STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676101	A. BUILDING _____ B. WING _____	09/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED TRANSITIONAL CARE AND REHABILITATION-RIDGM	6600 LANDS END COURT FORT WORTH, TX 76116

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to implement policies and procedures that prohibit neglect of residents for one (Resident #1) of eight residents reviewed for neglect. CNA A had worked with Resident #1 only one time prior to 08/23/14. CNA A had not read the plan of care for Resident #1 and thus was unaware Resident #1 could become resistant to care. On 08/23/14, CNA A assisted Resident #1 with incontinence care and putting on her pants. When she assisted the resident to sit up, the resident began cursing and swinging her arms. CNA A thought the resident was going to fall back and grabbed the resident by the arms resulting in bilateral avulsions (tearing away forcibly of a part or structure) from just below her elbows to just above her wrists. The resident was transferred to a local hospital's ER for evaluation and treatment. On 09/24/14 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/26/14, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope isolated because the facility was still evaluating the effectiveness of the Plan of Removal. This failure could affect the other 17 residents identified with a history of behaviors at risk of serious injuries due to failure of a nurse aide to know their assessed and care planned level of care and services. Findings included: Resident #1's Admission Record, dated 09/11/14, reflected she originally admitted to the facility on [DATE] and her most recent re-admission was 01/31/14. She was 94-years-old and her [DIAGNOSES REDACTED]. Resident #1's quarterly MDS assessment, dated 08/12/14, reflected she was oriented to year, month and day; exhibited no signs and symptoms of [MEDICAL CONDITION]; exhibited no behaviors; and required one person's extensive physical assistance with dressing and personal hygiene. Resident #1 was 65 inches tall and weighed 124 pounds and required staff assistance to stabilize her when she went from surface-to-surface, such as transfer from bed to chair. She was incontinent of bowel and bladder and had skin tears at that time. Resident #1's Care Plan, initiated 09/16/13 and revised 09/24/13, reflected she was resistive to care r/t (related to) adjustment to nursing home, behaviors: refusing showers and care. The interventions included if she resisted ADLs to reassure her and leave, then return 5 to 10 minutes later and try again. Resident #1's Progress Notes, reflected the following: -- Notes dated 08/23/14 at 10:52 PM and written by LVN B, reflected the resident was sent to the ER at 7:15 that morning. The Note reflected, CNA came and reported that the resident got combative when she was trying to get her up. Resident was swinging her arms and the CNA was trying to prevent her from hitting. Resident got skin tears to both forearms, approximately 7 inches long by 3 inches wide. Nurse tried to apply first aid, skin tears were too severe. Notified doctor to send out, notified family, administrator was notified. Resident was sent to (local) hospital. Will continue to monitor. -- Notes dated 08/23/14 at 10:55 PM and written by LVN B, noted (Resident #1) returned from the ER around 3 p.m. she was with her daughter. Resident has dry dressing and steri strips applied to her arms . Review of Resident #1's local hospital closed record, dated 08/23/14, reflected the following: -- The ED Physician Note, dated 08/23/14 at 8:06 AM noted: . (resident) presents to the ED c/o (complain of) avulsions, with daughter at bedside. Pt (Patient) reports via daughter that she was unruly this morning at her NH (nursing home) and when an aide restrained her manually, her skin ripped. Daughter reports her mother is frequently combative, and is suffering from a UTI. Pt has no other complaints at this time. -- That same date at 10:29 AM, it noted Resident #1 was ready to discharge and her [DIAGNOSES REDACTED]. Observation of Resident #1 at the facility in her room and in bed, on 09/11/14 at approximately 4:10 PM, revealed both arms were bandaged from her elbows to her wrists with purple bruising extending from the bottom of the bandage to the top/middle part of her hands. An interview with Resident #1 at that time revealed she could recall the incident. Resident #1 stated that black girl scratched me. Interview on 09/14/14 at 11:00 AM with LVN B revealed she had worked at the facility for almost one year. She stated she always worked weekend doubles and was on duty on 08/23/14. LVN B revealed on 08/23/14 CNA A came to her regarding a skin tear Resident #1 sustained. LVN B went to Resident #1's room and found Resident #1 lying sideways on her bed kind of crooked on the bed and at the foot of the bed with her arms drawn to her body. Resident #1 was dressed from the waist down with her pants and shoes on. The resident's wheelchair was positioned parallel to the bed. LVN B revealed CNA A told her she was getting ready to put Resident #1's shirt on and the resident started fighting. LVN B said when she approached the resident, she had blood all over the front her body but there was none on the bed. LVN B asked Resident #1 what happened. She stated Resident #1 told her she did not want to get up and CNA A pulled her by her arms and hurt her. She stated the injuries were from the elbow down to the wrists. LVN B revealed the resident's skin was pulled down to her wrists. She stated she was 'horrified at the injuries. LVN B revealed those were the worst injuries she had ever seen. LVN B continued by saying she had LVN C to come and assist her with pulling Resident #1's skin back up over the muscle on both arms. LVN B said Resident #1 had thin skin, and she saw the resident did not have any blood or skin under her nails and nothing on her hands which indicated to LVN B the resident did not make contact with CNA A. LVN B said she had RN D call 911 and contact the family and the doctor. LVN B revealed it was her opinion if things happened the way the aide told her, the resident's injuries would have been at the wrists and not the whole forearm. LVN B revealed the physician at the hospital called her to ask her what happened. The physician told LVN B Resident #1's injuries measured 10+ inches length on both arms. LVN B revealed she had provided care for Resident #1 over the past year and .if you rush her she gets combative or if she is tired. So you step away and come back later. LVN B said she never had a problem with Resident #1 being combative with her and she knew staff had to give the resident time and go back later if necessary. LVN B thought the CNA A was pretty nonchalant about the incident and did not display any emotion, which she thought was unusual because the injuries were so severe. LVN B had completed a written statement for the facility, dated 08/23/14. The statement reflected, (CNA A) came to me and stated that she was trying to get (Resident #1) up and she was getting aggressive. I went into the resident room and she was laying (sic) on her bed, both forearms had severe lacerations. I asked the CNA (CNA A) to please go get another nurse to assist me. Nurse (LVN C) came in to help apply pressure. Start first aide applied and there was a large amount of skin. Another nurse (LVN HH) went to notify the doctor & call the ambulance. (LVN HH) also notified (Resident #1's family member). I notified the (Administrator and DON). Had CNA write a statement and asked her to go home until she was notified. Resident stated she didn't want to get (up) and the CNA was pulling on her. An interview with the Paramedic, on 09/11/14 at 1:45 PM, revealed he responded to the 911 call from the facility. The Paramedic stated on 08/23/14 at 7:15 AM, his team had been picked to transport Resident #1 to the hospital for emergency medical services. The Paramedic stated a nurse met him at the door and she was crying because the resident's injuries were so bad. The Paramedic stated Resident #1 had large skin tears/shears to at least 50 to 60 % of both of her arms. He stated he had never seen injuries like that. An interview with LVN C on 09/14/14 at 11:25 AM confirmed LVN B came and got her to look at Resident #1's arms. She assisted LVN B with first aid. She stated the injuries were bad. The resident's skin was pulled down from her elbows to her wrists. LVN C revealed she had never seen injuries that bad and she

