STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255140	A. BUILDING _____ B. WING _____	C 04/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLUFFS REHABILITATION AND HEALTHCARE CENTER	2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

Based on communication with CMS on 5/20/19, this 2567 was amended.

The State Agency (SA) conducted an annual recertification along with complaint investigations (CI), MS #15825 and MS #15824, from 4/22/2019 to 4/26/2019. The complaints were not substantiated, however related deficiencies were cited for verbal abuse. During the survey, The SA determined, during the recertification, that the facility was not in compliance with the requirements of participation for Medicare and Medicaid and extended the survey, related to Immediate Jeopardy (IJ), with deficiencies cited.

The SA identified an IJ and Substandard Quality of Care (SQC) on 4/25/19, which began on 4/3/19, when Licensed Practical Nurse (LPN) #1 verbally abused Resident #14 On 4/3/19, at approximately 9:50 PM, Resident #14 reported an allegation of verbal abuse against LPN #1. The allegation consisted of Resident #14 using derogatory names towards LPN #1 and LPN #1 responded to the resident by using the same derogatory names. This occurred and was witnessed around the nurse's station. LPN #3 stated she heard LPN #1 say to Resident #14, "If I'm a bitch, you are a bitch. It takes one to know one". LPN #2 stated she heard LPN #1 say "Mother Fucker" to/or in the presence of Resident #14. LPN #1 was immediately suspended; however, LPN #1 was allowed to return to work on 4/17/19, after abuse had been substantiated by facility investigation, thus not protecting the residents of the facility from further abuse. Resident #14 refused medications from LPN #1 after she returned to the facility and was assigned

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

Electronically Signed | 05/24/2019

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F 000	Continued From page 1	F 000		

to the same hall with Resident #14. He made statements indicating that he didn't know what LPN #1 might do. The facility also failed to report the abuse to the appropriate State Agencies within two (2) hours of the allegation, as required.

The failure of the facility to protect residents by allowing a staff member to work in the facility following a witnessed incident of verbal abuse, and failure to report the abuse within two (2) hours to State designated agencies, placed Resident #14 and other residents in a situation that was likely to cause serious injury, harm, impairment, or death.

The facility's Administrator was notified of the IJ and SQC on 4/25/19, at 10:00 AM, and the IJ template was provided to the Administrator.

The IJ and SQC existed at:
42 CFR(s):483.12(a)(1)-Freedom from Abuse/Neglect, (F600);
42 CFR(s):483.12(b)(1)(3)-Develop/Implement Abuse/neglect policies, (F-607);
42 CFR(s)483.12(c)(1)(4)-Reporting of alleged violations, (F-609)
42 CFR(s)483.12(c)(2)-(4)-Investigate/prevent/correct alleged violation(F-610)

The facility provided a credible Removal Plan on 4/26/19, in which the facility alleged all corrective actions were completed as of 4/25/19, and the IJ was removed on 4/26/19.

The State Agency (SA) validated the Removal Plan and determined the IJ was removed on 4/26/19, prior to exit. Therefore, the scope and severity for 42 CFR(s):483.12(a)(1)-Freedom

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F 000	Continued From page 2 from Abuse/Neglect, (F600); 42 CFR(s):483.12(b)(1)(3)-Develop/Implement Abuse/neglect policies, (F-607); 42 CFR(s):483.12(c)(1)(4)-Reporting of alleged violations, (F-609); and 42 CFR(s): 483.12(c)(2)-(4) Investigate/prevent/correct alleged violation(F-610); were lowered to a "D", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The SA also cited deficiencies F550, F623, F636, F638, F641, F656, F690, F695, F773, F842, and F880, which were not at the IJ level. The facility held a license for 120 beds with a census of 98.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		5/31/19

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F 550	Continued From page 3 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review the facility failed to ensure the residents were treated with dignity and respect for one (1) of 24 residents observed for dignity, Resident #65. Findings include: Review of the facility's policy titled "Dignity", revised August 2009, revealed each resident shall be cared for in a manner that promotes and enhances quality of life, respect and individuality. Demeaning practices and standards of care that compromise dignity are prohibited; staff shall promote dignity and assist residents as needed	F 550	Preparation and submission of this plan of correction by The Bluffs Rehabilitation and Healthcare, does not constitute an admission or agreement by the provider of truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement under the state and federal laws.	

