STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445297	A. BUILDING _____ B. WING _____	05/08/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONCORDIA NURSING AND REHABILITATION-NORTHHAVEN	3300 BROADWAY NE KNOXVILLE, TN 37917

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on review of facility policy, medical record review, review of a facility investigation, observation, and interview, the facility failed to prevent abuse for 1 resident (#1) of 5 residents reviewed for abuse, which resulted in Resident #1 leaving the facility, being given alcohol, and being sexually assaulted. The facility's failure resulted in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). F-600 was cited at a scope and severity of J and is Substandard Quality of Care. The Nursing Home Administrator was informed of the Immediate Jeopardy (IJ) on 5/7/18 at 11:00 AM, in his office. The IJ was effective from 2/25/18 through 2/27/18. The IJ was removed on 2/28/18. The facility implemented a corrective action plan and corrective actions were validated onsite by the surveyor on 5/7/18 and 5/8/18. The IJ was cited as past noncompliance and the facility is not required to submit a plan of correction for those tags. The findings included: Review of facility policy, Resident Elopement, dated 11/28/17 revealed .identify when a resident has left the premises or a safe area without authorization and/or any necessary supervision to do so . Review of facility policy, Abuse, dated 11/28/17 revealed .Verbal, sexual, physical and mental abuse .are strictly prohibited . Medical record review of Resident #1;s Pre-Admission Screening and Resident Review (PASRR) document dated 7/26/17 revealed .This Level 1 shows her (Resident #1) to have suspected [MEDICAL CONDITION] and [MEDICAL CONDITION] disorder, alcohol and cocaine use disorder with most recent substance use in the past 15-30 days and dementia/neurocognitive disorder presenting with significant difficulty (with) communication, ambulating and/or completing routine motor tasks, recognizing familiar people or familiar objects, and has short/long term memory impairment. [MEDICAL CONDITION] medications have been prescribed. Currently or within the past 30 days, (resident) has had serious difficulty interacting with others, she has made substantial errors with tasks and she has experienced a life disruption due to mental health symptoms. (Resident) received mental health crisis services in the past 2-6 months and history of suicide attempt or gestures in the past 25 months - (to) 5 years and suicide attempt greater than 5 years ago . Medical record review revealed Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of Resident #1's care plan, dated 11/8/17, revealed the resident was at risk for elopement due to impaired safety awareness and the intervention was the placement of a wander guard bracelet (device worn by residents which automatically locks any facility exterior doors and sounds an alarm when approached by residents) on the resident's ankle. Medical record review of the Quarterly Minimum Data Set ((MDS) dated [DATE] revealed the resident scored a 15 (cognitively intact) on the Brief Interview Mental Status (BIMS). Continued review revealed the resident required supervision for bed mobility, transfers, and toilet use with 1 person assist, and required limited assist for bathing with 1 person assist. Review of a facility investigation dated 2/26/18 revealed, on 2/25/18 at approximately 9:00 PM, the facility staff were unable to locate Resident #1 and initiated the protocol for elopement of a resident. Continued review revealed the facility staff searched all rooms in the facility and the outside grounds and notified the Administrator and local police department of the missing resident. At approximately 10:15 PM, Resident #1 was returned to the facility by the alleged perpetrator, smelled of alcohol, and was unable to stand and exit the alleged perpetrator's vehicle. Further review revealed Licensed Practical Nurse (LPN) #2 and Certified Nurse Assistant (CNA) #4 assisted Resident #1 out of the vehicle, transferred her into a wheelchair, and took her to her room. Continued review revealed Resident #1 reported the alleged perpetrator took her out of the facility, got her drunk, and sexually assaulted her. LPN #2 notified the Nurse Practitioner (NP) and an order was obtained to send the resident to the hospital for evaluation and treatment. Medical record review of an acute care hospital nurse's triage note dated 2/25/18 at 11:14 PM, revealed .presenting complaint .EMS (emergency medical services) states called to (facility) for altered mental status .staff told EMS that another resident took pt's (patient's) wondering (wander) bracelet off of her and took her somewhere .pt. returned to facility intoxicated .asked what he had done to her .resident replied 'I (sexually