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

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) had been a nurse for [AGE] years. She stated CNA A was nonchalant about Resident #1's injuries. LVN C revealed she had worked with CNA A for six months and she thought she was a good aide. She stated CNA A was different that day. LVN C revealed she read CNA A's statement and she did not think it was consistent with what happened. Review of LVN C's written statement obtained by the facility and dated 08/23/14, reflected, I was called to (Resident #1's) room by (LVN B) to look at res (resident's) arms. Large amt (amount) of skin was hanging from res fore arms. First aid rendered & 911 called. Review on 09/12/14 of CNA A's written statement obtained by the facility and dated 08/22/14 (sic), reflected I (CNA A) went to get (Resident #1) up about 6:30 AM in room (room number) and I went to set (sic) her up on the edge of the bed she started swinging end (sic) fighting and her arm hit the wheel chair that's when I notice her arms was (sic) bleeding so I laid her back in the bed and went and got the nurse (LVN B). An interview with CNA A 09/12/14 at 12:00 PM, confirmed she was the nurse aide who had assisted Resident #1 at the time of the incident. At the time of the interview, CNA A was noted to have a dark complexion and stand approximately 5 feet tall. She stated she had worked for the facility for almost one year. She stated she worked as a floater and thus worked different halls. She stated she currently worked four days on and two days off working the 6:00 AM to 2:00 PM shift. She stated she had received training in managing behaviors in the past and in-services on Abuse and Neglect. CNA A revealed prior to the incident with Resident #1, she had not really worked that hall. When asked how she could learn about the residents' characteristics, CNA A replied there were mini care plans in the residents' rooms. CNA A said she could also reference the ADL (Activities of Daily Living) book at the Nurse's Station for information about the resident. CNA A revealed the first day she worked with Resident #1, the resident was fine. She stated the day of the incident was the second time she had provided care to Resident #1. She stated she had cleaned Resident #1 in her bed, put her slacks and shoes on and swung the resident's legs around to the floor. When she got the resident to the edge of the bed, Resident #1 started swinging and cussing at her. CNA A stated she put her hands up to protect her own face and protect herself from the resident. CNA A revealed she thought the resident was falling backwards and that was when she grabbed the resident's arms to keep her from falling backwards. CNA A stated she was putting Resident #1 back in bed and that was when she saw the blood on Resident #1's arms. She did not indicate Resident #1 hit her arms on a wheelchair. She notified LVN B of what had occurred. CNA A stated if she could have done anything differently, she should have stepped away and let Resident #1 calm down and go back later. When asked why she did not take that action, CNA A replied she was not sure why. On 09/12/14, CNA A completed a second statement at the request of the Investigator. She noted, On the morning of Aug (August) 23 (2014) I went in to get (Resident #1) out of bed for breakfast. I got her dress (sic) in bed, she was fine, but once she sat up on the side of the bed she started to swing & pull back so for to keep her from hitting her head on the railing I grab (sic) her hands and she kept swinging so I put her legs back on the bed to lye (sic) her back down that's when I noticed her arms were bleeding so I went and got the nurse (LVN B) and they sent her out to the hospital and sent me home. Review of CNA A's personnel record reflected she was hired on 09/15/13. The record contained no evidence of prior counseling(s) for failing to implement a resident's assessed and care planned level of care or for causing physical injuries to a resident. Review of training records, reflected CNA A had received training on Abuse and Neglect four times, Resident Rights two times and Dementia care once during the year of 09/15/13 through 09/15/14. Review of CNA A's time punch records revealed on 08/24/14, 08/25/14, 08/26/14 she did not work. On 08/29/14, she returned to work and worked through 09/11/14. CNA A did not work any additional days. Interview on 09/11/14 at approximately 3:15 PM with the Administrator revealed she had conducted the investigation of the incident involving Resident #1 and suspended CNA A pending the outcome of the investigation. The Administrator stated CNA A was brought back to work because the CNA didn't do anything wrong. The resident was combative and flailing her arms sitting on the side of her bed. The CNA grabbed the resident's arms to protect the resident and her skin tore. The resident had very thin skin and the aide was small in stature. The family requested CNA A not provide care to Resident #1, and the CNA was subsequently moved to another hall. An interview on 09/11/14 at approximately 4:00 PM with the Staff Development Coordinator revealed she read the Provider Investigation Report, dated 08/23/14, about Resident #1's avulsions and CNA A's witness statement. The Coordinator stated her concern was CNA A's witness statement indicated she was defending herself from the resident with crossed arms and open hands and that did not add up. An interview with the Administrator on 09/12/14 at approximately 3:45 PM revealed CNA A was suspended due to the surveyor's findings. The Administrator stated a decision on CNA A's employment would be determined based on the surveyor's findings. Further interview with the Administrator on 09/15/14 at approximately 1:10 PM revealed CNA A was terminated for failure to follow policies by not coming in to the facility to speak with the surveyor and Administrator. Interview on 09/12/14 at 2:00 PM with CNA D revealed he had been employed with the facility for a period of 10 months. He stated he had provided care for Resident #1 during seven of those months. CNA D revealed he never had a problem with her being aggressive or combative with him. He stated it was all in the approach with her. CNA D said it was all about what Resident #1 wanted. He revealed Resident #1 told him she and CNA A started to argue. He stated Resident #1 was able to recall what happened that day. Interview on 09/12/14 at 2:30 PM with LVN I revealed she had provided care to Resident #1 and some days she was combative. She stated it was all in the approach with the resident. LVN I revealed if the resident did not know someone, she might be combative. She stated someone could not just go in her room and start flipping the lights on and being abrupt. Review on 09/11/14 of the facility's current Abuse policy, with a release date 04/14/14, revealed, .physical and mental abuse.of the patient as well as mistreatment.are strictly prohibited.Patients have the right to be free of.physical, and mental abuse.of the patient as well mistreatment.1. Prohibitions on abuse apply to: a. Center staff.9. Identify patients most at risk of neglect and abuse, may include but is not limited to: a. Patients who have dementia. The facility's current Resident Refusal of Care policy, revised 04/28/10, reflected occasional refusals or failure to follow physician's orders [REDACTED]. Some residents consistently refused to accept or failed to follow the ordered treatment, therapeutic diet or services. Every attempt was made to accommodate the resident's request and still provide the appropriate care and services to meet the residents' needs while following the physician's orders [REDACTED]. On 09/24/14 at 6:10 PM., the Administrator, DON, LVN H, and LVN L were notified of the IJ had been identified for failure to ensure nurse aides provided residents their care planned level of care and services to prevent residents from sustaining serious injuries. Interview on 09/25/14 at 9:40 AM with the DON revealed since the incident with Resident #1, all Unit Managers now had a tool they could use that addressed staff interactions with the residents, identified as having behaviors. She said they initiated the in-services on 09/24/14. The training provided to staff included: How to recognize burnout, Kardex/CNA for CNA use regarding a resident's care requirements including behavior interventions, resident rights and abuse and neglect. Skin assessments were initiated on 09/12/14 and residents with fragile skin were identified to be at high risk for skin tears and the information was added to their care plans. Training for management/staff was provided in the area of residents with fragile skin and skin tear prevention. Audit rounds would be conducted by Nurse Managers and they would utilize a tool developed to monitor CNAs' knowledge of residents resistive to care, where they locate information pertaining to the residents and refusal of care. The tool was to be utilized by managers daily. All staff would be trained and those who had not had the training would not be allowed to return to work until they had received the required in-services. On 09/25/14, the Administrator was notified their Plan of Removal was accepted. The Plan of Removal, dated 09/25/14, reflected the following: -- Upon return from the hospital the resident (Resident #1) was evaluated and seen by the facility's certified Wound Care Nurse.The resident's Wound Care Physician , evaluated the resident's skin condition upon on 8/29/14. Additional skin treatment orders were ordered by wound care physician 8/29/14.The resident's care plan was reviewed and updated on 8/23/14 to reflect current health status by the facility's Minimum Data Set (MDS) nurse,(sic). The patient's medical history provides documentation of behavioral changes related to infection [MEDICAL CONDITION]. The resident's care plan reflects this information.(CNA A) was suspended pending outcome of facility investigation 8/23/14 and ultimately terminated from facility employment. -- On 08/23/14, CAN A was suspended pending the outcome of the facility's investigation. -- On 8/29/14, CNA A was re-in serviced on abuse related to this incident, and how to effectively deal with combative residents; this training was provided by the Staff Development Coordinator (sic). -- A Safe Survey was conducted after (CNA A) return on several residents throughout the facility whom (CNA A) had provided care with no negative outcome. (CNA A) returned to duty on 08/29/14 after the facility had completed its initial investigation of the incident. -- On 09/11/14, as a result of a complaint survey initiated by DADS, further details emerged questioning (CNA A) original statement. The facility reopened its investigation on 09/11/14. She (CNA A) was suspended as a result the reopening of the investigation. As a result of the facilities (sic)reopened investigation she was terminated on 09/15/14 primarily for her inability to provide a consistent statement regarding the incident with (Resident #1) on 08/23/14. (CNA A) failed to meet the facility standards of providing the highest standard of care to its residents. The facility is vigilant in protecting our residents from perceived mistreatment.Residents with behaviors were identified by resident assessment report in Point Click Care, electronic

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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) charting program, on 9/23/14. - The behavioral care plans and Certified Nursing Assistant (CNA) Kardex, (Kardex are a resource for CNAs, like a mini care plan to give personalized care to individual residents). Fragile skin is skin that has very thin tissue do to the loss of subcutaneous tissue. -- All of the residents identified were reviewed, and updated to reflect resident's current behavioral status by Director of Nursing, Unit Managers, (LVN H) and Assistant Director of Nursing ,(LVN J). -- The following residents have been identified with the potential for behaviors: (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, and #18).Identified residents exhibit the following types of behaviors; resistance to care, verbal outburst, inappropriate language, disrobing. -- Additionally, to assist in identifying the residents at risk, the facility consultant pharmacist reviewed residents receiving [MEDICAL CONDITION] medication to assure that appropriate recommendations are reviewed by resident's physician and subsequent orders are implemented by the licensed nurse; this review is done monthly and was last completed on 9/15/14. This review assures that the resident receives the appropriate medication to assist with behavior management and prevent adverse side effects. The consultant pharmacist will provide a monthly report of his/her review to the Director of Nursing. The Director of Nursing, will present a summary of the report to the Facility's Performance Improvement Committee on a monthly basis; this will be an on-going measure/intervention. -- Ad lib referrals to psychology and psychiatric services are determined by resident review in the Interdisciplinary Clinical Rounds (nursing, dietician, Social Worker, MDS, and Activities, process that occurs at least 5 days weekly. The Clinical Rounds Process is retrospective review of clinical needs of residents identified by the center's 24- hour reporting system. This process was implemented in February 2014 and is an ongoing facility practice with no end date. -- Residents identified will be discussed to assure that proper measures/interventions are implemented to resolve clinical concerns, assure that the MD and families are notified of concerns along with any appropriate follow up measures, care plans reviewed and updated and or created as new condition warrants, and that interventions are monitored until the clinical concern is resolved. -- All Kardex have been updated and are located at the nursing station for added security and confidentiality.Kardex will also notate residents identified with behaviors for additional interventions and suggestions to assure care is optimally provided. -- CNAs have been educated and are required to check it frequently for changes, as well as adding appropriate/helpful information. CNAs were in-serviced on Assessing Risk of Challenging Behaviors, Resident Rights, and Resident's Rights to Refuse Care, Definition(s) of Abuse, Behavioral Management, and Skin Tears: Prevention and Management, the dates of the in-services were on 09/12/14 -09/15/14. As part of the training, CNAs were in-serviced on the expectation of reviewing the Kardex prior to the start of each shift to assure that the CNA has the most updated information regarding the president's plan of care. Competency was evaluated and determined by questionnaire given by the Director of Nursing.This quiz tested the employee's knowledge of the following: How to deal with combative residents, Resident Right to refuse Care, notification to nursing supervisor and understanding that resident care is primary function. If employee missed more than one (1) question, additional training was provided. -- Additionally nursing staff have been in-serviced on 'burnout' and sign and symptoms of, as well as prevention and what to do if detected. quiz tested the employee's knowledge of the following: How to deal with combative residents, Resident Right to refuse Care, notification to nursing supervisor and understanding that resident care is their primary priority.Education/in-servicing was initiated and provided by the Staff Development Coordinator, 9/12-9/15/14. This education included: Assessing Risk of Challenging Behaviors, Resident Rights, Resident's Rights to Refuse Care, Definition(s) of Abuse, Behavioral Management, Skin Tears: Prevention and Management. These in-services were for Licensed Nurses and CNAs. Staff education was initiated and conducted by the Staff Development Coordinator on 8/25/14 for licensed nurses and CNAs on abuse training and how to effectively care for the combative resident. Subsequent staff education concluded on 9/13/14. -- As of 9/13/14, current licensed nurses and CNAs received the above training/education, and will be on-going annually and as needed.Additionally CNAs were educated on resident's plan of care, understanding the resident is priority, and steps to take when resident is combative.The competency evaluation(s) associated with this training was determined through quiz/test. This quiz tested the employee's knowledge of the subject matter. If employee missed more than one (1) question, additional training was provided.The facility will incorporate a behavior management review daily in the clinical rounds meeting. The behavioral management review will utilize an interdisciplinary approach to identify and analyze root cause(s) of behaviors. To verify the facility had implemented their Plan of Removal the following was conducted: -- Review of in-service training records for facility employees on all shifts confirmed training had been provided in the areas of : How do you identify burnout and what to do., fragile skin, Kardex (Resident information for the Certified Nurse Aides) and expected CNA use regarding a residents care, resident care requirements to include residents who had been identified with behaviors and expected staff interventions, resident rights and training in the area of abuse and neglect. Review of the sign in sheets revealed out of 128 employees all had received the in-service training except for 6 employees. - Review of the care plans for the identified 18 residents who were identified as exhibiting behaviors confirmed their care plans and Kardex records had been updated to reflect the identified behavior. -- Interview with the Administrator and the DON on 09/25/14 at 3:45 PM revealed they had already met on 09/23/14 with the Medical Director as part of the Quality Assurance Review related to the incident and addressed other quality concerns. - Interviews were conducted with staff, representing staff from each shift and working weekdays and/or weekends. The staff interviewed were three LVNs (LVNs L, R and U); 17 CNAs (CNAs M, N, O, P, Q, S, T, V, W, X, Y, Z, AA, CC, DD, EE and FF); Housekeeping Manager, Social Worker, Business Office Manager and Business Office Assistant. Each employee was able to articulate what constituted abuse and/or neglect, how they would determine the level of care a resident required, and what action they would take if they observed an employee continuing to provide care for a resident exhibiting a behavior of resistance to care. On 09/29/14 at 12:15 PM, the Administrator was informed the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy, and a scope of isolated because the facility was still monitoring the effectiveness of the Plan of Removal. The facility's Plan of Removal, dated 09/25/14, reflected 18 residents were at risk for behaviors including Resident #1.
F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**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 observation, interview and record review, it was determined the facility failed to conduct a thorough investigation of one of one incident of neglect involving Resident 1. The facility failed to thoroughly investigate the circumstances of Resident #1's injuries in order to know CNA A had only worked with Resident #1 one time prior to 08/23/14, CNA A had not read the plan of care for Resident #1, and the injuries were not caused by a wheelchair. CNA A was unaware Resident #1 could become resistant to care; thus, when Resident #1 began cursing and swinging her arms, the CNA A responded inappropriately resulting in Resident #1 sustaining bilateral avulsions (tearing away forcibly of a part or structure) from just below her elbows to just above her wrists. The resident was transferred to a local hospital's ER for evaluation and treatment. On 09/24/14 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/26/14, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope isolated because the facility was still evaluating the effectiveness of the Plan of Removal. Failure to thoroughly investigate incidents of neglect, placed the other 17 residents identified as having a behaviors, at risk for serious injuries due to failure of staff to provide care according to their assessed and care planned level of care and services. Findings included: 1. Review of the Abuse policy, with a release date 04/14/14, revealed, .physical and mental abuse.of the patient as well as mistreatment.are strictly prohibited.Patients have the right to be free of.physical, and mental abuse.of the patient as well mistreatment.1. Prohibitions on abuse apply to: a. Center staff.9. Identify patients most at risk of neglect and abuse, may include but is not limited to: a. Patients who have dementia. 2. Resident #1's Admission Record, dated 09/11/14, reflected she originally admitted to the facility on [DATE] and her most recent re-admission was 01/31/14. She was 94-years-old and her [DIAGNOSES REDACTED]. Resident #1's quarterly MDS assessment, dated 08/12/14, reflected she was oriented to year, month and day; exhibited no signs and symptoms of [MEDICAL CONDITION]; exhibited no behaviors; and required one person's extensive physical assistance with dressing and personal hygiene. Resident #1 was 65 inches tall and weighed 124 pounds and required staff assistance to stabilize her when she went from surface-to-surface, such as transfer from bed to chair. She was incontinent of bowel and bladder and had skin tears at that time. Resident #1's Care Plan,