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F 550	Continued From page 4 by helping the resident to keep urinary catheter bags covered, and promptly responding to the resident's request for toileting assistance. Staff shall treat cognitively impaired residents with dignity and sensitivity; for example addressing the underlying motives or root causes for behavior and not challenging or contradicting the resident's beliefs or statement. Staff shall speak respectfully to residents at all times. Resident #65 In an observation on 04/23/19 at 8:20 AM, Licensed Practical Nurse (LPN) #5 knocked on the door and entered Resident #65's room. CNA #2 was in the process of giving Resident #65 a bed bath. Upon entering the room, the curtain by the door was not pulled to shield Resident #65's naked body from the hall. CNA #2 never identified "patient care" before the LPN entered the room. The curtain between Resident #65 and her roommate was not pulled, exposing Resident #65's naked body to the roommate. Resident #65 was not covered with anything. After LPN #5 entered the room, another CNA started into the room but only opened the door and then started backing out of the room. The door was opened enough to expose Resident #65 to the hall again. CNA #2 then asked LPN #5 to close the curtain by the door and then CNA #2 turned and pulled the curtain between the resident's. An interview on 04/23/19 at 08:25 AM, with CNA #2 revealed, "The curtains were not pulled by the door or between the residents." She stated she had just finished bathing Resident #65's roommate, was bathing Resident #65, the roommate was yelling, so she was trying to see what the roommate wanted. CNA #2 stated, "No, neither curtain was pulled".	F 550	F550 □ Resident Rights 1. Resident #65 was evaluated by Social Services on 5/16/19 regarding unresolved concerns related to care or treatment from staff; no concerns reported by Resident #65. LPN#5 and CNA#2 was in-serviced on 4/23/2019, on Dignity, Respect, and Privacy by Director of Nursing and Corporate Clinical Specialist. 2. Facility residents have the potential to be affected. On 5/15/19, facility department heads including Social Services, Activities, Nursing Leadership, Business Office Manager, Minimum Data Set Nurses, Lead Certified Nursing Assistant (C.N.A.), Dietary Manager, Admissions Director, interviewed residents in their respective room assignments, regarding concerns related to dignity, privacy and care concerns; no concerns reported. 3. Beginning on 5/15/19, the facility staff including Licensed Nurses, Department Heads, Maintenance, Housekeeping, C.N.A.s, Business Office staff, Admissions, Dietary, and Therapy, was in-serviced in regards to resident right to be treated with dignity and respect and the requirement to provide privacy during personal care by Registered Nurses/Staff Development Coordinator. On 5/22/19, Corporate Support Administrator/Regional Nurse in-serviced facility staff in regards to requirement to provide care to	

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F 550	Continued From page 5 An interview on 04/23/19 at 8:30 AM, with LPN #5 revealed, "The curtain by the door was not pulled and the naked resident was exposed to hall. The curtain between the residents was not pulled either, exposing Resident #65 to her roommate while getting a bath". LPN #5 confirmed the dignity issue. An interview on 04/25/19 at 12:20 PM, with Interim DON #1 revealed that the curtain not being pulled at the entrance to Resident #65's door, and her nude body being exposed to the hall, is a dignity issue. The curtain not being pulled between Resident #65 and her roommate, with CNA #2 bathing the Resident, is a dignity issue. CNA #2 not identifying "resident care" while performing a bed bath, before LPN #5 entered the room, failed to provide the resident privacy, therefore it was a dignity issue.	F 550	residents in a manner that provides and protects residents privacy/dignity and respect. 4. Beginning on 5/27/19, facility department heads including Social Services, Activities, Nursing Leadership, Business Office Manager, Minimum Data Set nurses, Lead Certified Nursing Assistant (C.N.A.), Dietary Manager, Admissions Director, will interview residents in their respective facility areas weekly for twelve (12) weeks, in regards to concerns related to care or treatment from staff in regards to dignity/respect/privacy. A report will be presented to the Quality Assurance Performance Improvement Committee monthly for three (3) months by the Social Services Director, for review and recommendations. Beginning 5/27/19, the Staff Development Coordinator/Assistant Director of Nursing will conduct incontinent care observations on three (3) residents weekly for four (4) weeks, then monthly for three (3) months to observe for privacy being provided during care. The Staff Development Coordinator will report findings to the Quality Assurance Performance Improvement Committee monthly for three (3) months for review and further recommendations. The Administrator is responsible for on-going monitoring and compliance.	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		5/31/19