assaulted)' .KPD (Knoxville Police Department) present at this time . Continued review of a hospital physician's note dated 2/26/18 at 5:01 AM revealed .patient is in nursing home due to prior TBI [MEDICAL CONDITIONS]([MEDICAL CONDITION]). She was taken out of the NH (nursing home) by another resident's family. She returned intoxicated and stated she had been sexually assaulted . Medical record review of a nurse's note dated 2/25/18 at 11:46 PM (documented after the resident was sent to the hospital) revealed .Resident observed with slurred speech, unable walk or stand without assist, C/O (complains of) lower ABD (Abdominal) pain. Call to NP .sent to ER (emergency room) for evaluation . Medical record review of a hospital laboratory test result dated 2/26/18 revealed the resident's blood alcohol level was 0.19% (twice the legal limit). Medical record review of a psychiatric services progress note dated 2/26/18 and signed by Advanced Practice Nurse (APN) #2 revealed .History of Present illness: long term resident seen today for follow up at the request of staff. Last night, patient (Resident #1) was drinking with another resident and her male friend in facility. This patient (Resident #1) and the male friend cut off her wander guard, and exited facility and continued drinking. Patient has reported while she was out of the facility she was raped by male she was with .Staff report today, patient has been tearful and keeps to herself. She reports being 'sore' .recommend addition of [MEDICATION NAME] (antianxiety medication) 0.5 mg (milligrams) BID (twice daily) PRN (as needed) X (times) 7 days . Medical record review of a skin assessment dated [DATE] revealed .Site Lt (left) elbow, Description Bruise; Site Between Legs Description Red Bruises; Site Top of Lt hand Description Bruise; Site Rt (right) forearm Description Bruise . Observation and interview with Resident #1 on 5/1/18 at 2:30 PM, in her room, revealed .I knew him from that room over there where we go smoke .he was drinking and he was talking to me and we was going to get beer .don't like to talk about it (incident) . the psychiatrist is supposed to help me (coping with emotions from the assault) .I hope he (perpetrator) was put in jail .we went out the side door on the long hall (Northeast side of the building) .he forced himself on me . Observation on 5/1/18 revealed the facility had 4 entrance/exit doors with keypads that required a code to open or enter/exit: 1 main entrance doorway; 1 ambulance entrance/exit visible from nurse station #1; and 2 entrance/exit doors on the Northeast side of the building, which lead to the parking lot, with one of those doors visible from nurse station #2 and the other door not visible from any nurses station. Interview with the Maintenance Director on 5/2/18 at 4:15 PM, in his office, revealed .(Resident #1) wore a wander guard

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

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONCORDIA NURSING AND REHABILITATION-NORTHHAVEN	**3300 BROADWAY NE KNOXVILLE, TN 37917**

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) bracelet and on the day of the incident family members, friends, and all staff had the code to the doors .the same code was used on all of the doors .would change the door code monthly . Interview with the Social Services Director on 5/2/18 at 6:30 PM, in the conference room, revealed Resident #1 .is alert and oriented and can answer questions but her decision making and memory is not good .can try and educate her but she won't remember .met with her daily for 5 days (2/26/18 - 3/1/18) .still visit her weekly .the psychologist continues to visit her . Interview with Certified Nurse Assistant (CNA) #4 on 5/2/18 at 6:55 PM, in the conference room, revealed .it was after dinner .was making (resident) rounds .noticed (Resident #1) in (another resident's) room talking to the resident and her boyfriend .she does not normally go into the room .I went into the room and when I entered they all snickered .I went and told (LPN # 2) I thought something was going on and she told me to tell them both to leave the room .was always suspicious of him .he would say off the wall things .we looked everywhere .I got in my car and drove up and down (street) because I knew what his van looked like .just after I returned to the facility (LPN #2) asked me to come help her because (Resident #1) could not get out of the van .around 10:15 PM .Seemed like she (resident) was intoxicated or on something .she said 'He got me (expletive) up' .he (alleged perpetrator) was making excuses .her wander guard was found in the trash .was cut off . Interview with the Nurse Practitioner (NP) #1 on 5/3/18 at 10:45 AM, in the conference room, revealed .She (Resident #1) changes her story but consistently says he raped her .I think he brought in alcohol and enticed her .she is