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) initiated 09/16/13 and revised 09/24/13, reflected she was resistive to care r/t (related to) adjustment to nursing home, behaviors: refusing showers and care. The interventions included if she resisted ADLs to reassure her and leave, then return 5 to 10 minutes later and try again. Resident #1's Progress Notes, reflected the following: -- Notes dated 08/23/14 at 10:52 PM and written by LVN B, reflected the resident was sent to the ER at 7:15 that morning. The Note reflected, CNA came and reported that the resident got combative when she was trying to get her up. Resident was swinging her arms and the CNA was trying to prevent her from hitting. Resident got skin tears to both forearms, approximately 7 inches long by 3 inches wide. Nurse tried to apply first aid, skin tears were too severe. Notified doctor to send out, notified family, administrator was notified. Resident was sent to (local) hospital. Will continue to monitor. -- Notes dated 08/23/14 at 10:55 PM and written by LVN B, noted (Resident #1) returned from the ER around 3 p.m. she was with her daughter. Resident has dry dressing and steri strips applied to her arms . Review of Resident #1 ' s local hospital closed record, dated 08/23/14, reflected the following: -- The ED Physician Note, dated 08/23/14 at 8:06 AM noted: . (resident) presents to the ED c/o (complain of) avulsions, with daughter at bedside. Pt (Patient) reports via daughter that she was unruly this morning at her NH (nursing home) and when an aide restrained her manually, her skin ripped. Daughter reports her mother is frequently combative, and is suffering from a UTI. Pt has no other complaints at this time. -- That same date at 10:29 AM, it noted Resident #1 was ready to discharge and her [DIAGNOSES REDACTED]. Observation of Resident #1 at the facility in her room and in bed, on 09/11/14 at approximately 4:10 PM, revealed both arms were bandaged from her elbows to her wrists with purple bruising extending from the bottom of the bandage to the top/middle part of her hands. An interview with Resident #1 at that time revealed she could recall the incident. Resident #1 stated that black girl scratched me. Interview on 09/14/14 at 11:00 AM with LVN B revealed she had worked at the facility for almost one year. She stated she always worked weekend doubles and was on duty on 08/23/14. LVN B revealed on 08/23/14 CNA A came to her regarding a skin tear Resident #1 sustained. LVN B went to Resident #1's room and found Resident #1 lying sideways on her bed kind of crooked on the bed and at the foot of the bed with her arms drawn to her body. Resident #1 was dressed from the waist down with her pants and shoes on. The resident's wheelchair was positioned parallel to the bed. LVN B revealed CNA A told her she was getting ready to put Resident #1's shirt on and the resident started fighting. LVN B said when she approached the resident, she had blood all over the front her body but there was none on the bed. LVN B asked Resident #1 what happened. She stated Resident #1 told her she did not want to get up and CNA A pulled her by her arms and hurt her. She stated the injuries were from the elbow down to the wrists. LVN B revealed the resident's skin was pulled down to her wrists. She stated she was 'horrified at the injuries. LVN B revealed those were the worst injuries she had ever seen. LVN B continued by saying she had LVN C to come and assist her with pulling Resident #1's skin back up over the muscle on both arms. LVN B said Resident #1 had thin skin, and she saw the resident did not have any blood or skin under her nails and nothing on her hands which indicated to LVN B the resident did not make contact with CNA A. LVN B said she had RN D call 911 and contact the family and the doctor. LVN B revealed it was her opinion if things happened the way the aide told her, the resident's injuries would have been at the wrists and not the whole forearm. LVN B revealed the physician at the hospital called her to ask her what happened. The physician told LVN B Resident #1's injuries measured 10+ inches length on both arms. LVN B revealed she had provided care for Resident #1 over the past year and .if you rush her she gets combative or if she is tired. So you step away and come back later. LVN B said she never had a problem with Resident #1 being combative with her and she knew staff had to give the resident time and go back later if necessary. LVN B thought the CNA A was pretty nonchalant about the incident and did not display any emotion, which she thought was unusual because the injuries were so severe. LVN B had completed a written statement for the facility, dated 08/23/14. The statement reflected, (CNA A) came to me and stated that she was trying to get (Resident #1) up and she was getting aggressive. I went into the resident room and she was laying (sic) on her bed, both forearms had severe lacerations. I asked the CNA (CNA A) to please go get another nurse to assist me. Nurse (LVN C) came in to help apply pressure. Start first aide applied and there was a large amount of skin. Another nurse (LVN HH) went to notify the doctor & call the ambulance. (LVN HH) also notified (Resident #1's family member). I notified the (Administrator and DON). Had CNA write a statement and asked her to go home until she was notified. Resident stated she didn't want to get (up) and the CNA was pulling on her. An interview with the Paramedic, on 09/11/14 at 1:45 PM, revealed he responded to the 911 call from the facility. The Paramedic stated on 08/23/14 at 7:15 AM, his team had been picked to transport Resident #1 to the hospital for emergency medical services. The Paramedic stated a nurse met him at the door and she was crying because the resident's injuries were so bad. The Paramedic stated Resident #1 had large skin tears/shears to at least 50 to 60 % of both of her arms. He stated he had never seen injuries like that. An interview with LVN C on 09/14/14 at 11:25 AM confirmed LVN B came and got her to look at Resident #1's arms. She assisted LVN B with first aid. She stated the injuries were bad. The resident's skin was pulled down from her elbows to her wrists. LVN C revealed she had never seen injuries that bad and she had been a nurse for [AGE] years. She stated CNA A was nonchalant about Resident #1's injuries. LVN C revealed she had worked with CNA A for six months and she thought she was a good aide. She stated CNA A was different that day. LVN C revealed she read CNA A's statement and she did not think it was consistent with what happened. Review of LVN C's written statement obtained by the facility and dated 08/23/14, reflected, I was called to (Resident #1's) room by (LVN B) to look at res (resident's) arms. Large amt (amount) of skin was hanging from res fore arms. First aid rendered & 911 called. Review on 09/12/14 of CNA A's written statement obtained by the facility and dated 08/22/14 (sic), reflected I (CNA A) went to get (Resident #1) up about 6:30 AM in room (room number) and I went to set (sic) her up on the edge of the bed she started swinging end (sic) fighting and her arm hit the wheel chair that's when I notice her arms was (sic) bleeding so I laid her back in the bed and went and got the nurse (LVN B). An interview with CNA A 09/12/14 at 12:00 PM, confirmed she was the nurse aide who had assisted Resident #1 at the time of the incident. At the time of the interview, CNA A was noted to have a dark complexion and stand approximately 5 feet tall. She stated she had worked for the facility for almost one year. She stated she worked as a floater and thus worked different halls. She stated she currently worked four days on and two days off working the 6:00 AM to 2:00 PM shift. She stated she had received training in managing behaviors in the past and in-services on Abuse and Neglect. CNA A revealed prior to the incident with Resident #1, she had not really worked that hall. When asked how she could learn about the residents' characteristics, CNA A replied there were mini care plans in the residents' rooms. CNA A said she could also reference the ADL (Activities of Daily Living) book at the Nurse's Station for information about the resident. CNA A revealed the first day she worked with Resident #1, the resident was fine. She stated the day of the incident was the second time she had provided care to Resident #1. She stated she had cleaned Resident #1 in her bed, put her slacks and shoes on and swung the resident's legs around to the floor. When she got the resident to the edge of the bed, Resident #1 started swinging and cussing at her. CNA A stated she put her hands up to protect her own face and protect herself from the resident. CNA A revealed she thought the resident was falling backwards and that was when she grabbed the resident's arms to keep her from falling backwards. CNA A stated she was putting Resident #1 back in bed and that was when she saw the blood on Resident #1's arms. She did not indicate Resident #1 hit her arms on a wheelchair. She notified LVN B of what had occurred. CNA A stated if she could have done anything differently, she should have stepped away and let Resident #1 calm down and go back later. When asked why she did not take that action, CNA A replied she was not sure why. On 09/12/14, CNA A completed a second statement at the request of the Investigator. She noted, On the morning of Aug (August) 23 (2014) I went in to get (Resident #1) out of bed for breakfast. I got her dress (sic) in bed, she was fine, but once she sat up on the side of the bed she started to swing & pull back so for to keep her from hitting her head on the railing I grab (sic) her hands and she kept swinging so I put her legs back on the bed to lye (sic) her back down that's when I noticed her arms were bleeding so I went and got the nurse (LVN B) and they sent her out to the hospital and sent me home. Review of CNA A's personnel record reflected she was hired on 09/15/13. The record contained no evidence of prior counseling(s) for failing to implement a resident's assessed and care planned level of care or for causing physical injuries to a resident. Review of training records, reflected CNA A had received training on Abuse and Neglect four times, Resident Rights two times and Dementia care once during the year of 09/15/13 through 09/15/14. Review of CNA A's time punch records revealed on 08/24/14, 08/25/14, 08/26/14 she did not work. On 08/29/14, she returned to work and worked through 09/11/14. CNA A did not work any additional days. Interview on 09/11/14 at approximately 3:15 PM with the Administrator revealed she had conducted the investigation of the incident involving Resident #1 and suspended CNA A pending the outcome of the investigation. The Administrator stated CNA A was brought back to work because the CNA didn't do anything wrong. The resident was combative and flailing her arms sitting on the side of her bed. The CNA grabbed the resident's arms to protect the resident and her skin tore. The resident had very thin skin and the aide was small in stature. The family requested CNA A not provide care to Resident #1, and the CNA was subsequently moved to another hall. An interview on 09/11/14 at approximately 4:00 PM with the Staff Development Coordinator revealed