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F 600	Continued From page 6 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review and facility policy review, the facility failed to ensure a resident was free from verbal abuse for one (1) of 24 residents reviewed for abuse, Resident #14. On 4/3/19, at approximately 9:50 PM, Resident #14 reported an allegation of verbal abuse against Licensed Practical Nurse (LPN) #1. The allegation consisted of Resident #14 using derogatory names towards LPN #1. LPN #1 responded to the resident by using the same derogatory names. This occurred around the nursing station and was witnessed by other staff. LPN #3 stated she heard LPN #1 say "If I'm a bitch, you are a bitch. It takes one to know one". LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was notified by LPN #2 at approximately 10:00 PM. LPN #1 was suspended, however, was allowed to return to work on 4/17/19, and allowed to work on the same assigned hall where Resident #14 resided.	F 600	F600 □ Abuse & Neglect 1. Resident #14 was interviewed on 5/15/19 by Corporate Clinical Specialist regarding abuse/neglect concerns; Resident #14 denies any other instances of abuse or neglect. LPN#1 was terminated on 4/25/2019. 2.Facility Residents have the potential to be affected by deficit practice. Residents with Brief Interview for Mental Status (BIMS) scores of 12 or higher were interviewed by Director of Nursing/Human Resources/Minimum Data Set Registered Nurses/Staff Development Coordinator/Activity Director/Social Services under the direction of the Administrator and Director of Nursing, on 4/29/19, regarding concerns of abuse or neglect; no concerns noted. Facility staff were interviewed beginning on 4/27/19 by	

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F 600	Continued From page 7 The resident refused to take medications from LPN #1, stating he did not trust her. The facility's failure to protect Resident #14 from verbal abuse and allow a staff member to work in the facility following investigation of an incident of witnessed verbal abuse, placed Resident #14 and other residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 4/3/19, when the verbal abuse occurred. The facility's Administrator was notified of the IJ and SQC on 4/25/19, at 10:00 AM, and provided with the IJ template. An acceptable credible Removal Plan was provided by the facility on 4/26/19, in which the facility alleged all corrective actions were completed as of 4/25/19, and the IJ was removed on 4/26/19. The State Agency (SA) validated the Removal Plan and determined that the IJ was removed on 4/26/19, prior to exit. Therefore, the scope and severity for the IJ and SQC at 42 CFR(s): 483.12 (a)(1) F600 , Freedom from Abuse, Neglect, and Exploitation, was lowered to a "D", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's policy entitled "Abuse Prohibition Policy", Revision: 03/18/2019, revealed: This protocol was intended to assist in the prevention of abuse, neglect and	F 600	Director of Nursing/Human Resources/Minimum Data Set Registered Nurses/Staff Development Coordinator/Activity Director/Social Services/Business Office Manager/Corporate Clinical Specialist Registered Nurse/Case Mix Specialist Registered Nurse/Regional Vice President, regarding concerns of abuse or neglect; no concerns noted. 3. On 4/26/19,Regional Vice President educated facility Administrator on requirements of abuse/neglect prohibition policy including reporting requirements. Beginning 4/27/19,facility staff participated in abuse/neglect questionnaires to determine knowledge retention on abuse/neglect prohibition training; individuals who could not answer each question correctly were provided one-to-one additional training. Beginning on 4/30/19, facility staff were in-serviced by Corporate Clinical Specialist/Director of Nursing regarding abuse and neglect prohibition policy, reporting concerns regarding abuse and/or neglect immediately, two hour required reporting timeframe by the facility to the Mississippi State Department of Health, Licensure and Certification, protecting residents immediately following allegation of abuse/neglect. On 5/6/19, representative of the Mississippi Attorney Generals Office provided in-service to facility staff in regards to abuse/neglect prevention, reporting, Vulnerable Adults Act, Medicaid Fraud, types of abuse. On 5/22/19,Corporate Support	