classic [MEDICAL CONDITION] .history of substance abuse .does not have the ability to make good decisions . Interview with LPN #3 on 5/3/18 at 11:00 AM, in the conference room, confirmed completion of a skin assessment on 2/26/18, which revealed Resident #1 had bruises to bilateral elbows, left wrist, right forearm, redness to both knees, and redness and bruising between her thighs. Continued interview revealed .she had knots on her head .she told me he pulled her hair . Interview with the Clinical Psychologist on 5/3/18 at 11:30 AM, in the activity room, revealed .the ability to make good decisions is not there .she (Resident #1) still having flashbacks .still has anger about the situation .has had an increase in the number of outbursts . Telephone interview with the Violent Crimes Investigator on 5/7/18 at 9:00 AM, revealed .The case is still open .will take another 2-3 months to get the results of the DNA (deoxyribonucleic acid) testing . Interview with Resident #1 on 5/7/18 at 9:40 AM, in her room, revealed .He (alleged perpetrator) cut it (wander guard) off in that room over (another resident's room) there and threw it in the garbage can . Interview with the Administrator on 5/7/18 at 11:00 AM, in his office, revealed .No one saw them leave .we had a camera malfunction .we think they went out the side door .they wouldn't have been seen going out that door .He had been given the door code. At that point in time visitors had the door code . Telephone interview with Resident #1's Physician (Medical Director) on 5/7/18 at 11:45 AM, revealed .She clearly has a cognitive impairment .needs supervision .this has been a learning experience .hard to imagine this would happen . Telephone interview with LPN #2 on 5/7/18 at 5:00 PM revealed .I was passing medications when (CNA #) came up and said he thought something was going on in the room (another resident's room). I told him (Resident #1) needed to go back to her room and he (alleged perpetrator) needed to leave .saw her come out and go down hallway toward her room .she looked mad .did not see him leave .thought I would talk with her in a few minutes .my main concern was to get her out of that room .did you ever see someone and just think I don't like them .nothing could put your finger on .maybe just how he looked .nothing he had done .the night before he gave (Resident #1) a soda and I told him he could not give residents food or drinks because they may have diet restrictions .at that time the (door) code was the current month and year. It was changed monthly; everybody just knew it . Continued interview revealed LPN #2 was not aware anyone had been drinking alcohol in the resident's room and LPN #2 did not go check on Resident #1. Interview with CNA #8 on 5/8/18 at 8:15 AM, on the 200 hallway, revealed since the incident .no one comes in and out the side doors unless a staff member lets someone in the handicapped accessible door .that is monitored by a camera at nurse station 1 .employees have to enter and exit through the front doors also .in-serviced to report any suspicious persons or activity to nurse or supervisor . Interview with LPN #4 on 5/8/18 at 8:45 AM, at nurse station #1, confirmed staff education since the event on 2/25/18 included to immediately investigate any concern of suspicious activity, and also to report the suspicious activity to the supervisor immediately. Interview with the Speech Language Pathologist on 5/8/18 at 9:00 AM, in the conference room, confirmed Resident #1 completed the Saint Louis University Mental Status Examination, not dated, with a score of 6 (indictor of dementia) on a scale to 30. Further interview revealed the resident completed the Montreal Cognitive Assessment on 2/27/18 with a score of 17 on a scale to 30 (score equal to or greater than 26 indicates normal cognition). Continued interview revealed .she (Resident #1) has deficits with higher level thinking skills .that has been consistent since she has been here .she says she wants to go home, leave, go to a motel .she does not comprehend that she would need money .feel like she is still at risk for elopement .she has mentioned to me in therapy that she still wants alcohol and drugs . The facility's corrective action plan included the following: On 2/25/18 the facility did the following: The facility checked the placement and functionality of wander guard bracelets (a device worn by residents that will automatically lock any facility exterior doors and sound an alarm when approached by residents) of all residents identified as being at risk for elopement. On 2/26/17 the facility did the following: A. The Nursing Home Administrator, Director of Nursing Services, Director of Social Services, Director of Activities, Director of Nutrition, Business Office Manager, Maintenance Director, Director of Rehabilitation, Medical Director, Minimum Data Set Coordinator, Director