STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115516	A. BUILDING _____ B. WING _____	01/08/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH - LILBURN	788 INDIAN TRAIL ROAD LILBURN, GA 30047

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 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure that after verbal abuse was reported and the resident was protected for one (1) resident (R#1) of the nine (9) sampled residents. Resident #1 suffered actual verbal abuse and alleged physical abuse. Based on the corrective actions that the facility implemented immediately upon discovery, it was determined that a past noncomplaince beginning on 12/25/2015 and corrected on 12/29/2015. On 12/25/2016, R#1 was verbally abused and allegedly physically abused by a Certified Nursing Assistant. Upon discovery of the allegation on 12/27/2015, the facility took immediate actions including: 1. All staff was re-educated on the Abuse Policy including reporting and recognition of Abuse by the Administrator, Director of Nursing and/or Social Services, completed on 12/29/15. 2. All new staff will be educated during the orientation program by the Administrator and the Social Service Director with post testing. All 129 staff have been educated. 3. A Resident Rights inservice was conducted including the Hand in Hand module. 4. The staff identified to witness the verbal abuse was re-educated and had received training in September and December 2015. Direct one-to one (1:1) education was also provided. In addition a verbal reprimand was completed on timely reporting. 5. Residents were interviewed by social services to ensure they felt safe and had no reports of abuse. 6. Weekly meetings will continue to be held with residents to address concerns of issues that affect them. 7. The Family Council has been reinstated and the first meeting was conducted on 1/10/2016. 8. Mandatory manger rounds to communicate with staff, residents and family members occur daily. 9. All identified problems will be forward to the QAPI for investigation and resolution. Findings include: Review of the medical record for Resident #1 revealed an admission date of [DATE]. Review of the record revealed the primary language is Spanish. The resident has [DIAGNOSES REDACTED]., [MEDICAL CONDITION] below Knee-Secondary to Diabetes, Diabetes, Muscle Weakness-general, Lack of Coordination, Cognitive communicate deficit, [MEDICAL CONDITION], and Chronic Ischemic [MEDICAL CONDITION]. Review of the Minimum Data Set (MDS) 3.0 Assessment Summary Report dated 12/1/15 indicated a Brief Interview for Mental Status (BIMS) score of 4.0, indicating severe cognitive impairment. Observation on 1/6/16 at 9:30 a.m. revealed resident #1 lying in bed, eyes closed with bruising under left eye. The head of bed elevated with padded grab bars (2) up. Fall mats on the left and right side of bed. Interview on 1/6/15 at 11:30 a.m. with R#1 revealed that she did not remember what happened to her eye. Review of the Police Department Incident Report indicated that on 12/27/15 around 11:46 a.m. the police indicated that they made contact with R#1 family. The police officer revealed that the family was in the room with the resident to help her explain the incident. The police officer revealed that the family explained they had come to visit R#1 daughter for Christmas. When they arrived on 12/27/15 around 11:00 a.m. they observed R#1 had a swollen black eye. They stated they asked R#1 what happened. Then R#1 stated to the family that on 12/25/15 early in the morning a Certified Nursing Assistant (CNA) entered the room to change her. During the changing process the CNA punched, R#1 in the left eye. R#1 described the CNA was a black female around 5' 8 with short black hair, slimmer body build and appeared to be young. R#1 revealed that the CNA had taken care of her before on different days; but, did not know her name. The police asked the resident if she would be able to recognize the CNA again; she revealed that she would. The resident was asked if the CNA was at work that day, she revealed that the CNA was not at work. Review of Situation Behavior Assessment Report (SBAR) Communication Form dated 12/27/15 indicated situation- drainage in left eye. Request: family at bedside of R#1. Family called 911, and wants R#1 to be transferred to emergency room (ER) for drainage of left eye. R#1 transferred to ER per family request via stretcher. Review of the Physician's Interim Orders indicated an order dated 12/27/15 for X-Ray of left orbit. Review of the physician's orders [REDACTED]. Review of the Discharge Instructions for R#1 dated 12/27/15 from the hospital indicated discharge instructions-Nasal Fracture and Subconjunctival Hemorrhage-Brief (which may be due to injury or to straining (lifting,sneezing, or coughing). Review of the Ear Throat NoseMedical Doctor (MD) indicated R#1 was seen on 12/31/15 and [MEDICATION NAME] Propionate 50 MCG/ACT Suspension 2 spray each nostril QD (every day) was ordered. Review of the Radiology Report dated 1/4/16 indicated exam: X-Rays of the Nasal Bones, findings: No gross nasal bone fracture. Bone mineral density is preserved. The maxillary spine is grossly intact bilaterally. Review of Eye MD assessment of R#1, dated 1/5/16 indicated a [DIAGNOSES REDACTED]. 