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F 600	Continued From page 8 misappropriation of property. Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse. Policy: 1. The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property or finances of residents. Review of the facility's policy entitled "Abuse Program", Revision 11/2017, revealed,....Investigation: 1. The facility will thoroughly investigate all alleged violations and take appropriate actions. 2. The Abuse Coordinator will report such allegations to the state agency in accordance with state law. The Abuse Coordinator will report all allegations of abuse,...within two (2) hours of the allegation... Protection: 1. All residents will be immediately protected from harm... Statement of Policy, Regarding the Reporting of Abuse and Associate Acknowledgement,....Remember our policy is all residents and patients of this nursing home are to be treated with dignity and respect at all times, under all circumstances. Mistreatment or abuse of any nature will not be tolerated... Review of a Facility Reported Incident (FRI), dated 4/5/19, revealed staff statements concerning an allegation of verbal abuse by an employee, Licensed Practical Nurse (LPN) #1, toward Resident #14 that occurred on 4/3/19. LPN #4 reported that on 4/3/19, at 9:50 PM, Resident #14 was tapping his hand on the counter to get the nurse's attention. Resident #14 wanted a snack and to use the cordless phone, but it was not charged. Resident #14 became agitated and began hitting the nurse's station desk loudly with the palm of his hand and	F 600	Administrator/Registered Nurse in-serviced facility staff on Abuse and Neglect Prohibition program including but not limited to the requirement to protect residents, if a staff is involved, they will be suspended, facility is required to report to authorities within two (2) hour time frame, facility is required to conduct a thorough investigation and findings of investigation could lead to staff termination. A Quality Assurance Performance Improvement committee meeting was held on 5/22/19 with the Administrator, the Director of Nursing, the Corporate Clinical Specialist and Medical Director to review the statement of deficiencies and plan of correction; no further recommendations were made. 4. Beginning on 5/27/19, facility department heads including Social Services, Activities, Nursing Leadership, Business Office Manager, Minimum Data Set nurses, Lead Certified Nursing Assistant (C.N.A.), Dietary Manager, Admissions Director, will interview residents in their respective facility areas weekly for twelve (12) weeks, in regards to concerns related to care or treatment from staff related to abuse and/or neglect issues; any negative concern will be immediately reported to the Administrator or Director of Nursing for further intervention. Beginning on 5/27/19, the Administrator will review the incident log weekly to ensure reportable events have been investigated and reported as required. Beginning on 5/27/19, the Administrator will review the grievance log	

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F 600	Continued From page 9 snatched papers from a chart on the desk attempting to read them. Resident #14 cursed LPN #1 who cursed him in return. This was witnessed by LPN #2 and LPN #3, who stated that LPN #1 used profanity such as "Mother Fucker", and "If I'm a bitch, you are a bitch. It takes one to know one". LPN #1 was suspended pending investigation. On 04/22/19, at 4:03 PM, during an interview with Resident #14, he stated, "Everything is okay except for that woman who pushed me up against that wall". He stated this happened about two (2) weeks ago and her name was (LPN #1 Proper Name). He stated "If y'all don't do anything about it, I will". Resident #14 stated that he did not trust LPN #1 after she shoved him into a wall and hurt his left foot. He said he refused to take any medication or receive any care from her after that stating, "No telling what she might do". The resident had an angry tone and expression. He stated that he could not recall exactly what was said, but that he cursed her and she cursed him back. He stated that he stands by his original statement to LPN #4, given on 4/3/19. Review of the resident's statement, documented in the facility's investigation, taken by LPN #4 on 4/3/19 at 9:50 PM, revealed Resident #14 stated he was tapping his hand on the counter to get the nurse's attention. He stated the nurse got up from the desk and pushed his wheelchair into the wall by the DON's office on the 300 hall. Resident stated he hit his foot on the wall. Resident stated he cursed the nurse and the nurse cursed him back, got her purse, and left the building. On 04/23/19, at 8:04 PM, an interview with LPN #4 revealed that she was working on the hall and	F 600	weekly to ensure any allegations have been investigated and reported as required. A report will be submitted by the Administrator to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The Administrator is responsible for monitoring and compliance.	

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F 600	Continued From page 10	F 600		

that she did not witness the alleged abuse but was told about it by LPN #2. She stated she obtained a statement from Resident #14. She stated that he reported he had cursed LPN #1 and that she cursed him back and pushed him into the wall, hurting his foot. LPN #4 stated that she examined the resident's foot and did not notice any injury or swelling that was unusual for him. She stated he always had lymphedema, but there was no unusual swelling.