of Admissions, and Licensed Practical Nurse (LPN) #3 conducted an ad hoc Quality Assurance Meeting to review the circumstances of the incident and implement an immediate action plan for the investigation of the incident. B. The Maintenance Director changed the codes to all the exterior entrance/exit doors. C. Conducted in-services with staff on abuse, reporting any unusual appearing activity and systemic changes that were implemented to enhance resident/staff safety. Staff was required to complete a post test. Systemic changes and in-services included: 1. A book placed at the entrance of the facility for visitors/vendors to sign-in and sign-out, all visitors/vendors are to sign when they arrive and when they exit the facility. 2. The door code is not to be given to any resident, visitor, or vendor under any circumstances; staff are to direct the visitor/vendor to the front door and the receptionist will assist the visitor/vendor. If a receptionist is not at the door the staff member will enter the code and let the visitor out the front door. The front door will be the only entrance and exit for the facility. All other exits will be used for emergencies only. If the code is given to any resident, visitor, or vendor disciplinary action will be taken. 3. If staff witness any activity in the facility that they feel is different or odd they report it to their supervisor immediately. The supervisor is responsible to investigate immediately and notify the Executive Director (ED) and/or Director of Nursing Services (DNS). D. Audited to ensure all residents at risk for elopement were assessed accurately. E. Head to toe skin assessment completed for all non-interviewable residents. F. Safe surveys (interviews with residents to determine their safety) were completed with all alert and oriented residents. G. Posted a photo at both nurses station of the alleged perpetrator. H. Notification was given to the alleged perpetrator's girlfriend (also a resident) that he was not allowed to visit. I. Family notification by mail of a change in the process for entrance/exit to the facility was completed for 100% of the families. J. The DNS or designee initiated a daily walk through on both shifts, on all hallways, and interviews with staff to ensure no unusual behaviors, reported allegations of abuse, or any unauthorized entry/exit of the doors on the Northeast side of the facility had occurred. This process is ongoing. K. The Administrator began an audit of all allegations of abuse or reportable incidents and this process is ongoing. L. The facility implemented an elopement drill twice monthly for 2 months, and then monthly, ongoing. On 2/27/18 the facility did the following:

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CONCORDIA NURSING AND REHABILITATION-NORTHHAVEN	3300 BROADWAY NE KNOXVILLE, TN 37917

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) A. Conducted an ad hoc Quality Assurance meeting to ensure all interventions of the immediate action plan were implemented. B. Continued staff in-services and post tests for 100% completion of all staff. The surveyor verified the facility's corrective action plan as follows: A. Review of the Quality Assurance Meeting, Attendance, and Agenda sheets confirmed the facility conducted ad hoc Quality Assurance meetings on 2/26/18, 2/27/18, and began review monthly on 3/21/18 to ensure sustainability of the plan of correction. B. Comparison of the room roster dated 2/26/18 with the completed safe survey individual questionnaires and completed skin assessments revealed all residents were assessed for abuse between 2/26/18 - 2/27/18 with 100% completion on 2/27/18. The facility completed weekly safe survey individual questionnaires through 3/22/18 and weekly skin assessments are ongoing. C. Medical record review revealed the 4 residents at risk for elopement on 2/25/18 were re-evaluated using the Unsafe Wandering Risk Evaluation with 100% completion on 2/27/18. D. Nursing Home Administrator on 5/2/18 at 2:45 PM, in the conference room, confirmed letters were mailed to all responsible parties on 2/26/17 to inform of the new process of entering and exiting the facility. Continued interview revealed the Administrator began auditing all allegations of abuse or any reportable incident for timely reporting to the state agency and is ongoing. E. Observation of the wander guard tracking log, door alarms, and interview with the Maintenance Director on 5/2/18 at 4:10 PM, in the maintenance room, confirmed the wander guards are checked weekly for expiration date, function, and door alarm. Continued interview confirmed the keypad code for all entrance/exit doors was changed on 2/26/18 and the implementation of the use of 1 door for entry/exit of the facility. The facility staff must enter the door code to allow visitors/vendors exit from the facility. F. Medical record