing a pillow over Resident #1 ' s face and grabbing his arm and pulling him back in bed. The Administrator stated NA #1 started to deny the abuse until she told NA #1 there was a video. NA #1 stated that she and Resident #1 were joking and laughing and Resident #1 stated he yelled help, help, call the police. NA #1 stated at this time she started giggling and placed a pillow on Resident #1 ' s face not to suffocate or harm Resident #1. NA #1 stated she was not aware at the time of the incident that NA #2 had videoed the incident until after the incident had taken place. NA #1 made the Administrator aware that NA #3 and NA #4 were aware of the video in regards to NA #1 placing a pillow on Resident #1 ' s face. A review of a written statement from NA #1 written on 11/26/17 revealed: NA #2 took the video without my knowledge of it. I did not know until after the fact. But we, me and Resident #1 were laughing and joking like always and he started yelling help, help, somebody call the police. I started giggling and took the pillow and placed it on his face, not to suffocate or harm him. NA #2 showed NA #3 and NA #4 the video. Those are the only two of my knowledge that knows. On 12/13/17 at 11:15 am attempted to interview NA #1 via phone. NA #1 was unavailable for an interview. The Administrator reported on 11/26/17 at 8:30 pm she interviewed NA #2 regarding the video of NA #1 placing a pillow on Resident #1 ' s face. NA #2 stated she did not take a video of NA #1 abusing Resident #1. A review of a written statement written on 11/26/17 revealed, in part, NA #2 never recorded NA #1 in the room with Resident #1. On 12/13/17 at 11:48 am attempted to interview NA #2 via phone. NA #2 was unavailable for an interview. The Administrator reported on 11/26/17 at 8:45 pm, she interviewed NA #3 regarding the video of NA #1 placing a pillow on Resident #1 ' s face. NA #3 stated he did not see the video but NA #2 and NA #3 ' s FM #1 told NA #3 about the video. NA #3 stated he did not report the abuse of Resident #1. A review of a written statement from NA #3 written on 11/26/17 revealed, in part, as far as the video, I have not seen the video but my mother (FM #1) told me FM #1 recorded NA #1 abusing Resident #1 and I needed to report it, but I never did. Also, NA #1 told NA #3 that NA #1 hated coming in Resident #1 ' s room because he got up too much and urinates on the floor, which was why NA #1 put baby oil on his feet so he can fall when he gets up. On 12/13/17 at 11:17 am attempted to interview NA #3 via phone. NA #3 was unavailable for an interview. The Administrator reported at about 11:00 pm on 11/26/17, a female person (FM #1) appeared at the facility and stated I took the video of NA #1 and Resident #1. The Administrator stated she asked who she was and FM #1 reported she was a FM of NA #2 and NA #3. The Administrator stated she asked why she did not report the incident to her or the DON. FM #1 replied I reported it to who I felt it needed to be reported to, the parents! FM #1 stated she did not show the video to NA #2 and NA #3, but told them they needed to report it to the facility. A review of the video was conducted. The video revealed NA #1 standing in front of Resident #1 ' s bed. Resident #1 was sitting upright in the bed with his feet on the floor. Resident #1 was fully dressed and shoes were on his feet. NA #1 had one knee up on the bed between Resident #1 ' s legs. NA #1 was observed pulling Resident #1 ' s right arm as he attempted to move away from NA #1. Resident #1 was observed yelling, Help, help, somebody call the police! NA #1 was observed placing a pillow over Resident #1 ' s face. An interview was conducted with Detective #2 on 12/11/17 at 3:49 pm. Detective #2 stated Detective #1 did the initial interview with NA #1 and NA #2 on 11/26/17. Detective #2 stated on 11/26/17 when Detective #1 interviewed NA #2, she denied she took the video of NA #1. Detective #2 stated during her interview with NA #2, she admitted she took the video of NA #1 and also stated NA #1 told her she put baby oil on Resident #1 ' s feet so he would not get up, and if he did, he would fall. Detective #2 stated during an interview with FM #1 she stated that FM #1 and NA #2 shared a phone and while she was at church services on 11/26/17, she saw the video of the abuse on the shared cell phone. FM #1 stated she sent the video to RP #1. FM #1 also reported to Detective #2 that NA #2 stated NA #1 said she puts baby oil on Resident #1 ' s feet and she messed up one night because he fell . FM #1 stated she spoke with NA #4 and NA #4 stated that NA #1 only put baby oil on the resident ' s feet once. An interview was conducted