On 04/23/19, at 8:16 PM, during a phone interview with LPN #2, she stated at approximately 8:15-8:20 PM, on 4/3/19, that she walked up to the nurse's station from the 200 Hall. LPN #1 was sitting at the desk working on charting and Resident #14 was sitting across from LPN #1 in his wheelchair at the nurse's station hitting the top of the desk with the palm of his hand very loudly. LPN #2 stated that she told Resident #14 that she had sensitive ears and that it was hurting her ears and asked him to stop and he stopped. She stated that LPN #1 had told her that Resident #14 was pulling orders out of charts and she had to move them. LPN #2 proceeded through the nurse's station and toward the 500 Hall to the treatment cart when she overheard LPN #1, say, "Bitch, I got your bitch, you Mother Fucker". She stated that LPN #1 left the facility a few minutes later (no more than 5 minutes) and that she called the Administrator to report the incident and reported it to Resident #14's Charge Nurse, LPN #4. She stated that three (3) or four (4) other residents were sitting in the area. Resident #45 and Resident #13 were the ones she remembered. She stated Resident #45 might be interviewable, but Resident #13 wouldn't recall anything.

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Review of the signed and documented statement from LPN #2, from the facility's investigation, (not dated) revealed LPN #1 stated, "Mother Fucker", while at the nurse's station, but LPN #2 didn't know who she was talking to. It was noted in further documentation that LPN #2 saw another Resident at the station, (Resident #13), who had a documented interview by the Administrator on 4/4/19, in which the resident denied hearing profanity.

Interview on 04/23/19, at 4:30 PM, with the Administrator confirmed that LPN #1 continued to work for the facility and was scheduled to work on 4/24/19, the 7 AM-7 PM shift. On 04/24/19, at 8:33 AM, during a further interview with the Administrator, she stated that she did feel that verbal abuse had occurred based upon the statements of LPN #2 and LPN #3 obtained during the investigation for the incident with Resident #14. She stated that she had requested termination of LPN #1 from corporate, but that request was denied by Human Resources. She stated that LPN #1 was suspended from 4/3/19 - 4/17/19, and then LPN #1 was allowed to return to work on 4/17/19, after the investigation was completed, because it was determined that abuse could not be substantiated on the part of the facility. The Administrator stated that LPN #1 had been re-assigned to Resident #14 since returning to work, stating that was the hall that LPN #1 was assigned to before she was suspended, so she was re-assigned to that hall upon return on 4/17/19. The Administrator stated that LPN #1 was issued a "Final Warning" due to a previous Verbal Warning for using profanity in the common area of a sister facility.

Review of an electronic communication,

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documented by the Administrator on 4/8/19, revealed a subject: Suspension. The documentation included: Attached is an allegation of verbal abuse investigation that was reported to the state and AG...Based on the other 2 LPN's statements, I would like to request termination.

Review of Resident #45's MDS, with an ARD of 1/24/19, revealed a BIMS of 15. Interview with Resident #45 revealed he did not recall what was said on 4/3/19 at the nurse's station between Resident #14 and LPN #1.

Record review of the Daily Assignment Sheets for 4/17/19 - 4/21/19, revealed that LPN #1 was assigned to the 300/400 Hall. Resident #14 resided on the 300 Hall.

Interview with LPN #1, on 4/24/19, at 11:10 AM, in the Medical Records building, revealed that she was removed from the 300-400 Hall assignment by the Administrator earlier that morning and re-assigned to file records in a separate building. She stated that on 4/3/19, she was working on charting at the nurse's station when Resident #14 came up in his wheelchair and asked for the phone. She stated that the phone was not charged and he became angry. She stated that she asked him to leave the desk so she could finish her work and he said, "Fuck you, bitch". She stated that she did move Resident #14 away from the nurse's station toward his room, but denied hitting his foot on a wall. She stated that the resident came back to the nurse's station and began banging his hand on the desk. LPN #1 stated that she never cursed Resident #14, and that she told him, "You're cursing me out. If you want me to respect you, you've got to respect me, too." She stated that a couple of nurses walked

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by every now and then and Resident #45 rolled up, but that she did not know what he heard. She revealed that she had completed in-services on Abuse after coming back to work on 4/17/19. She stated that Resident #14 took meds from her on 4/17/19, but began refusing on 4/18/19, saying, "I don't want to take it, I don't trust you". LPN #1 revealed that she had been assigned to Resident #14 on 4/17/19 - 4/24/19, (after returning to work from being suspended for abuse).

Telephone interview with LPN #3 on 4/24/19 at 2:50 PM, revealed that she was down the hall when the incident occurred. She stated that she walked to the nurse's station to see what was going on because Resident #14 was beating on the desk. LPN #3 stated that LPN #1 was mad because she said Resident #14 had called her a Bitch. LPN #3 stated LPN #1 was behind the desk and Resident #14 was on the other side of the desk in his wheelchair. She stated, "She was saying something. They were going back and forth with each other but I don't recall exactly what was said."