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	676101	A. BUILDING _____ B. WING _____	09/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED TRANSITIONAL CARE AND REHABILITATION-RIDGM	6600 LANDS END COURT FORT WORTH, TX 76116

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) she read the Provider Investigation Report, dated 08/23/14, about Resident #1's avulsions and CNA A's witness statement. The Coordinator stated her concern was CNA A's witness statement indicated she was defending herself from the resident with crossed arms and open hands and that did not add up. An interview with the Administrator on 09/12/14 at approximately 3:45 PM revealed CNA A was suspended due to the surveyor's findings. The Administrator stated a decision on CNA A's employment would be determined based on the surveyor's findings. Further interview with the Administrator on 09/15/14 at approximately 1:10 PM revealed CNA A was terminated for failure to follow policies by not coming in to the facility to speak with the surveyor and Administrator. Interview on 09/12/14 at 2:00 PM with CNA D revealed he had been employed with the facility for a period of 10 months. He stated he had provided care for Resident #1 during seven of those months. CNA D revealed he never had a problem with her being aggressive or combative with him. He stated it was all in the approach with her. CNA D said it was all about what Resident #1 wanted. He revealed Resident #1 told him she and CNA A started to argue. He stated Resident #1 was able to recall what happened that day. Interview on 09/12/14 at 2:30 PM with LVN I revealed she had provided care to Resident #1 and some days she was combative. She stated it was all in the approach with the resident. LVN I revealed if the resident did not know someone, she might be combative. She stated someone could not just go in her room and start flipping the lights on and being abrupt. The facility's current Resident Refusal of Care policy, revised 04/28/10, reflected occasional refusals or failure to follow physician's orders [REDACTED]. Some residents consistently refused to accept or failed to follow the ordered treatment, therapeutic diet or services. Every attempt was made to accommodate the resident's request and still provide the appropriate care and services to meet the residents' needs while following the physician's orders [REDACTED]. On 09/24/14 at 6:10 PM., the Administrator, DON, LVN H, and LVN L were notified of the IJ had been identified for failure to ensure nurse aides provided residents their care planned level of care and services to prevent residents from sustaining serious injuries. Interview on 09/25/14 at 9:40 AM with the DON revealed since the incident with Resident #1, all Unit Managers now had a tool they could use that addressed staff interactions with the residents, identified as having behaviors. She said they initiated the in-services on 09/24/14. The training provided to staff included: How to recognize burnout, Kardex/CNA for CNA use regarding a resident's care requirements including behavior interventions, resident rights and abuse and neglect. Skin assessments were initiated on 09/12/14 and residents with fragile skin were identified to be at high risk for skin tears and the information was added to their care plans. Training for management/staff was provided in the area of residents with fragile skin and skin tear prevention. Audit rounds would be conducted by Nurse Managers and they would utilize a tool developed to monitor CNAs' knowledge of residents resistive to care, where they locate information pertaining to the residents and refusal of care. The tool was to be utilized by managers daily. All staff would be trained and those who had not had the training would not be allowed to return to work until they had received the required in-services. On 09/25/14, the Administrator was notified their Plan of Removal was accepted. The Plan of Removal, dated 09/25/14, reflected the following: -- Upon return from the hospital the resident (Resident #1) was evaluated and seen by the facility's certified Wound Care Nurse.The resident's Wound Care Physician , evaluated the resident's skin condition upon on 8/29/14. Additional skin treatment orders were ordered by wound care physician 8/29/14.The resident's care plan was reviewed and updated on 8/23/14 to reflect current health status by the facility's Minimum Data Set (MDS) nurse,(sic). The patient's medical history provides documentation of behavioral changes related to infection [MEDICAL CONDITION]. The resident's care plan reflects this information.(CNA A) was suspended pending outcome of facility investigation 8/23/14 and ultimately terminated from facility employment. -- On 08/23/14, CAN A was suspended pending the outcome of the facility's investigation. -- On 8/29/14, CNA A was re-in serviced on abuse related to this incident, and how to effectively deal with combative residents; this training was provided by the Staff Development Coordinator (sic). -- A Safe Survey was conducted after (CNA A) return on several residents throughout the facility whom (CNA A) had provided care with no negative outcome. (CNA A) returned to duty on 08/29/14 after the facility had completed its initial investigation of the incident. -- On 09/11/14, as a result of a complaint survey initiated by DADS, further details emerged questioning (CNA A) original statement. The facility reopened its investigation on 09/11/14. She (CNA A) was suspended as a result the reopening of the investigation. As a result of the facilities (sic)reopened investigation she was terminated on 09/15/14 primarily for her inability to provide a consistent statement regarding the incident with (Resident #1) on 08/23/14. (CNA A) failed to meet the facility standards of providing the highest standard of care to its residents. The facility is vigilant in protecting our residents from perceived mistreatment.Residents with behaviors were identified by resident assessment report in Point Click Care, electronic charting program, on 9/23/14. - The behavioral care plans and Certified Nursing Assistant (CNA) Kardex, (Kardex are a resource for CNAs, like a mini care plan to give personalized care to individual residents). Fragile skin is skin that has very thin tissue do to the loss of subcutaneous tissue. -- All of the residents identified were reviewed, and updated to reflect resident's current behavioral status by Director of Nursing, Unit Managers, (LVN H) and Assistant Director of Nursing ,(LVN J). -- The following residents have been identified with the potential for behaviors: (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, and #18).Identified residents exhibit the following types of behaviors; resistance to care, verbal outburst, inappropriate language, disrobing. -- Additionally, to assist in identifying the residents at risk, the facility consultant pharmacist reviewed residents receiving [MEDICAL CONDITION] medication to assure that appropriate recommendations are reviewed by resident's physician and subsequent orders are implemented by the licensed nurse; this review is done monthly and was last completed on 9/15/14. This review assures that the resident receives the appropriate medication to assist with behavior management and prevent adverse side effects. The consultant pharmacist will provide a monthly report of his/her review to the Director of Nursing. The Director of Nursing, will present a summary of the report to the Facility's Performance Improvement Committee on a monthly basis; this will be an on-going measure/intervention. -- Ad lib referrals to psychology and psychiatric services are determined by resident review in the Interdisciplinary Clinical Rounds (nursing, dietician, Social Worker, MDS, and Activities, process that occurs at least 5 days weekly. The Clinical Rounds Process is retrospective review of clinical needs of residents identified by the center's 24- hour reporting system. This process was implemented in February 2014 and is an ongoing facility practice with no end date. -- Residents identified will be discussed to assure that proper measures/interventions are implemented to resolve clinical concerns, assure that the MD and families are notified of concerns along with any appropriate follow up measures, care plans reviewed and updated and or created as new condition warrants, and that interventions are monitored until the clinical concern is resolved. -- All Kardex have been updated and are located at the nursing station for added security and confidentiality.Kardex will also notate residents identified with behaviors for additional interventions and suggestions to assure care is optimally provided. -- CNAs have been educated and are required to check it frequently for changes, as well as adding appropriate/helpful information. CNAs were in-serviced on Assessing Risk of Challenging Behaviors, Resident Rights, and Resident's Rights to Refuse Care, Definition(s) of Abuse, Behavioral Management, and Skin Tears: Prevention and Management, the dates of the in-services were on 09/12/14 -09/15/14. As part of the training, CNAs were in-serviced on the expectation of reviewing the Kardex prior to the start of each shift to assure that the CNA has the most updated information regarding the president's plan of care. Competency was evaluated and determined by questionnaire given by the Director of Nursing.This quiz tested the employee's knowledge of the following: How to deal with combative residents, Resident Right to refuse Care, notification to nursing supervisor and understanding that resident care is primary function. If employee missed more than one (1) question, additional training was provided. -- Additionally nursing staff have been in-serviced on 'burnout' and sign and symptoms of, as well as prevention and what to do if detected. quiz tested the employee's knowledge of the following: How to deal with combative residents, Resident Right to refuse Care, notification to nursing supervisor and understanding that resident care is their primary priority.Education/in-servicing was initiated and provided by the Staff Development Coordinator, 9/12-9/15/14. This education included: Assessing Risk of Challenging Behaviors, Resident Rights, Resident's Rights to Refuse Care, Definition(s) of Abuse, Behavioral Management, Skin Tears: Prevention and Management. These in-services were for Licensed Nurses and CNAs. Staff education was initiated and conducted by the Staff Development Coordinator on 8/25/14 for licensed nurses and CNAs on abuse training and how to effectively care for the combative resident. Subsequent staff education concluded on 9/13/14. -- As of 9/13/14, current licensed nurses and CNAs received the above training/education, and will be on-going annually and as needed.Additionally CNAs were educated on resident's plan of care, understanding the resident is priority, and steps to take when resident is combative.The competency evaluation(s) associated with this training was determined through quiz/test. This quiz tested the employee's knowledge of the subject matter. If employee missed more than one (1) question, additional training was provided.The facility will incorporate a behavior management review daily in the clinical rounds meeting. The behavioral management review will utilize an interdisciplinary approach to identify and analyze root cause(s) of behaviors. To verify the

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	676101	A. BUILDING _____ B. WING _____	09/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED TRANSITIONAL CARE AND REHABILITATION-RIDGM	6600 LANDS END COURT FORT WORTH, TX 76116