1. Interview on 1/6/16 at 2:29 p.m. with Housekeeping staff NN revealed attending classes on abuse. Housekeeping staff NN revealed that he had not seen any physical abuse towards the residents. Continued interview on 1/6/16 at 2:29 p.m. with Housekeeping staff NN revealed that on 12/25/15 at about 9:45 a.m., he was asked to get some pillowcases. Housekeeping staff NN revealed that he and Housekeeping staff OO were outside of R#1 room. Housekeeping staff NN revealed that CNA JJ was inside of the doorway of R#1 by herself. Housekeeping staff NN revealed that he heard CNA JJ say to the R#1 , don't give me a f-cki-n- hard time about putting on your clothes!. Housekeeping staff NN revealed that when CNA JJ saw him, JJ closed the door. Housekeeping staff NN revealed that JJ later came out and asked another CNA (KK) to help her. Housekeeping staff NN revealed that he left the area. Housekeeping staff NN further revealed seeing R#1 on 12/25/15 in the morning and, that R#1 did not have any problems with her eye. Housekeeping staff NN revealed seeing R#1 on 12/26/15 around 7:00 a.m. to 7:15 a.m. when he arrived for dusting and mopping of the floor. Housekeeping staff NN stated that R#'1's eye were puffy, messed up, black and bruised. Housekeeping staff NN revealed that one of the nurses that speak Spanish, the Supervisor on the weekend spoke Spanish asked R#1 what happened and no one knows. Review of a written signed statement by Housekeeping NN confirmed the above interview, including hearing the verbal abuse from CNA JJ to R#1, and leaving the area without intervention. In review of the written statement, he described the door to be slammed. 2. Interview on 1/6/15 at 1:19 p.m. with CNA KKrevealed that she has had inservice on abuse. She revealed on 12/25/15 CNA JJ asked if she could come over to help with R#1. She revealed that after she finished with her resident, she went to assist CNA JJ with R#1. She revealed that while helping with R#1, she noticed one of resident's eye was closed. She revealed that she asked, CNA JJ why was the resident's eye closed and CNA JJ stated that she did not know, but that she noticed that the

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

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F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) R#1 eye was grayish. Continued interview on with CNA KK revealed that License Practical Nurse (LPN) LL completed an assessment on R#1, and notified the Supervisor Registered Nurse (RN) MM. CNA KK revealed that she did not hear any noise coming from R#1 room, and normally R#1 would fight when care was given but, R#1 was at ease. CNA KK continued to reveal that LPN LL had given R#1 medication to keep R#1 calm. Then, CNA KK asked R#1, what happened to her eye, she revealed that the resident revealed that a lady hit her; but, she could not remember who. CNA KK revealed that the eye looked grayish. She revealed that this occurred right before 11:30 am - lunch time (on 12/25/15). She revealed that R#1 did not seem to be frighten of CNA JJ. CNA KK revealed that R#1 did not make any type of move as if afraid of the CNA JJ. CNA KK revealed that the door was open across the hall from R#1 room; and, that she did not hear any screaming from R#1, whose her door was cracked open. Review of the Medication Record for R#1 dated 12/1/15 through 12/31/15 indicated [MEDICATION NAME] (a medication used for anxiety) tablet 0.5 mg one (1)tablet was administered given 12/25/15 at 8:00 a.m. and 1:00 p.m. Second interview on 1/8/16 at 2:00 p.m. with CNA KK revealed that they (CNA JJ) were transferring R#1 with the Hoyer lift from the bed to the chair, when she noticed R#1 eye, it was grayish, the eye was not able to be opened, and it was red. CNA KK revealed that the R#1 was not combative because the nurse had given her medication and the nurse said that it was a reaction to medication. 