with Detective #1 on 12/13/17 at 1:11 pm. Detective #1 reported he responded to a 911 call by RP #1 of Resident #1 on 11/26/17. Detective #1 reported he arrived to RP #1 ' s home and was informed about concerns the RP #1 had regarding falls and abuse at the facility. Detective #1 stated while he was at the RP ' s home a video was presented without sound of NA #1 pushing and shoving Resident #1 and putting a pillow over his face. Detective #1 stated he notified the facility and made the Administrator aware. Detective #1 stated when he arrived at the facility, he interviewed NA #1. Detective #1 stated NA #1 admitted she was aware of the video and said it look bad, like she was being aggressive. NA #1 stated her and the resident were just joking around. NA #1 said she was getting the resident ready for bed and he was not complying so she put the pillow on his head and pushed him back just joking around. Detective #1 stated NA #1 reported one time she put baby oil on her finger and ran it on the bottom of his foot so he would not be able to get out of bed because

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) she did not like to have falls on her assigned floor. NA #1 stated she told NA #4 and NA #4 stated you can ' t do that and after that night she did not do it anymore. The medication aide/NA #4 who was working on the 11-7 shift from 11/25 – 11/26/17 morning was suspended pending an investigation for Resident #1 and was unable to be interviewed. On 12/13/17 at 3:00 pm an interview was conducted with the Administrator. The Administrator stated she had initiated in services for all staff regarding the use of electronic communication devices and put a plan of correction in place. The corrective action for non-compliance dated 11/26/17 was as follows: 1. A thorough investigation was initiated on 11/26/17 to ascertain the root cause was failure of NA #2 to follow the electronic communications device policy by utilizing a cell phone to video tape Resident #1 being abused by NA #1. On Sunday, 11/26/17 at 7:14 pm, it was reported to the Administrator that Resident #1 was hit in the face and had a pillow put over his face by one of the staff. The family reported to the local Sherriff ' s Department they had a video of a staff member at the facility mistreating Resident #1. The Administrator received a phone call from RP #1 of Resident #1 who placed Detective #1 on the phone. Detective #1 stated we have a video of Resident #1 being mistreated by one of your staff members at the facility. Detective #1 met the Administrator at the facility on 11/26/17. NA #1 was immediately removed from the hall and questioned. The Administrator and the DON interviewed NA #1 and she reported that her and Resident #1 were laughing and joking like always and Resident #1 started yelling help, help, somebody call the police. NA #1 stated she then placed the pillow on his face, not to suffocate or harm him. The police escorted NA #1 out of the facility. The investigation report indicated based on the facility investigation, it was determined abuse did occur. NA #1 was terminated. The report stated the Sherriff ' s Department had an on-going investigation to determine if any criminal charges would be filed against NA #1. The DON provided statements from staff that were working on 11/25/17 and 11/26/17, skin assessment audits of all the residents, in services and education provided to all staff regarding abuse policy and procedures, HIPPA regulations, and the use of electronic devices in the facility. The DON reported the in services and audits were put in place on 11/26/17. The DON reported the initial 24 hour report was sent indicating injury of unknown origin, however it was amended once the video was discovered of NA #1 abusing Resident #1 and was faxed to the Health Care Investigations. 2. The facility created a QI (Quality Improvement) team to direct and implement this plan of correction. The team was formed and met for the first time on 11/28/17. Team members included the Nursing Home Administrator, DON, Medical Director, QI Nurse, Patient Care Coordinator, Staff Facilitator and the MDS nurses. Additional members can be added at the discretion of the Facility Administrator as/if needed. This QI team collaborated to create the in service, the schedule for in servicing all staff, the QA tool (15 minute checks QA Monitoring Tool) for monitoring and the review Resident #1. To address this issue and to prevent future similar issues: The facility created a QI team including the Nursing Home Administrator, DON, QI Nurse, Patient Care Coordinator, Staff Facilitator and the MDS nurses on 11/26/17 to continuously review and