review of a progress note dated 2/26/18 and interview with the Social Service Director on 5/2/18 at 6:30 PM, in the conference room, confirmed the perpetrator's girlfriend was notified he was no longer allowed to visit. G. Review of a facility document Room Roster (list of wandering residents) initiated 2/25/18, revealed the roster was used to document verification all residents identified as at risk for elopement were accounted for and to document verification of placement and function of the wander guards. Interview with LPN #2 on 5/2/18 at 7:00 PM, in the conference room, and review of the documentation, confirmed residents identified for risk of elopement had a functioning wander guard in place. H. Comparison of facility in-service records, sign in/out sheets, employee roster, and post tests for systemic changes and abuse dated 2/26/18 -2/27/18, and interview with the Director of Nursing Services (DNS) on 5/8/18 at 8:00 AM, in the conference room, confirmed staff education was 100% complete on 2/27/18. Continued review of the facility visitor sign in/out log and interview confirmed the facility initiated the process on 2/26/18 and is ongoing. Further interview with the DNS confirmed the process is monitored daily by DNS or designee which included: a walk through on all hallways, interviews with staff for any unusual behaviors, any allegation of abuse, and monitoring of visitor entrance and exit through the designated entrance door. Continued interview revealed the facility had conducted drills with facility staff for elopement on 2/26/18, 2/28/18, 3/6/18, 3/19/18, 4/4/18, and 5/3/18, and continues monthly. I. On 5/8/18 at 8:40 AM the surveyor attempted to exit through the doorway located on the Northeast side of the building setting off the alarm. The facility staff responded immediately and implemented the elopement protocol. J. Multiple observations and interviews were conducted by the surveyor with residents, visitors, and employees on both shifts throughout the complaint survey conducted from 5/1/18 through 5/8/18, which confirmed full implementation of the systemic changes to enhance resident/staff safety and the reporting of any unusual appearing activity.
F 0609 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on facility policy review, medical record review, review of a facility investigation, and interviews, the facility failed to report an allegation of abuse to the State Survey Agency timely for 1 resident (#1) of 5 residents reviewed for abuse. Resident #1 was sexually assaulted and the incident was not reported to the State Survey Agency within 2 hours. The facility's failure resulted in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). F-609 was cited at a scope and severity of J and is Substandard Quality of Care. The Nursing Home Administrator was informed of the Immediate Jeopardy (IJ) on 5/7/18 at 11:00 AM, in his office. The IJ was effective from 2/25/18 through 2/27/18. The IJ was removed on 2/28/18. The facility's corrective action plan which removed the immediacy of the jeopardy was received and corrective actions were validated onsite by the surveyor on 5/7/18 and 5/8/18. The IJ was cited as past noncompliance and the facility is not required to submit a plan of correction for those tags. The findings included: Review of the facility policy, Abuse, dated 11/28/17 revealed .2. The center staff reports any alleged violations involving verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the resident as well as mistreatment, injuries of unknown source and misappropriation immediately to a Senior Clinician, or Operational Leader at the facility, or District, or National Level and to other officials in accordance with State regulations through established procedures (including to State survey and certification agency) . Medical record review revealed Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the Quarterly Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 15 (cognitively intact). Further review revealed the resident required supervision for bed mobility, transfers, and toilet use with 1 person assist, and required limited assist for bathing with 1 person assist. Medical record review of an acute care hospital nurse's triage note dated 2/25/18 at 11:14 PM, revealed .presenting complaint .staff told EMS (Emergency Medical Services) that another resident took pt's (patient's) wondering (wander) bracelet off of her and took her somewhere .pt returned to facility intoxicated . Continued review of a hospital physician's note dated 2/26/18 at 5:01 AM revealed .She was taken out of the NH (nursing home) by another resident's family. She returned intoxicated and stated she had been sexually assaulted . Review of a facility investigation dated 2/26/18 revealed on the evening of 2/25/18, Resident #1 left the facility with the boyfriend of another resident, returned