3. Interview on 1/8/16 at 1:34 p.m. with LPN LL confirmed that she was the nurse on duty 12/25/15 of the 7-3 shift. LPN LL revealed she saw R#1 on 12/25/15 as follows: at 7:00 a.m. to 7:30 a.m., rounds were made and R#1, had no problems; at 9:00 a.m. R#1 received medications and had no problems, and; at 11:00 a.m. to 12:00 p.m. Supervisor RN MM, CNA JJ and CNA KK were in R#1 room, when R#1 left eye was discolored and was a little swollen. LPN LL revealed that she asked what happened to the the eye, and no one knew what had happened. LPN LL stated that all the staff noticed the resident's eye at the same time. She revealed that she asked the resident what happened to the eye, and R#1 did not say any thing. LPN LL revealed documenting and completing the Situation Behavior Assessment Report (SBAR) communication form. LPN LL revealed that she notified the MD and Family. LPN LL revealed that she talked to the MD, they were not sure of what had happened to the resident's eye, an eye ointment was ordered. LPN LL stated the family said, okay about the eye. LPN LL revealed that the CNAs have had abuse inservices. She revealed that the CNA's were using the Hoyer Lift. Review of the SBAR Communication Form dated 12/25/15 indicated situation-increase swelling, increase redness, increase discoloration to left eye. Request: On call Nurse Practitioner (NP) notified-new order received to start [MEDICATION NAME] 0.5% oint every six (6) hours for seven (7) days. Responsible Party J notified. 4. Interview on 1/6/16 at 1:35 p.m. with Supervisor Registered Nurse (RN) MM revealed that she had inservice on abuse and that there had been no complaints about resident abuse to her. Supervisor RN MM confirmed being the supervision on 12/25/15. RN MM stated that the staff called her to say that the family of R#1, called to say that they were taking R#1 out for the day. Supervisor RN MM revealed that R#1 had to be taken out in a reclining chair, because the resident could not sit in a wheelchair. Supervisor RN MM stated that she went to do the assessment on R#1, and noted the resident's left eye was red and swollen. Supervisor RN MM revealed that she instructed the LPN LL to notify the Medical Doctor (MD) and the family. Supervisor RN MM revealed that LPN LL notified the MD and the family about the eye and the need of a recliner. The family decided not to take R#1 out at that time. Supervisor RN MM revealed assessing the eye to have an infection due to the redness and the swelling. The MD was notified and antibiotics were ordered. Supervisor RN MM that all of this took place around the time that the residents were dining on 12/25/2015. Supervisor RN MM revealed that she requested all the staff write a statement, since they did not know what happen to R#1 revealed that she notified the Administrator and the Director of Nursing of what had happened. Supervisor RN MM revealed that she did not talk to the family, or R#1, however she stated that R#1 did not appear to be afraid of anyone of make any type of motions indicating fear while they were in the room. Supervisor RN MM revealed that LPN LL talked to the family on 12/25/2015, about the eye, and again on that the resident's eye was red; and, on Sunday 12/27/15 when the family came to visit R#1. 5. Interview on 1/6/16 at 3:54 p.m. with LPN PP of the 3-11 shift revealed that she has had inservices on abuse. She revealed that she had not seen any abuse towards the residents. LPN PP revealed that R#1 was sometime combative; and, that usually more that one person takes care of the resident. LPN PP revealed that she came in on the evening of the allegation (12/25/15) and saw the left eye of R#1 red with pockets under it. LPN PP revealed that she asked the R#1 what happened to her eye, and R#1 would not answer. LPN PP revealed that she went and got a nurse that speaks Spanish to ask her what happen to her eye. She revealed that the resident would not explain any thing to the nurse LPN QQ . She revealed that the R#1 was started on antibiotics for her eye and it started clearing up. She revealed that the next day the swelling started going down, and the left eye sclera was clearing. She revealed that she did not see any problems with the R#1 nose. She revealed that she sent in the evening CNA to R#1; but, she would not talk to her about her eye. 6. Interview on 1/6/16 at 4:09 p.m with CNA RRof the 3-11 shift revealed that she has had inservices on abuse. She revealed that she has not seen any abuse; and, there had been no report from any family members about abuse. She revealed that she took care of R#1, that she asked R#1 what happened to her eye, R#1 revealed that she did not remember what happened to her eye. She revealed that she has a good relationship with R#1. 7. Interview on 1/6/16 at 4:21 p.m. with LPN QQ of the 3-11 shift revealed that he has had inservice on abuse. He revealed that he has not seen any abuse towards the residents. LPN QQ revealed that nurse PP asked him to go and talk to R#1, to see if she would tell him what happened to her eye. He revealed that he and the resident spoke the same language (Spanish). LPN QQ revealed that R#1 revealed that she did not know what happened. 