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F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 5) facility had implemented their Plan of Removal the following was conducted: -- Review of in-service training records for facility employees on all shifts confirmed training had been provided in the areas of : How do you identify burnout and what to do., fragile skin, Kardex (Resident information for the Certified Nurse Aides) and expected CNA use regarding a residents care, resident care requirements to include residents who had been identified with behaviors and expected staff interventions, resident rights and training in the area of abuse and neglect. Review of the sign in sheets revealed out of 128 employees all had received the in-service training except for 6 employees. - Review of the care plans for the identified 18 residents who were identified as exhibiting behaviors confirmed their care plans and Kardex records had been updated to reflect the identified behavior. -- Interview with the Administrator and the DON on 09/25/14 at 3:45 PM revealed they had already met on 09/23/14 with the Medical Director as part of the Quality Assurance Review related to the incident and addressed other quality concerns. - Interviews were conducted with staff, representing staff from each shift and working weekdays and/or weekends. The staff interviewed were three LVNs (LVNs L, R and U); 17 CNAs (CNAs M, N, O, P, Q, S, T, V, W, X, Y, Z, AA, CC, DD, EE and FF); Housekeeping Manager, Social Worker, Business Office Manager and Business Office Assistant. Each employee was able to articulate what constituted abuse and/or neglect, how they would determine the level of care a resident required, and what action they would take if they observed an employee continuing to provide care for a resident exhibiting a behavior of resistance to care. On 09/29/14 at 12:15 PM, the Administrator was informed the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy, and a scope of isolated because the facility was still monitoring the effectiveness of the Plan of Removal. The facility's Plan of Removal, dated 09/25/14, reflected 18 residents were at risk for behaviors including Resident #1.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**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, interview and record review, it was determined the facility failed to implement written policies and procedures for abuse and neglect prevention when they 1) Failed to prohibit neglect of residents for one (Resident #1) of eight residents reviewed for neglect. 2) Failed to ensure administrative staff conducted a thorough investigation of one of one incident involving Resident #1 sustaining serious injuries during care performed by CNA A. The facility failed to thoroughly investigate the circumstances of Resident #1's injuries in order to know CNA A had only worked with Resident #1 one time prior to 08/23/14, CNA A had not read the plan of care for Resident #1, and the injuries were not caused by a wheelchair. CNA A was unaware Resident #1 could become resistant to care; thus, when Resident #1 began cursing and swinging her arms, the CNA A responded inappropriately resulting in Resident #1 sustaining bilateral avulsions (tearing away forcibly of a part or structure) from just below her elbows to just above her wrists. The resident was transferred to a local hospital's ER for evaluation and treatment. On 09/24/14 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/26/14, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope isolated because the facility was still evaluating the effectiveness of the Plan of Removal. This failure could affect the other 17 residents identified with a history of behaviors at risk for injuries due to failure of a nurse aide to know their assessed and care planned level of care and services. Findings included: 1. Review of the Abuse policy, with a release date 04/14/14, revealed, .physical and mental abuse.of the patient as well as mistreatment.are strictly prohibited.Patients have the right to be free of.physical, and mental abuse.of the patient as well mistreatment.1. Prohibitions on abuse apply to: a. Center staff.9. Identify patients most at risk of neglect and abuse, may include but is not limited to: a. Patients who have dementia. 2. Resident #1's Admission Record, dated 09/11/14, reflected she originally admitted to the facility on [DATE] and her most recent re-admission was 01/31/14. She was 94-years-old and her [DIAGNOSES REDACTED]. Resident #1's quarterly MDS assessment, dated 08/12/14, reflected she was oriented to year, month and day; exhibited no signs and symptoms of [MEDICAL CONDITION]; exhibited no behaviors; and required one person's extensive physical assistance with dressing and personal hygiene. Resident #1 was 65 inches tall and weighed 124 pounds and required staff assistance to stabilize her when she went from surface-to-surface, such as transfer from bed to chair. She was incontinent of bowel and bladder and had skin tears at that time. Resident #1's Care Plan, initiated 09/16/13 and revised 09/24/13, reflected she was resistive to care r/t (related to) adjustment to nursing home, behaviors: refusing showers and care. The interventions included if she resisted ADLs to reassure her and leave, then return 5 to 10 minutes later and try again. Resident #1's Progress Notes, reflected the following: -- Notes dated 08/23/14 at 10:52 PM and written by LVN B, reflected the resident was sent to the ER at 7:15 that morning. The Note reflected, CNA came and reported that the resident got combative when she was trying to get her up. Resident was swinging her arms and the CNA was trying to prevent her from hitting. Resident got skin tears to both forearms, approximately 7 inches long by 3 inches wide. Nurse tried to apply first aid, skin tears were too severe. Notified doctor to send out, notified family, administrator was notified. Resident was sent to (local) hospital. Will continue to monitor. -- Notes dated 08/23/14 at 10:55 PM and written by LVN B, noted (Resident #1) returned from the ER around 3 p.m. she was with her daughter. Resident has dry dressing and steri strips applied to her arms . Review of Resident #1 ' s local hospital closed record, dated 08/23/14, reflected the following: -- The ED Physician Note, dated 08/23/14 at 8:06 AM noted: . (resident) presents to the ED c/o (complain of) avulsions, with daughter at bedside. Pt (Patient) reports via daughter that she was unruly this morning at her NH (nursing home) and when an aide restrained her manually, her skin ripped. Daughter reports her mother is frequently combative, and is suffering from a UTI. Pt has no other complaints at this time. -- That same date at 10:29 AM, it noted Resident #1 was ready to discharge and her [DIAGNOSES REDACTED]. Observation of Resident #1 at the facility in her room and in bed, on 09/11/14 at approximately 4:10 PM, revealed both arms were bandaged from her elbows to her wrists with purple bruising extending from the bottom of the bandage to the top/middle part of her hands. An interview with Resident #1 at that time revealed she could recall the incident. Resident #1 stated that black girl scratched me. Interview on 09/14/14 at 11:00 AM with LVN B revealed she had worked at the facility for almost one year. She stated she always worked weekend doubles and was on duty on 08/23/14. LVN B revealed on 08/23/14 CNA A came to her regarding a skin tear Resident #1 sustained. LVN B went to Resident #1's room and found Resident #1 lying sideways on her bed kind of crooked on the bed and at the foot of the bed with her arms drawn to her body. Resident #1 was dressed from the waist down with her pants and shoes on. The resident's wheelchair was positioned parallel to the bed. LVN B revealed CNA A told her she was getting ready to put Resident #1's shirt on and the resident started fighting. LVN B said when she approached the resident, she had blood all over the front her body but there was none on the bed. LVN B asked Resident #1 what happened. She stated Resident #1 told her she did not want to get up and CNA A pulled her by her arms and hurt her. She stated the injuries were from the elbow down to the wrists. LVN B revealed the resident's skin was pulled down to her wrists. She stated she was 'horrified at the injuries. LVN B revealed those were the worst injuries she had ever seen. LVN B continued by saying she had LVN C to come and assist her with pulling Resident #1's skin back up over the muscle on both arms. LVN B said Resident #1 had thin skin, and she saw the resident did not have any blood or skin under her nails and nothing on her hands which indicated to LVN B the resident did not make contact with CNA A. LVN B said she had RN D call 911 and contact the family and the doctor. LVN B revealed it was her opinion if things happened the way the aide told her, the resident's injuries would have been at the wrists and not the whole forearm. LVN B revealed the physician at the hospital called her to ask her what happened. The physician told LVN B Resident #1's injuries measured 10+ inches length on both arms. LVN B revealed she had provided care for Resident #1 over the past year and .if you rush her she gets combative or if she is tired. So you step away and come back later. LVN B said she never had a problem with Resident #1 being combative with her and she knew staff had to give the resident time and go back later if necessary. LVN B thought the CNA A was pretty nonchalant about the incident and did not display any emotion, which she thought was unusual because the injuries were so severe. LVN B had completed a written statement for the facility, dated 08/23/14. The statement reflected, (CNA A) came to me and stated that she was trying to get (Resident #1) up and she was getting aggressive. I went into the resident room and she was laying (sic) on her bed, both forearms had severe lacerations. I asked the CNA (CNA A) to please go get another nurse to assist me. Nurse (LVN C) came in to help apply pressure. Start first aide applied and there was a large amount of skin. Another nurse (LVN HH) went to notify the doctor & call the ambulance. (LVN HH) also notified (Resident #1's family member). I notified the (Administrator and DON). Had CNA write a statement and asked her to go home until she was notified. Resident stated she didn't want to get (up) and the CNA was pulling on her. An interview with the Paramedic, on 09/11/14 at 1:45 PM, revealed he responded to the 911 call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676101	A. BUILDING _____ B. WING _____	09/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED TRANSITIONAL CARE AND REHABILITATION-RIDGM	6600 LANDS END COURT FORT WORTH, TX 76116