Review of the written facility investigative statement, dated 4/5/19, for LPN #3, documented by Interim DON #1, revealed that she had walked to the nurse's station and Resident #14 was beating his hand on the desk and LPN #1 was on the computer. Documentation of the statement included, "He called her a Bitch and she said, if I'm a bitch, you are a bitch, it takes one to know one. They were arguing back and forth. I couldn't hear exactly what they said."

Record review of Progress Notes revealed, "4/18/19 14:05, Type: Gen Nurses Notes - narrative, Note Text: Writer approached the

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resident to give him his medication and he stated 'I am not taking them for you', writer in return asked Director of Nursing (DON) who was standing at the nurse's station and she gave the resident his medication, he took his medication just fine for me yesterday. Author: - LPN#1 [e-SIGNED]".

Review of Progress Notes revealed, "4/19/2019 14:45, Type: Gen Nurses Notes - narrative, Note Text: The resident continues to refuse to take his medications from me, other nurses have been giving him his medications for me, writer continues to maintain a professional level with him, he is stating to other staff and residents that he don't trust me and stating that I pushed him into the wall, which is not true. No acute distress noted, will continue to medicate and monitor per MD orders as the resident will allow. Author: LPN #1 [e-SIGNED]".

Review of LPN #1's personnel file revealed a "Disciplinary Action Record", dated 4/24/19, that documented LPN #1 was suspended on 4/3/19, for using profanity in the presence of residents. A "Disciplinary Action Record" dated 4/25/19, documented LPN #1 was terminated related to the 4/3/19 incident of using profanity in the presence of residents. The personnel file contained a "Corrective Action Plan", dated 6/27/18, for a verbal warning of using profanity in the common area of the facility. This indicated the facility was aware of LPN's verbal profanity in the past.

Review of the In-service Attendance record dated 12/23/18, Topic: Neglect and Abuse in Healthcare Setting, revealed that LPN #1 attended this in-service. Review of the In-Service Training Log

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(General), Dated 4/17/19, In-Service Subject: Abuse/Neglect/Hand in Hand video, revealed LPN #1 signed the log and the Statement of Policy regarding Abuse.

Record review of the Disciplinary Action Record for LPN #1, dated 4/25/19, revealed that the facility terminated her employment for using profanity in the presence of residents.

Review of the Admission Record revealed the facility admitted Resident #14 on 10/7/15. Diagnoses included Abnormal Posture, Acute Pain, Edema, Aneurysm of Unspecified Site, Hypertension, Other Seizures, Diabetes Mellitus, Hemiplegia, Unspecified Affecting Left Non-dominant Side, and Dysphagia following Cerebral Infarction.

Review of the Minimum Data Set (MDS) Quarterly Assessment with an Assessment Reference Date (ARD) of 1/2/19, revealed that the resident had a Brief Interview for Mental Status (BIMS) of 14, indicating intact cognitive skills for daily decision making.

The facility submitted an acceptable Removal Plan on 4/26/19, for the IJ.

Review of the facility's Removal Plan revealed the facility took the following corrective actions to remove the IJ prior to exit:

1. The facility failed to assure the resident was free from verbal abuse and failed to report the abuse within the required two (2) hour reporting period, failing to keep the resident safe. On April 3, 2019, at approximately 10:00 PM, Resident #14 reported an allegation of verbal abuse

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against Licensed Practical Nurse (LPN) #1. The allegation consisted of the Resident #14 using a derogatory name towards LPN #1. LPN #1 responded to the resident by using the same derogatory name. This occurred around the nursing station. LPN #3 stated she heard LPN #1 say "If I'm a bitch, you are a bitch. It takes one to know one" at the nurses station. LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was immediately notified by LPN #2 at approximately 10:00 PM. LPN #1 was immediately suspended, abuse in-services and the abuse investigation was initiated.

2. The following parties were notified of the incident:
· Responsible party was notified April 4, 2019 at approximately 10:38 AM.
· Primary Physician was notified April 4, 2019 at 12:50 PM.
· Medical Director was notified April 4, 2019 at 11:44 AM.
· Mississippi State Department of Health was notified April 4, 2019 at 5:20 PM.
· Mississippi State Attorney General was notified April 4, 2019 at 5:01 PM.
· Mississippi State Board of Nursing was notified April 25, 2019 at 9:11 PM.