8. Interview on 1/6/15 at 1:03 pm with the Social Worker II revealed that she interviewed R#1 and other staff members about the abuse allegation to R#1. She revealed that she turned her investigation over to the Administrator. She revealed that R#1 revealed that a thin white lady hit her in the eye with her fist. She revealed that R#1 further revealed that she was not afraid of the staff members. She revealed that the allegation supposedly occurred on the 7-3 shift on 12/25/15. She revealed that she talked to CNA JJ who revealed that CNA KK assisted her with R#1. 9. Interview on 1/6/16 at 3:43 pm with the Administrator revealed that she had training with all the staff since the allegations; and, that there was abuse training before the allegations. She revealed that she was unable to substantiate the cause of the eye injury and that she turned in her investigation to the state regulatory agency. She revealed that she went to the hospital to interview the resident; but, was not allowed to do so. She revealed that she was told by the nursing staff that they felt that it was an eye infection; because, the R#1 constantly played in feces and rubbed her eyes. She revealed that a Psych consult was completed on the resident. She revealed that the CNA JJ was inconsistent about what happened to R#1. The CNA JJ was terminated. She revealed that there had been no problems with the CNA prior to this allegation. Interview on 1/8/16 at 2:02 pm with the Administrator revealed that the MD saw the resident on 1/5/16. She revealed that the R#1 had been seen by the ENT and the EYE doctors before the MD visit. She revealed that the MD did not believe that R#1 had a nasal fracture; but, he did believe that there was trauma to her eye. She revealed that the nurses are doing two (2) hour checks on the resident,monitoring her constantly and reporting to the family. She revealed that no facility has accepted the R#1; so the family plan to take R#1 home by the end of the month.
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** Based on review of the Policy entitled, Prevention of Abuse, Neglect and Exploitation, record review and interview the facility failed to effectively implement their own policy to assure that resident abuse did not occur, and when it occurred the facility failed to ensure that employees followed the policy. This failure resulted in actual harm to one (1) resident (R#1) of the sampled (9) residents.

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) On 12/25/2016, R#1 was verbally abused and allegedly physically abused by a Certified Nursing Assistant. Upon discovery of the allegation on 12/27/2015, the facility took immediate actions including: 1. All staff was re-educated on the Abuse Policy including reporting and recognition of Abuse by the Administrator, Director of Nursing and/or Social Services, completed on 12/29/15. 2. All new staff will be educated during the orientation program by the Administrator and the Social Service Director with post testing. All 129 staff have been educated. 3. A Resident Rights inservice was conducted including the Hand in Hand module. 4. The staff idenitified to witness the verbal abuse was re-educated and had received training in September and December 2015. Direct one-to one (1:1) education was also provided. In addition a verbal reprimand was completed on timely reporting. 5. Residents were interviewed by social services to ensure they felt safe and had no reports of abuse. 6. Weekly meetings will continue to be held with residents to address concerns of issues that affect them. 7. The Family Council has been reinstated and the first meeting was conducted on 1/10/2016. 8. Mandatory manger rounds to communicate with staff, residents and family members occur daily. 9. All identified problems will be forward to the QAPI for investigation and resolution. Cross reference to F223 Findings include: Review of the policy entitled, Prevention of Abuse, Neglect and Exploitation, revision date of 9/21/2015, revealed the following: Procedures: 1. Providers are to identify, correct and intervene in situation in which abuse, neglect, or exploitation may occur. This should include an analysis of: The supervision of staff to identify in appropriate behaviors, such as using derogatory language; Interview on 1/6/16 at 2:29 pm with Housekeeping staff NN revealed that on 12/25/2015 at 9:45 a.m. that he was outside of R#1 room, and that CNA JJ was inside of the room with R#1, and CNA JJ said to R#1, don't give me a f-cki-n- hard time about putting on your clothes!!. He revealed that when she saw him, JJ closed the door. He revealed that he left. Interview on 1/6/16 at 1:35 p.m. with Supervisor Registered Nurse (RN) MM revealed that there had been no complaints about resident abuse to her. Supervisor RN MM revealed that she was the supervisor on duty 12/25/15.