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) from the facility. The Paramedic stated on 08/23/14 at 7:15 AM, his team had been picked to transport Resident #1 to the hospital for emergency medical services. The Paramedic stated a nurse met him at the door and she was crying because the resident's injuries were so bad. The Paramedic stated Resident #1 had large skin tears/shears to at least 50 to 60 % of both of her arms. He stated he had never seen injuries like that. An interview with LVN C on 09/14/14 at 11:25 AM confirmed LVN B came and got her to look at Resident #1's arms. She assisted LVN B with first aid. She stated the injuries were bad. The resident's skin was pulled down from her elbows to her wrists. LVN C revealed she had never seen injuries that bad and she had been a nurse for [AGE] years. She stated CNA A was nonchalant about Resident #1's injuries. LVN C revealed she had worked with CNA A for six months and she thought she was a good aide. She stated CNA A was different that day. LVN C revealed she read CNA A's statement and she did not think it was consistent with what happened. Review of LVN C's written statement obtained by the facility and dated 08/23/14, reflected, I was called to (Resident #1's) room by (LVN B) to look at res (resident's) arms. Large amt (amount) of skin was hanging from res fore arms. First aid rendered & 911 called. Review on 09/12/14 of CNA A's written statement obtained by the facility and dated 08/22/14 (sic), reflected I (CNA A) went to get (Resident #1) up about 6:30 AM in room (room number) and I went to set (sic) her up on the edge of the bed she started swinging end (sic) fighting and her arm hit the wheel chair that's when I notice her arms was (sic) bleeding so I laid her back in the bed and went and got the nurse (LVN B). An interview with CNA A 09/12/14 at 12:00 PM, confirmed she was the nurse aide who had assisted Resident #1 at the time of the incident. At the time of the interview, CNA A was noted to have a dark complexion and stand approximately 5 feet tall. She stated she had worked for the facility for almost one year. She stated she worked as a floater and thus worked different halls. She stated she currently worked four days on and two days off working the 6:00 AM to 2:00 PM shift. She stated she had received training in managing behaviors in the past and in-services on Abuse and Neglect. CNA A revealed prior to the incident with Resident #1, she had not really worked that hall. When asked how she could learn about the residents' characteristics, CNA A replied there were mini care plans in the residents' rooms. CNA A said she could also reference the ADL (Activities of Daily Living) book at the Nurse's Station for information about the resident. CNA A revealed the first day she worked with Resident #1, the resident was fine. She stated the day of the incident was the second time she had provided care to Resident #1. She stated she had cleaned Resident #1 in her bed, put her slacks and shoes on and swung the resident's legs around to the floor. When she got the resident to the edge of the bed, Resident #1 started swinging and cussing at her. CNA A stated she put her hands up to protect her own face and protect herself from the resident. CNA A revealed she thought the resident was falling backwards and that was when she grabbed the resident's arms to keep her from falling backwards. CNA A stated she was putting Resident #1 back in bed and that was when she saw the blood on Resident #1's arms. She did not indicate Resident #1 hit her arms on a wheelchair. She notified LVN B of what had occurred. CNA A stated if she could have done anything differently, she should have stepped away and let Resident #1 calm down and go back later. When asked why she did not take that action, CNA A replied she was not sure why. On 09/12/14, CNA A completed a second statement at the request of the Investigator. She noted, On the morning of Aug (August) 23 (2014) I went in to get (Resident #1) out of bed for breakfast. I got her dress (sic) in bed, she was fine, but once she sat up on the side of the bed she started to swing & pull back so for to keep her from hitting her head on the railing I grab (sic) her hands and she kept swinging so I put her legs back on the bed to lye (sic) her back down that's when I noticed her arms were bleeding so I went and got the nurse (LVN B) and they sent her out to the hospital and sent me home. Review of CNA A's personnel record reflected she was hired on 09/15/13. The record contained no evidence of prior counseling(s) for failing to implement a resident's assessed and care planned level of care or for causing physical injuries to a resident. Review of training records, reflected CNA A had received training on Abuse and Neglect four times, Resident Rights two times and Dementia care once during the year of 09/15/13 through 09/15/14. Review of CNA A's time punch records revealed on 08/24/14, 08/25/14, 08/26/14 she did not work. On 08/29/14, she returned to work and worked through 09/11/14. CNA A did not work any additional days. Interview on 09/11/14 at approximately 3:15 PM with the Administrator revealed she had conducted the investigation of the incident involving Resident #1 and suspended CNA A pending the outcome of the investigation. The Administrator stated CNA A was brought back to work because the CNA didn't do anything wrong. The resident was combative and flailing her arms sitting on the side of her bed. The CNA grabbed the resident's arms to protect the resident and her skin tore. The resident had very thin skin and the aide was small in stature. The family requested CNA A not provide care to Resident #1, and the CNA was subsequently moved to another hall. An interview on 09/11/14 at approximately 4:00 PM with the Staff Development Coordinator revealed she read the Provider Investigation Report, dated 08/23/14, about Resident #1's avulsions and CNA A's witness statement. The Coordinator stated her concern was CNA A's witness statement indicated she was defending herself from the resident with crossed arms and open hands and that did not add up. An interview with the Administrator on 09/12/14 at approximately 3:45 PM revealed CNA A was suspended due to the surveyor's findings. The Administrator stated a decision on CNA A's employment would be determined based on the surveyor's findings. Further interview with the Administrator on 09/15/14 at approximately 1:10 PM revealed CNA A was terminated for failure to follow policies by not coming in to the facility to speak with the surveyor and Administrator. Interview on 09/12/14 at 2:00 PM with CNA D revealed he had been employed with the facility for a period of 10 months. He stated he had provided care for Resident #1 during seven of those months. CNA D revealed he never had a problem with her being aggressive or combative with him. He stated it was all in the approach with her. CNA D said it was all about what Resident #1 wanted. He revealed Resident #1 told him she and CNA A started to argue. He stated Resident #1 was able to recall what happened that day. Interview on 09/12/14 at 2:30 PM with LVN I revealed she had provided care to Resident #1 and some days she was combative. She stated it was all in the approach with the resident. LVN I revealed if the resident did not know someone, she might be combative. She stated someone could not just go in her room and start flipping the lights on and being abrupt. The facility's current Resident Refusal of Care policy, revised 04/28/10, reflected occasional refusals or failure to follow physician's orders [REDACTED]. Some residents consistently refused to accept or failed to follow the ordered treatment, therapeutic diet or services. Every attempt was made to accommodate the resident's request and still provide the appropriate care and services to meet the residents' needs while following the physician's orders [REDACTED]. On 09/24/14, an IJ was identified. On 09/24/14 at 6:10 PM., the Administrator, DON, LVN H, and LVN L were notified of the IJ had been identified for failure to ensure nurse aides provided residents their care planned level of care and services to prevent residents from sustaining serious injuries. Interview on 09/25/14 at 9:40 AM with the DON revealed since the incident with Resident #1, all Unit Managers now had a tool they could use that addressed staff interactions with the residents, identified as having behaviors. She said they initiated the in-services on 09/24/14. The training provided to staff included: How to recognize burnout, Kardex/CNA for CNA use regarding a resident's care requirements including behavior interventions, resident rights and abuse and neglect. Skin assessments were initiated on 09/12/14 and residents with fragile skin were identified to be at high risk for skin tears and the information was added to their care plans. Training for management/staff was provided in the area of residents with fragile skin and skin tear prevention. Audit rounds would be conducted by Nurse Managers and they would utilize a tool developed to monitor CNAs' knowledge of residents resistive to care, where they locate information pertaining to the residents and refusal of care. The tool was to be utilized by managers daily. All staff would be trained and those who had not had the training would not be allowed to return to work until they had received the required in-services. On 09/25/14, the Administrator was notified their Plan of Removal was accepted. The Plan of Removal, dated 09/25/14, reflected the following: -- Upon return from the hospital the resident (Resident #1) was evaluated and seen by the facility's certified Wound Care Nurse.The resident's Wound Care Physician , evaluated the resident's skin condition upon on 8/29/14. Additional skin treatment orders were ordered by wound care physician 8/29/14.The resident's care plan was reviewed and updated on 8/23/14 to reflect current health status by the facility's Minimum Data Set (MDS) nurse,(sic). The patient's medical history provides documentation of behavioral changes related to infection [MEDICAL CONDITION]. The resident's care plan reflects this information.(CNA A) was suspended pending outcome of facility investigation 8/23/14 and ultimately terminated from facility employment. -- On 08/23/14, CAN A was suspended pending the outcome of the facility's investigation. -- On 8/29/14, CNA A was re-in serviced on abuse related to this incident, and how to effectively deal with combative residents; this training was provided by the Staff Development Coordinator (sic). -- A Safe Survey was conducted after (CNA A) return on several residents throughout the facility whom (CNA A) had provided care with no negative outcome. (CNA A) returned to duty on 08/29/14 after the facility had completed its initial investigation of the incident. -- On 09/11/14, as a result of a complaint survey initiated by DADS, further details emerged questioning (CNA A) original statement. The facility reopened its investigation on 09/11/14. She (CNA A) was suspended as a result the reopening of the investigation. As a result of the facilities (sic)reopened investigation she was terminated on 09/15/14 primarily for her inability to provide a consistent statement regarding the incident with

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F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 7) (Resident #1) on 08/23/14. (CNA A) failed to meet the facility standards of providing the highest standard of care to its residents. The facility is vigilant in protecting our residents from perceived mistreatment.Residents with behaviors were identified by resident assessment report in Point Click Care, electronic charting program, on 9/23/14. - The behavioral care plans and Certified Nursing Assistant (CNA) Kardex, (Kardex are a resource for CNAs, like a mini care plan to give personalized care to individual residents). Fragile skin is skin that has very thin tissue do to the loss of subcutaneous tissue. -- All of the residents identified were reviewed, and updated to reflect resident's current behavioral status by Director of Nursing, Unit Managers, (LVN H) and Assistant Director of Nursing ,(LVN J). -- The following residents have been identified with the potential for behaviors: (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, and #18).Identified residents exhibit the following types of behaviors; resistance to care, verbal outburst, inappropriate language, disrobing. -- Additionally, to assist in identifying the residents at risk, the facility consultant pharmacist reviewed residents receiving [MEDICAL CONDITION] medication to assure that appropriate recommendations are reviewed by resident's physician and subsequent orders are implemented by the licensed nurse; this review is done monthly and was last completed on 9/15/14. This review assures that the resident receives the appropriate medication to assist with behavior management and prevent adverse side effects. The consultant pharmacist will provide a monthly report of his/her review to the Director of Nursing. The Director of Nursing, will present a summary of the report to the Facility's Performance Improvement Committee on a monthly basis; this will be an on-going measure/intervention. -- Ad lib referrals to psychology and psychiatric services are determined by resident review in the Interdisciplinary Clinical Rounds (nursing, dietician, Social Worker, MDS, and Activities, process that occurs at least 5 days weekly. The Clinical Rounds Process is retrospective review of clinical needs of residents identified by the center's 24- hour reporting system. This process was implemented in February 2014 and is an ongoing facility practice with no end date. -- Residents identified will be discussed to assure that proper measures/interventions are implemented to resolve clinical concerns, assure that the MD and families are notified of concerns along with any appropriate follow up measures, care plans reviewed and updated and or created as new condition warrants, and that interventions are monitored until the clinical concern is resolved. -- All Kardex have been updated and are located at the nursing station for added security and confidentiality.Kardex will also notate residents identified with behaviors for additional interventions and suggestions to assure care is optimally provided. -- CNAs have been educated and are required to check it frequently for changes, as well as adding appropriate/helpful information. CNAs were in-serviced on Assessing Risk of Challenging Behaviors, Resident Rights, and Resident's Rights to Refuse Care, Definition(s) of Abuse, Behavioral Management, and Skin Tears: Prevention and Management, the dates of the in-services were on 09/12/14 -09/15/14. As part of the training, CNAs were in-serviced on the expectation of reviewing the Kardex prior to the start of each shift to assure that the CNA has the most updated information regarding the president's plan of care. Competency was evaluated and determined by questionnaire given by the Director of Nursing.This quiz tested the employee's knowledge of the following: How to deal with combative residents, Resident Right to refuse Care, notification to nursing supervisor and understanding that resident care is primary function. If employee missed more than one (1) question, additional training was provided. -- Additionally nursing staff have been in-serviced on 'burnout' and sign and symptoms of, as well as prevention and what to do if detected. quiz tested the employee's knowledge of the following: How to deal with combative residents, Resident Right to refuse Care, notification to nursing supervisor and understanding that resident care is their primary priority.Education/in-servicing was initiated and provided by the Staff Development Coordinator, 9/12-9/15/14. This education included: Assessing Risk of Challenging Behaviors, Resident Rights, Resident's Rights to Refuse Care, Definition(s) of Abuse, Behavioral Management, Skin Tears: Prevention and Management. These in-services were for Licensed Nurses and CNAs. Staff education was initiated and conducted by the Staff Development Coordinator on 8/25/14 for licensed nurses and CNAs on abuse training and how to effectively care for the combative resident. Subsequent staff education concluded on 9/13/14. -- As of 9/13/14, current licensed nurses and CNAs received the above training/education, and will be on-going annually and as needed.Additionally CNAs were educated on resident's plan of care, understanding the resident is priority, and steps to take when resident is combative.The competency evaluation(s) associated with this training was determined through quiz/test. This quiz tested the employee's knowledge of the subject matter. If employee missed more than one (1) question, additional training was provided.The facility will incorporate a behavior management review daily in the clinical rounds meeting. The behavioral management review will utilize an interdisciplinary approach to identify and analyze root cause(s) of behaviors. To verify the facility had implemented their Plan of Removal the following was conducted: -- Review of in-service training records for facility employees on all shifts confirmed training had been provided in the areas of : How do you identify burnout and what to do., fragile skin, Kardex (Resident information for the Certified Nurse Aides) and expected CNA use regarding a residents care, resident care requirements to include residents who had been identified with behaviors and expected staff interventions, resident rights and training in the area of abuse and neglect. Review of the sign in sheets revealed out of 128 employees all had received the in-service training except for 6 employees. - Review of the care plans for the identified 18 residents who were identified as exhibiting behaviors confirmed their care plans and Kardex records had been updated to reflect the identified behavior. -- Interview with the Administrator and the DON on 09/25/14 at 3:45 PM revealed they had already met on 09/23/14 with the Medical Director as part of the Quality Assurance Review related to the incident and addressed other quality concerns. - Interviews were conducted with staff, representing staff from each shift and working weekdays and/or weekends. The staff interviewed were three LVNs (LVNs L, R and U); 17 CNAs (CNAs M, N, O, P, Q, S, T, V, W, X, Y, Z, AA, CC, DD, EE and FF); Housekeeping Manager, Social Worker, Business Office Manager and Business Office Assistant. Each employee was able to articulate what constituted abuse and/or neglect, how they would determine the level of care a resident required, and what action they would take if they observed an employee continuing to provide care for a resident exhibiting a behavior of resistance to care. On 09/29/14 at 12:15 PM, the Administrator was informed the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy, and a scope of isolated because the facility was still monitoring the effectiveness of the Plan of Removal. The facility's Plan of Removal, dated 09/25/14, reflected 18 residents were at risk for behaviors including Resident #1.
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to ensure one (Resident #1) of eight residents reviewed for prevention of accidents, received adequate supervision to prevent incidents. CNA A had worked with Resident #1 only one time prior to 08/23/14. CNA A had not read the plan of care for Resident #1 and thus was unaware Resident #1 could become resistant to care. On 08/23/14, CNA A assisted Resident #1 with incontinence care and putting on her pants. When she assisted the resident to sit up, the resident began cursing and swinging her arms. CNA A thought the resident was going to fall back and grabbed the resident by the arms resulting in bilateral avulsions (tearing away forcibly of a part or structure) from just below her elbows to just above her wrists. The resident was transferred to a local hospital's ER for evaluation and treatment. On 09/24/14 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/26/14, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope isolated because the facility was still evaluating the effectiveness of the Plan of Removal. This failure could affect the other 17 residents identified with a history of behaviors at risk of sericous injuries due to failure of a nurse aide to know their assessed and care planned level of care and services. Findings included: Resident #1's Admission Record, dated 09/11/14, reflected she originally admitted to the facility on [DATE] and her most recent re-admission was 01/31/14. She was 94-years-old and her [DIAGNOSES REDACTED]. Resident #1's quarterly MDS assessment, dated 08/12/14, reflected she was oriented to year, month and day; exhibited no signs and symptoms of delirium; exhibited no behaviors; and required one person's extensive physical assistance with dressing and personal hygiene. Resident #1 was 65 inches tall and weighed 124 pounds and required staff assistance to stabilize her when she went from surface-to-surface, such as transfer from bed to chair. She was incontinent of bowel and bladder and had skin tears at that time. Resident #1's Care Plan, initiated 09/16/13 and revised 09/24/13, reflected she was resistive to care r/t (related to) adjustment to nursing home, behaviors: refusing showers and care. The interventions included if she resisted ADLs to reassure her and leave, then return 5 to 10 minutes later and try again. Resident #1's Progress Notes, reflected the following: -- Notes