3. LPN #1 was brought back on April 17, 2019, and received an inservice on abuse, neglect, and exploitation. She was then assigned to Resident #14, thus not protecting the residents in the facility from further abuse and the facility not following their policy for abuse. LPN #1 was subsequently suspended on April 24, 2019, pending an investigation. LPN #1 was terminated on April 25, 2019, for verbal abuse against Resident #14.

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4. On April 24, 2019, at approximately 9:00 AM, the Administrator removed LPN #1 from all resident care areas.

5. On April 24, 2019, beginning at approximately 8:00 PM, the Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC), and Assistant DON initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, reporting abuse and/or neglect within the required two (2) hour time frame. Focus was placed on immediately removing the resident from the abuse situation; reporting all allegations of abuse, neglect and exploitation to the Administrator immediately; and that any staff member accused of abuse, neglect or exploitation will be suspended immediately pending investigation. No staff member will be allowed to return to work without completing required education. Currently, 76 of 88 staff members have completed required education.

6. On April 24, 2019, beginning at approximately 8:45 PM, the Interim Director of Nursing, Corporate Clinical Specialist, Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) provided posttest to employees in regards to Abuse and Neglect prohibition policy that was initiated on April 24, 2019, to ascertain understanding of Abuse and Neglect prohibition policy training. Any employee that was not able to answer the posttest answers correctly was provided a one-to-one (1:1)re-education at that time. No staff will be allowed to return to work without completing the

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required education posttest.

7. On April 24, 2019, beginning at approximately 9:15 PM, Social Worker, Human Resource Director, Business Office Manager (BOM), Respiratory Therapist, Assistant BOM, Activities Director, Minimum Data Set nurses, SDC, Registered Nurse (RN) Charge Nurse interviewed forty-five (45) residents in the facility at that time, with a Brief Interview of Mental Status (BIMS) of 12 or higher, in regards to had they ever experienced any verbal or physical abuse. Findings of the interviews were reviewed by the Administrator to determine any on-going or previously unidentified allegations of abuse and/or neglect; two (2) residents relayed information from a prior incident, which was investigated and reported. No abuse was substantiated.

8. On April 24, 2019, beginning at approximately 9:00 PM, the Corporate Clinical Specialist, both MDS nurses and the Regional Case Mix Specialist reviewed clinical documentation for Resident #14, to determine any negative changes to daily routines, activity participation, socialization, meal intake; Resident #14 began refusing medication from LPN #1 on April 18, 2019. No other changes where identified with Resident #14.

9. On April 24, 2019 and April 26, 2019, the Chief Operating Officer in-serviced the Director of Field Human Resources on the policy and procedures for Abuse and Neglect.

10. On April 25, 2019 at approximately 12:30 PM, the grievance log, beginning January 1, 2019 through April 25, 2019, and incident log,

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beginning January 1, 2019 through April 25, 2019, were reviewed by the Administrator to identify potential allegations abuse/neglect for reporting potential. No grievances or incidence were identified as a potential allegation that had not already been reported.

11. On April 25, 2019, at 2:00 PM, the Medical Director, Administrator, interim Director of Nursing, Social Services Director, Activities Director, BOM, SDC, ADON, Dietary Supervisor, Housekeeping Supervisor, Maintenance Director, HR director and Director of Rehab held a Quality Assurance Performance Improvement (QAPI) meeting following notification of Immediate Jeopardy to review steps initiated to identify any on-going or previously unreported allegations of abuse and/or neglect and to administer posttest to employees to determine understanding of education provided. There were no new policy or procedure changes.

12. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of April 25, 2019, and the Immediate Jeopardy was removed April 26, 2019.

The State Agency (SA) validated the facility's Removal Plan and determined the facility took the following actions to correct the IJ:

1. The SA validated that Resident #14 was not free from verbal abuse and the facility failed to report the abuse within the required two (2) hour reporting period, failed to keep residents safe. On April 3, 2019, at approximately 10:00 PM, Resident #14 reported an allegation of verbal abuse against Licensed Practical Nurse (LPN) #1. The allegation consisted of the Resident #14

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using a derogatory name towards LPN #1 and LPN #1 responded to the resident by using the same derogatory name. This occurred around the nursing station. The SA validated through interviews that LPN #3 stated she heard LPN #1 say "If I'm a bitch, you are bitch. It takes one to know one" at the nurses station. LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was notified by LPN #2. LPN #1 was suspended, abuse in-services and the abuse investigation was initiated.