monitor the interventions put into place specific to the plan of correction. The facility QI team members including the Nursing Home Administrator, DON, QI Nurse, Patient Care Coordinator, Staff Facilitator and the MDS nurses initiated 100% in services with all staff in the facility on 11/26/17 at 9:00 pm regarding the abuse policy to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, Administrator, DON, administrative assistant, admissions coordinator, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler and resident care coordinator to be completed by 11/28/17. No staff will be allowed to work until staff has been in serviced in regards to abuse. The facility initiated abuse questionnaires with all staff in the facility on 11/26/17 at 9:00 pm by the DON to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler and resident care coordinator to be completed on 11/28/17 in regards to : 1. Have you ever observed any resident abuse? If so, did you report the abuse? 2. Has anyone ever talked to you or have you ever heard of anyone talking about a resident being abused? If so, did you report the abuse? 3. Do you know the process of how to and when to report abuse? Please explain. No staff will be allowed to work until abuse questionnaire is completed. Administrator reviewed and initiated all abuse questionnaires. Any areas of concern were immediately addressed by the Administrator. No new areas of concerns identified. The facility initiated 100% of abuse quizzes with all staff in the facility at 9:00 pm on 11/26/17 by the DON and to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator to be completed by 11/28/17 in regards to: 1. Who should you report abuse to? 2. When should you report abuse? 3. Give 2 examples of abuse. 4. What is the first thing you do if you see or hear a resident being abused from a staff member, visitor or another resident? No staff would be allowed to work until abuse quizzes were completed. The DON will re-educate any employee who did not answer the quizzes at the time quiz was completed. No areas of concern identified during quizzes. The facility initiated interviews for 100% of alert and oriented residents on 11/26/17 by the Social Worker and completed on 11/27/17 in regards to: 1. Do you know what it means to be abused? 2. Are there any instances that you felt you were verbally or physically abused? 3. Do you know of any residents that have been verbally or physically abused? 4. Do you know who to report abuse to? No new allegations of abuse noted. The facility initiated 100% staff in services with all staff in the facility on 11/26/17 at 9:00 pm by the DON to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, accounts receivable, accounts payable, activities director, activities assistant, QI nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator in regards to burn out and to be completed on 11/28/17. No staff will be allowed to work until burn out in servicing completed. The facility initiated 100% staff in services with all staff in the facility on 11/26/17 at 9:00 pm by the DON to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator to be completed 11/28/17 in regards to: 1. Was care performed using correct procedure (Staff interacted in an appropriate manner? 2. If care performed incorrectly, Administrator/DON immediately notified? Interaction tool revised on 11/28/17: 1. Was care performed using correct procedure? (Staff interaction with resident in an appropriate manner (observed for any signs of abuse/neglect) 2. If care performed incorrectly, Administrator/DON immediately notified? All staff interactions completed after 11/28/17 will be completed on revised tool. Any areas of concern will be addressed during the interaction. No staff will be allowed to work until staff interactions completed. The facility initiated 100% of review of all residents to include Resident #1 ' s progress notes on 11/27/17 by the Facility Nurse Consultant to ensure that there was no other allegations of abuse noted in the progress notes without proper investigation to be completed on 11/28/17. The DON addressed all identified areas of concern. 3. 25% of all staff to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	**12/13/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREENDALE FOREST NURSING AND REHABILITATION CENTER	**1304 SE SECOND STREET SNOW HILL, NC 28580**