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F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 8) dated 08/23/14 at 10:52 PM and written by LVN B, reflected the resident was sent to the ER at 7:15 that morning. The Note reflected, CNA came and reported that the resident got combative when she was trying to get her up. Resident was swinging her arms and the CNA was trying to prevent her from hitting. Resident got skin tears to both forearms, approximately 7 inches long by 3 inches wide. Nurse tried to apply first aid, skin tears were too severe. Notified doctor to send out, notified family, administrator was notified. Resident was sent to (local) hospital. Will continue to monitor. -- Notes dated 08/23/14 at 10:55 PM and written by LVN B, noted (Resident #1) returned from the ER around 3 p.m. she was with her daughter. Resident has dry dressing and steri strips applied to her arms . Review of Resident #1 ' s local hospital closed record, dated 08/23/14, reflected the following: -- The ED Physician Note, dated 08/23/14 at 8:06 AM noted: . (resident) presents to the ED c/o (complain of) avulsions, with daughter at bedside. Pt (Patient) reports via daughter that she was unruly this morning at her NH (nursing home) and when an aide restrained her manually, her skin ripped. Daughter reports her mother is frequently combative, and is suffering from a UTI. Pt has no other complaints at this time. -- That same date at 10:29 AM, it noted Resident #1 was ready to discharge and her [DIAGNOSES REDACTED]. Observation of Resident #1 at the facility in her room and in bed, on 09/11/14 at approximately 4:10 PM, revealed both arms were bandaged from her elbows to her wrists with purple bruising extending from the bottom of the bandage to the top/middle part of her hands. An interview with Resident #1 at that time revealed she could recall the incident. Resident #1 stated that black girl scratched me. Interview on 09/14/14 at 11:00 AM with LVN B revealed she had worked at the facility for almost one year. She stated she always worked weekend doubles and was on duty on 08/23/14. LVN B revealed on 08/23/14 CNA A came to her regarding a skin tear Resident #1 sustained. LVN B went to Resident #1's room and found Resident #1 lying sideways on her bed kind of crooked on the bed and at the foot of the bed with her arms drawn to her body. Resident #1 was dressed from the waist down with her pants and shoes on. The resident's wheelchair was positioned parallel to the bed. LVN B revealed CNA A told her she was getting ready to put Resident #1's shirt on and the resident started fighting. LVN B said when she approached the resident, she had blood all over the front her body but there was none on the bed. LVN B asked Resident #1 what happened. She stated Resident #1 told her she did not want to get up and CNA A pulled her by her arms and hurt her. She stated the injuries were from the elbow down to the wrists. LVN B revealed the resident's skin was pulled down to her wrists. She stated she was 'horrified at the injuries. LVN B revealed those were the worst injuries she had ever seen. LVN B continued by saying she had LVN C to come and assist her with pulling Resident #1's skin back up over the muscle on both arms. LVN B said Resident #1 had thin skin, and she saw the resident did not have any blood or skin under her nails and nothing on her hands which indicated to LVN B the resident did not make contact with CNA A. LVN B said she had RN D call 911 and contact the family and the doctor. LVN B revealed it was her opinion if things happened the way the aide told her, the resident's injuries would have been at the wrists and not the whole forearm. LVN B revealed the physician at the hospital called her to ask her what happened. The physician told LVN B Resident #1's injuries measured 10+ inches length on both arms. LVN B revealed she had provided care for Resident #1 over the past year and .if you rush her she gets combative or if she is tired. So you step away and come back later. LVN B said she never had a problem with Resident #1 being combative with her and she knew staff had to give the resident time and go back later if necessary. LVN B thought the CNA A was pretty nonchalant about the incident and did not display any emotion, which she thought was unusual because the injuries were so severe. LVN B had completed a written statement for the facility, dated 08/23/14. The statement reflected, (CNA A) came to me and stated that she was trying to get (Resident #1) up and she was getting aggressive. I went into the resident room and she was laying (sic) on her bed, both forearms had severe lacerations. I asked the CNA (CNA A) to please go get another nurse to assist me. Nurse (LVN C) came in to help apply pressure. Start first aide applied and there was a large amount of skin. Another nurse (LVN HH) went to notify the doctor & call the ambulance. (LVN HH) also notified (Resident #1's family member). I notified the (Administrator and DON). Had CNA write a statement and asked her to go home until she was notified. Resident stated she didn't want to get (up) and the CNA was pulling on her. An interview with the Paramedic, on 09/11/14 at 1:45 PM, revealed he responded to the 911 call from the facility. The Paramedic stated on 08/23/14 at 7:15 AM, his team had been picked to transport Resident #1 to the hospital for emergency medical services. The Paramedic stated a nurse met him at the door and she was crying because the resident's injuries were so bad. The Paramedic stated Resident #1 had large skin tears/shears to at least 50 to 60 % of both of her arms. He stated he had never seen injuries like that. An interview with LVN C on 09/14/14 at 11:25 AM confirmed LVN B came and got her to look at Resident #1's arms. She assisted LVN B with first aid. She stated the injuries were bad. The resident's skin was pulled down from her elbows to her wrists. LVN C revealed she had never seen injuries that bad and she had been a nurse for [AGE] years. She stated CNA A was nonchalant about Resident #1's injuries. LVN C revealed she had worked with CNA A for six months and she thought she was a good aide. She stated CNA A was different that day. LVN C revealed she read CNA A's statement and she did not think it was consistent with what happened. Review of LVN C's written statement obtained by the facility and dated 08/23/14, reflected, I was called to (Resident #1's) room by (LVN B) to look at res (resident's) arms. Large amt (amount) of skin was hanging from res fore arms. First aid rendered & 911 called. Review on 09/12/14 of CNA A's written statement obtained by the facility and dated 08/22/14 (sic), reflected I (CNA A) went to get (Resident #1) up about 6:30 AM in room (room number) and I went to set (sic) her up on the edge of the bed she started swinging end (sic) fighting and her arm hit the wheel chair that's when I notice her arms was (sic) bleeding so I laid her back in the bed and went and got the nurse (LVN B). An interview with CNA A 09/12/14 at 12:00 PM, confirmed she was the nurse aide who had assisted Resident #1 at the time of the incident. At the time of the interview, CNA A was noted to have a dark complexion and stand approximately 5 feet tall. She stated she had worked for the facility for almost one year. She stated she worked as a floater and thus worked different halls. She stated she currently worked four days on and two days off working the 6:00 AM to 2:00 PM shift. She stated she had received training in managing behaviors in the past and in-services on Abuse and Neglect. CNA A revealed prior to the incident with Resident #1, she had not really worked that hall. When asked how she could learn about the residents' characteristics, CNA A replied there were mini care plans in the residents' rooms. CNA A said she could also reference the ADL (Activities of Daily Living) book at the Nurse's Station for information about the resident. CNA A revealed the first day she worked with Resident #1, the resident was fine. She stated the day of the incident was the second time she had provided care to Resident #1. She stated she had cleaned Resident #1 in her bed, put her slacks and shoes on and swung the resident's legs around to the floor. When she got the resident to the edge of the bed, Resident #1 started swinging and cussing at her. CNA A stated she put her hands up to protect her own face and protect herself from the resident. CNA A revealed she thought the resident was falling backwards and that was when she grabbed the resident's arms to keep her from falling backwards. CNA A stated she was putting Resident #1 back in bed and that was when she saw the blood on Resident #1's arms. She did not indicate Resident #1 hit her arms on a wheelchair. She notified LVN B of what had occurred. CNA A stated if she could have done anything differently, she should have stepped away and let Resident #1 calm down and go back later. When asked why she did not take that action, CNA A replied she was not sure why. On 09/12/14, CNA A completed a second statement at the request of the Investigator. She noted, On the morning of Aug (August) 23 (2014) I went in to get (Resident #1) out of bed for breakfast. I got her dress (sic) in bed, she was fine, but once she sat up on the side of the bed she started to swing & pull back so for to keep her from hitting her head on the railing I grab (sic) her hands and she kept swinging so I put her legs back on the bed to lye (sic) her back down that's when I noticed her arms were bleeding so I went and got the nurse (LVN B) and they sent her out to the hospital and sent me home. Review of CNA A's personnel record reflected she was hired on 09/15/13. The record contained no evidence of prior counseling(s) for failing to implement a resident's assessed and care planned level of care or for causing physical injuries to a resident. Review of training records, reflected CNA A had received training on Abuse and Neglect four times, Resident Rights two times and Dementia care once during the year of 09/15/13 through 09/15/14. Review of CNA A's time punch records revealed on 08/24/14, 08/25/14, 08/26/14 she did not work. On 08/29/14, she returned to work and worked through 09/11/14. CNA A did not work any additional days. Interview on 09/11/14 at approximately 3:15 PM with the Administrator revealed she had conducted the investigation of the incident involving Resident #1 and suspended CNA A pending the outcome of the investigation. The Administrator stated CNA A was brought back to work because the CNA didn't do anything wrong. The resident was combative and flailing her arms sitting on the side of her bed. The CNA grabbed the resident's arms to protect the resident and her skin tore. The resident had very thin skin and the aide was small in stature. The family requested CNA A not provide care to Resident #1, and the CNA was subsequently moved to another hall. An interview on 09/11/14 at approximately 4:00 PM with the Staff Development Coordinator revealed she read the Provider Investigation Report, dated 08/23/14, about Resident #1's avulsions and CNA A's witness statement. The Coordinator stated her concern was CNA A's witness statement indicated she was defending herself from the resident with crossed arms and open hands and that did not add up. An interview with the Administrator on 09/12/14