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure that the plan of care was implemented to include assistance of two (2) when giving care to one (1) resident (R#1) of the nine (9) sampled residents. On 12/25/2016, R#1 was verbally abused and allegedly physically abused by a Certified Nursing Assistant. Upon discovery of the allegation on 12/27/2015, the facility took immediate actions including: 1. All staff was re-educated on the Abuse Policy including reporting and recognition of Abuse by the Administrator, Director of Nursing and/or Social Services, completed on 12/29/15 . 2. All new staff will be educated during the orientation program by the Administrator and the Social Service Director with post testing. All 129 staff have been educated. 3. A Resident Rights inservice was conducted including the Hand in Hand module. 4. The staff identified to witness the verbal abuse was re-educated and had received training in September and December 2015. Direct one-to one (1:1) education was also provided. In addition a verbal reprimand was completed on timely reporting. 5. Residents were interviewed by social services to ensure they felt safe and had no reports of abuse. 6. Weekly meetings will continue to be held with residents to address concerns of issues that affect them. 7. The Family Council has been reinstated and the first meeting was conducted on 1/10/2016. 8. Mandatory manger rounds to communicate with staff, residents and family members occur daily. 9. All identified problems will be forward to the QAPI for investigation and resolution. Cross reference to F 223 Findings include: Review of the medical record for Resident #1 revealed an admission date of [DATE]. Review of the record revealed the primary language is Spanish. The resident has [DIAGNOSES REDACTED]., [MEDICAL CONDITION] Below Knee-Secondary to Diabetes, Diabetes, Muscle Weakness-general, Lack of Coordination, Cognitive communicate deficit, [MEDICAL CONDITION], and Chronic Ischemic [MEDICAL CONDITION]. Review of the Minimum Data Set (MDS) 3.0 Assessment Summary Report dated 12/1/15 indicated a Brief Interview for Mental Status (BIMS) score of 4.0, indicating severe cognitive impairment. Review of R#1 Care Plan dated 7/4/2012 revealed a problem statement, Socially inappropriate/disruptive behavior, yells out at staff and other residents and refuses to participate in therapy. Interventions include, two (2) staff to provide care, if resident is upset, do not provide care. Review of R#1 Care Plan dated 8/18/15 indicated residents makes false statements about staff, approach included to respond immediately to any criticism or complaints. Refer concerns to appropriate persons to discuss solutions. Respond calmly without defense to negative type statements. Review of R#1 Care Plan dated on 3/20/15, indicated socially inappropriate/disruptive behavior R#1 yells out at staff and other residents, plays with feces, and refuses to participate in therapy. Interview on 1/6/16 at 2:29 p.m. with Housekeeping (HSK) NN revealed that on 12/25/2015 at about 9:45 a.m., he was asked to get some pillowcases. HSK NN revealed that he and HSK OO were outside of the room of resident #1. HSK NN revealed that CNA JJ was inside of the room with resident #1 by herself. HSK NN revealed that he heard CNA JJ say to resident #1 , don't give me a f-cki-n- hard time about putting on your clothes!. Per the interview with Housekeeping employee NN, CNA JJ entered R#1 room alone, after verbally abusing R#1.