to the facility intoxicated, and alleged she had been sexually assaulted. Interview with the Administrator on 5/3/18 at 11:15 AM, in his office, revealed .I either faxed or called the State Agency that evening (2/25/18) .don't remember . Continued interview revealed the Administrator did not have documentation to support notification of the incident to the State Agency within 2 hours. Review of the facility self-report, and interview with the Director of Nursing on 5/3/18 at 11:15 AM, in the Administrator's office, confirmed the facility reported the incident to the state survey agency on the morning of 2/26/18 (at 8:43 AM, approximately 10 ½ hours after the incident). The facility's corrective action plan included the following: On 2/26/17 the facility did the following: A. The Nursing Home Administrator, Director of Nursing Services, Director of Social Services, Director of Activities, Director of Nutrition, Business Office Manager, Maintenance Director, Director of Rehabilitation, Medical Director, Minimum Data Set Coordinator, Director of Admissions, and Licensed Practical Nurse (LPN) #3 conducted an ad hoc Quality Assurance Meeting to review the circumstances of the incident and implement an immediate action plan for the investigation of the incident. B. Conducted in-services with staff on abuse, reporting any unusual appearing activity and systemic changes that were implemented to enhance resident/staff safety. Staff was required to complete a post test. Systemic changes and in-services included if staff witness any activity in the facility that they feel is different or odd, they report it to their supervisor immediately. The supervisor is responsible to investigate immediately and notify the Executive Director (ED) and/or Director of Nursing Services (DNS). C. Head to toe skin assessment completed for all non-interviewable residents. D. Safe surveys (interviews with residents to determine their safety) were completed with all alert and oriented residents.

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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 0609 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) E. The DNS or designee initiated a daily walk through on both shifts, on all hallways, and interviews with staff to ensure no unusual behaviors, reported allegations of abuse, or any unauthorized entry/exit of the doors on the Northeast side of the facility had occurred. This process is ongoing. F. The Administrator began an audit of all allegations of abuse or reportable incidents and this process is ongoing. On 2/27/18 the facility did the following: A. Conducted an ad hoc Quality Assurance meeting to ensure all interventions of the immediate action plan were implemented. B. Continued staff in-services and post tests for 100% completion of all staff. The surveyor verified the facility's corrective action plan as follows: A. Review of the Quality Assurance Meeting, Attendance, and Agenda sheets confirmed the facility conducted ad hoc Quality Assurance meetings on 2/26/18, 2/27/18, and began review monthly on 3/21/18 to ensure sustainability of the plan of correction. B. Comparison of the room roster dated 2/26/18 with the completed safe survey individual questionnaires and completed skin assessments revealed all residents were assessed for abuse between 2/26/18 - 2/27/18 with 100% completion on 2/27/18. The facility completed weekly safe survey individual questionnaires through 3/22/18 and weekly skin assessments are ongoing. C. Nursing Home Administrator on 5/2/18 at 2:45 PM, in the conference room, revealed the Administrator began auditing all allegations of abuse or any reportable incident for timely reporting to the state agency and is ongoing. D. Comparison of facility in-service records, employee roster, and post tests for systemic changes and abuse dated 2/26/18 -2/27/18. Interview with the Director of Nursing Services (DNS) on 5/8/18 at 8:00 AM, in the conference room, confirmed staff education was 100% complete on 2/27/18. Further interview with the DNS confirmed the process is monitored daily by DNS or designee which included: a walk through on all hallways, interviews with staff for any unusual behaviors, any allegation of abuse, and monitoring of visitor entrance and exit through the designated entrance door. E. Multiple observations and interviews were conducted by the surveyor with residents, visitors, and employees on both shifts throughout the complaint survey conducted from 5/1/18 through 5/8/18, which confirmed full implementation of the systemic changes to enhance resident/staff safety and the reporting of any unusual appearing activity. F. Review of all of the facility's self-reported incidents to the State Survey Agency and allegations of abuse revealed the facility had no other regulatory deficiencies since implementation of the Plan of Correction.