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 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator will complete a staff abuse questionnaire to ensure that staff are reporting abuse. Questionnaires will occur weekly X 8 weeks and monthly X 1 month. The Administrator will review and sign the staff abuse questionnaires for completion and that any areas of concern were addressed appropriately. Nurse ' s Progress Notes and Risk Management Reports will be reviewed for all residents to include Resident #1 5X week X 4 weeks, weekly X 4 weeks, then monthly X 1 month to ensure that the incident report was completed to include witness statement and interventions in place and to ensure that abuse or injury of unknown origin was investigated utilizing a QI Tool abuse/injury of unknown origin by the staff facilitator, QI Nurse and patient care coordinator. Notification to the Administrator for any abuse/injury of unknown origin will be completed by the staff facility, QI nurse and patient care coordinator during the audit for any identified areas of concern. The DON will review and initial the QI tool abuse/injury of unknown origin 5 x a week X 4 weeks weekly for 4 weeks then monthly X 1 month for completion and to ensure all areas of concern are addressed. 25% of all staff to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator will complete an abuse quiz weekly to ensure that staff are knowledgeable on the policy of abuse. Quizzes will occur weekly X 8 weeks and monthly X 1 month. The Administrator will review and sign the abuse quizzes for completion and that any areas of concern are addressed appropriately. 25% of all staff will be audited by the Staff Facilitator, QI Nurse, MDS Nurses and the patient care coordinator utilizing a staff interaction tool to include licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, Administrator, DON, administrative assistant, admissions coordinator, accounts receivable, accounts payable, activities director, activities assistant, QI Nurse, medical records, MDS Nurses, staff facilitator, central supply clerk, maintenance director, maintenance assistant, Social Worker, scheduler, and resident care coordinator weekly X 8 weeks and monthly X 1 month. The DON will review and initial all staff interaction tools to ensure completion and that any areas of concern are addressed appropriately. The Social Worker will interview 100% of alert and oriented residents utilizing a resident abuse questionnaire for resident ' s understanding of abuse and if abuse has occurred to the resident weekly X 8 weeks and monthly X 1. The Administrator will forward the results of the staff abuse questionnaires, abuse quizzes, resident abuse questionnaires, staff interaction tool and QI tool Abuse/injury of unknown origin to the Executive QI committee monthly X 3 months. The Executive QI committee will meet monthly X 3 months and review the staff abuse questionnaires, abuse quizzes, resident abuse questionnaires and the QI tool/Injury of Unknown Origin to determine trends and or issues that may need further interventions put into place and to determine the need for further and or frequency of monitoring. 4. The QI team met on 11/28/17 and have met daily since 11/28/17. They plan to meet again on 12/19/17. The purpose of these QI meetings being to gauge the plan of correction progress and to ensure ongoing compliance. The QI team will meet at least monthly for the next 12 months. The Administrator will be responsible for chairing this QI team in addition to assign new members, changes or updates to the plan of correction and the responsibility of ensuring monitoring of the abuse interventions. As part of the validation process on 12/11/17 through 12/13/17, the plan of correction was reviewed and included the in services, questionnaires and quizzes in regards to abuse, staff burn out and staff interaction for all staff members, questionnaires regarding abuse for all alert and oriented residents and the skin assessments and incident report audits for all residents. The Abuse Prohibition Review was completed. The licensed staff, nursing assistants, supervisors who interact with residents and alert and oriented residents that were interviewed were aware of to whom and how to report allegations, incidents, and or complaints. Five direct care staff representing all three shifts were interviewed to determine whether each staff member was trained in and knowledgeable about, how to appropriately intervene in situations involving residents who have aggressive or catastrophic reactions and knowledgeable regarding what, when, and to who to report according to the facility policies. A review of an ongoing log revealed Resident #1 was being observed by nursing staff every 15 minutes since 11/26/17 as well as an observation for one hour revealing Resident #1 was being observed by nursing every 15 minutes. The facility alleges full compliance with this plan of correction effective 11/28/17.