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	676101	A. BUILDING _____ B. WING _____	09/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED TRANSITIONAL CARE AND REHABILITATION-RIDGM	6600 LANDS END COURT FORT WORTH, TX 76116

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

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) at approximately 3:45 PM revealed CNA A was suspended due to the surveyor's findings. The Administrator stated a decision on CNA A's employment would be determined based on the surveyor's findings. Further interview with the Administrator on 09/15/14 at approximately 1:10 PM revealed CNA A was terminated for failure to follow policies by not coming in to the facility to speak with the surveyor and Administrator. Interview on 09/12/14 at 2:00 PM with CNA D revealed he had been employed with the facility for a period of 10 months. He stated he had provided care for Resident #1 during seven of those months. CNA D revealed he never had a problem with her being aggressive or combative with him. He stated it was all in the approach with her. CNA D said it was all about what Resident #1 wanted. He revealed Resident #1 told him she and CNA A started to argue. He stated Resident #1 was able to recall what happened that day. Interview on 09/12/14 at 2:30 PM with LVN I revealed she had provided care to Resident #1 and some days she was combative. She stated it was all in the approach with the resident. LVN I revealed if the resident did not know someone, she might be combative. She stated someone could not just go in her room and start flipping the lights on and being abrupt. Review on 09/11/14 of the facility's current Abuse policy, with a release date 04/14/14, revealed, .physical and mental abuse.of the patient as well as mistreatment.are strictly prohibited.Patients have the right to be free of.physical, and mental abuse.of the patient as well mistreatment.1. Prohibitions on abuse apply to: a. Center staff.9. Identify patients most at risk of neglect and abuse, may include but is not limited to: a. Patients who have dementia. The facility's current Resident Refusal of Care policy, revised 04/28/10, reflected occasional refusals or failure to follow physician's orders [REDACTED]. Some residents consistently refused to accept or failed to follow the ordered treatment, therapeutic diet or services. Every attempt was made to accommodate the resident's request and still provide the appropriate care and services to meet the residents' needs while following the physician's orders [REDACTED]. On 09/24/14 at 6:10 PM., the Administrator, DON, LVN H, and LVN L were notified of the IJ had been identified for failure to ensure nurse aides provided residents their care planned level of care and services to prevent residents from sustaining serious injuries. Interview on 09/25/14 at 9:40 AM with the DON revealed since the incident with Resident #1, all Unit Managers now had a tool they could use that addressed staff interactions with the residents, identified as having behaviors. She said they initiated the in-services on 09/24/14. The training provided to staff included: How to recognize burnout, Kardex/CNA for CNA use regarding a resident's care requirements including behavior interventions, resident rights and abuse and neglect. Skin assessments were initiated on 09/12/14 and residents with fragile skin were identified to be at high risk for skin tears and the information was added to their care plans. Training for management/staff was provided in the area of residents with fragile skin and skin tear prevention. Audit rounds would be conducted by Nurse Managers and they would utilize a tool developed to monitor CNAs' knowledge of residents resistive to care, where they locate information pertaining to the residents and refusal of care. The tool was to be utilized by managers daily. All staff would be trained and those who had not had the training would not be allowed to return to work until they had received the required in-services. On 09/25/14, the Administrator was notified their Plan of Removal was accepted. The Plan of Removal, dated 09/25/14, reflected the following: -- Upon return from the hospital the resident (Resident #1) was evaluated and seen by the facility's certified Wound Care Nurse.The resident's Wound Care Physician , evaluated the resident's skin condition upon on 8/29/14. Additional skin treatment orders were ordered by wound care physician 8/29/14.The resident's care plan was reviewed and updated on 8/23/14 to reflect current health status by the facility's Minimum Data Set (MDS) nurse,(sic). The patient's medical history provides documentation of behavioral changes related to infection (UTI). The resident's care plan reflects this information.(CNA A) was suspended pending outcome of facility investigation 8/23/14 and ultimately terminated from facility employment. -- On 08/23/14, CAN A was suspended pending the outcome of the facility's investigation. -- On 8/29/14, CNA A was re-in serviced on abuse related to this incident, and how to effectively deal with combative residents; this training was provided by the Staff Development Coordinator (sic). -- A Safe Survey was conducted after (CNA A) return on several residents throughout the facility whom (CNA A) had provided care with no negative outcome. (CNA A) returned to duty on 08/29/14 after the facility had completed its initial investigation of the incident. -- On 09/11/14, as a result of a complaint survey initiated by DADS, further details emerged questioning (CNA A) original statement. The facility reopened its investigation on 09/11/14. She (CNA A) was suspended as a result the reopening of the investigation. As a result of the facilities (sic)reopened investigation she was terminated on 09/15/14 primarily for her inability to provide a consistent statement regarding the incident with (Resident #1) on 08/23/14. (CNA A) failed to meet the facility standards of providing the highest standard of care to its residents. The facility is vigilant in protecting our residents from perceived mistreatment.Residents with behaviors were identified by resident assessment report in Point Click Care, electronic charting program, on 9/23/14. - The behavioral care plans and Certified Nursing Assistant (CNA) Kardex, (Kardex are a resource for CNAs, like a mini care plan to give personalized care to individual residents). Fragile skin is skin that has very thin tissue do to the loss of subcutaneous tissue. -- All of the residents identified were reviewed, and updated to reflect resident's current behavioral status by Director of Nursing, Unit Managers, (LVN H) and Assistant Director of Nursing ,(LVN J). -- The following residents have been identified with the potential for behaviors: (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, and #18).Identified residents exhibit the following types of behaviors; resistance to care, verbal outburst, inappropriate language, disrobing. -- Additionally, to assist in identifying the residents at risk, the facility consultant pharmacist reviewed residents receiving psychotropic medication to assure that appropriate recommendations are reviewed by resident's physician and subsequent orders are implemented by the licensed nurse; this review is done monthly and was last completed on 9/15/14. This review assures that the resident receives the appropriate medication to assist with behavior management and prevent adverse side effects. The consultant pharmacist will provide a monthly report of his/her review to the Director of Nursing. The Director of Nursing, will present a summary of the report to the Facility's Performance Improvement Committee on a monthly basis; this will be an on-going measure/intervention. -- Ad lib referrals to psychology and psychiatric services are determined by resident review in the Interdisciplinary Clinical Rounds (nursing, dietician, Social Worker, MDS, and Activities, process that occurs at least 5 days weekly. The Clinical Rounds Process is retrospective review of clinical needs of residents identified by the center's 24- hour reporting system. This process was implemented in February 2014 and is an ongoing facility practice with no end date. -- Residents identified will be discussed to assure that proper measures/interventions are implemented to resolve clinical concerns, assure that the MD and families are notified of concerns along with any appropriate follow up measures, care plans reviewed and updated and or created as new condition warrants, and that interventions are monitored until the clinical concern is resolved. -- All Kardex have been updated and are located at the nursing station for added security and confidentiality.Kardex will also notate residents identified with behaviors for additional interventions and suggestions to assure care is optimally provided. -- CNAs have been educated and are required to check it frequently for changes, as well as adding appropriate/helpful information. CNAs were in-serviced on Assessing Risk of Challenging Behaviors, Resident Rights, and Resident's Rights to Refuse Care, Definition(s) of Abuse, Behavioral Management, and Skin Tears: Prevention and Management, the dates of the in-services were on 09/12/14 -09/15/14. As part of the training, CNAs were in-serviced on the expectation of reviewing the Kardex prior to the start of each shift to assure that the CNA has the most updated information regarding the president's plan of care. Competency was evaluated and determined by questionnaire given by the Director of Nursing.This quiz tested the employee's knowledge of the following: How to deal with combative residents, Resident Right to refuse Care, notification to nursing supervisor and understanding that resident care is primary function. If employee missed more than one (1) question, additional training was provided. -- Additionally nursing staff have been in-serviced on 'burnout' and sign and symptoms of, as well as prevention and what to do if detected. quiz tested the employee's knowledge of the following: How to deal with combative residents, Resident Right to refuse Care, notification to nursing supervisor and understanding that resident care is their primary priority.Education/in-servicing was initiated and provided by the Staff Development Coordinator, 9/12-9/15/14. This education included: Assessing Risk of Challenging Behaviors, Resident Rights, Resident's Rights to Refuse Care, Definition(s) of Abuse, Behavioral Management, Skin Tears: Prevention and Management. These in-services were for Licensed Nurses and CNAs. Staff education was initiated and conducted by the Staff Development Coordinator on 8/25/14 for licensed nurses and CNAs on abuse training and how to effectively care for the combative resident. Subsequent staff education concluded on 9/13/14. -- As of 9/13/14, current licensed nurses and CNAs received the above training/education, and will be on-going annually and as needed.Additionally CNAs were educated on resident's plan of care, understanding the resident is priority, and steps to take when resident is combative.The competency evaluation(s) associated with this training was determined through quiz/test. This quiz tested the employee's knowledge of the subject matter. If employee missed more than one (1) question, additional training was provided.The facility will incorporate a behavior management review daily in the clinical rounds meeting. The behavioral management

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) review will utilize an interdisciplinary approach to identify and analyze root cause(s) of behaviors. To verify the facility had implemented their Plan of Removal the following was conducted: -- Review of in-service training records for facility employees on all shifts confirmed training had been provided in the areas of : How do you identify burnout and what to do., fragile skin, Kardex (Resident information for the Certified Nurse Aides) and expected CNA use regarding a residents care, resident care requirements to include residents who had been identified with behaviors and expected staff interventions, resident rights and training in the area of abuse and neglect. Review of the sign in sheets revealed out of 128 employees all had received the in-service training except for 6 employees. - Review of the care plans for the identified 18 residents who were identified as exhibiting behaviors confirmed their care plans and Kardex records had been updated to reflect the identified behavior. -- Interview with the Administrator and the DON on 09/25/14 at 3:45 PM revealed they had already met on 09/23/14 with the Medical Director as part of the Quality Assurance Review related to the incident and addressed other quality concerns. - Interviews were conducted with staff, representing staff from each shift and working weekdays and/or weekends. The staff interviewed were three LVNs (LVNs L, R and U); 17 CNAs (CNAs M, N, O, P, Q, S, T, V, W, X, Y, Z, AA, CC, DD, EE and FF); Housekeeping Manager, Social Worker, Business Office Manager and Business Office Assistant. Each employee was able to articulate what constituted abuse and/or neglect, how they would determine the level of care a resident required, and what action they would take if they observed an employee continuing to provide care for a resident exhibiting a behavior of resistance to care. On 09/29/14 at 12:15 PM, the Administrator was informed the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy, and a scope of isolated because the facility was still monitoring the effectiveness of the Plan of Removal. The facility's Plan of Removal, dated 09/25/14, reflected 18 residents were at risk for behaviors including Resident #1.