2. The following parties were notified of the incident:
· The SA validated through interview with the Responsible Party that she was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Primary Physician was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Medical Director that he was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Department of Health was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Attorney General was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Board of Nursing was notified April 25, 2019, of the alleged abuse by LPN #1.

3. The SA validated through interview with LPN #1 and the Administrator and record review that

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LPN #1 was suspended and was brought back to work on April 17, 2019, and received an inservice on abuse, neglect, and exploitation. She was then assigned to Resident #14, thus not protecting the residents in the facility from further abuse and the facility not following their policy for abuse. LPN #1 was subsequently suspended on April 24, 2019, pending an investigation. The SA validated that LPN #1 was terminated on April 25, 2019, for verbal abuse against Resident #14.

4. The SA validated through interview with the Administrator and LPN #1 and record review, that on April 24, 2019, the Administrator removed LPN #1 from all resident care areas and placed her in another building with Medical Records duty.

5. The SA validated through interview with the Administrator, and staff from Nursing, Dietary, Social Services, Therapy, Business Office and Housekeeping/Maintenance and record review that on April 24, 2019, beginning at approximately 8:00 PM, the Administrator, DON, SDC and ADON initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, reporting abuse and/or neglect within the required two (2) hour time frame. Focus was placed on immediately removing the resident from the abuse situation; reporting all allegations of abuse, neglect and exploitation to the Administrator immediately; and that any staff member accused of abuse, neglect or exploitation will be suspended immediately pending investigation. No staff member was allowed to return to work, without completing required education. Currently, 76 of 88 staff

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members have completed required education.

6. The SA validated through interview with the Administrator and staff from Nursing, Dietary, Social Services, Therapy, Business Office and Housekeeping/Maintenance and record review that on April 24, 2019, beginning at approximately 8:45 PM, the interim Director of Nursing, Corporate Clinical Specialist, Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) provided posttest to employees in regards to Abuse and Neglect prohibition policy that was initiated on April 24, 2019, to ascertain understanding of Abuse and Neglect prohibition policy training. Any employee that was not able to answer the posttest answers correctly was provided a one-to-one (1:1) re-education at that time. No staff was allowed to return to work without completing the required education posttest.

7. The SA validated through interview with the Administrator and record review that on April 24, 2019, the Social Worker, Human Resource Director, Business Office Manager (BOM), Respiratory Therapist, Assistant BOM, Activities Director, Minimum Data Set nurses, SDC, Registered Nurse (RN) Charge Nurse interviewed forty-five (45) residents in the facility at that time, with a BIMS of 12 or higher, in regards to had they ever experienced any verbal or physical abuse. Findings of the interviews were reviewed by the Administrator to determine any on-going or previously unidentified allegations of abuse and/or neglect; two (2) residents relayed information from a prior incident, which was investigated and reported. The SA validated no abuse was substantiated.

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8. The SA validated through interview with the Administrator, Corporate Clinical Specialist, and one (1) MDS nurse, that on April 24, 2019, the Corporate Clinical Specialist, both MDS nurses and the Regional Case Mix Specialist reviewed clinical documentation for Resident #14, to determine any negative changes to daily routines, activity participation, socialization, meal intake; Resident #14 began refusing medication from LPN #1 on April 18, 2019. No other changes where identified with Resident #14. The SA validated that Resident #14 did receive medication from other nurses.

9. The SA validated through interview with the Chief Operating Officer, and dated/signed in-service sheets, that the Director of Field Human Resources was educated on the abuse and neglect policy and procedures with emphasis of investigation and to err on the side of the resident.

10. The SA validated through interview with the Administrator and record review that on April 25, 2019, the grievance log, beginning January 1, 2019 through April 25, 2019, and incident log, beginning January 1, 2019 through April 25, 2019, were reviewed by the Administrator to identify potential allegations abuse/neglect for reporting potential. No grievances or incidence were identified as a potential allegation that had not already been reported.

11. The SA validated through interview with the Administrator and record review that on April 25, 2019, at 2:00 PM, the Medical Director, Administrator, interim Director of Nursing, Social Services Director, Activities Director, BOM, SDC, ADON, Dietary Supervisor, Housekeeping

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F 600	Continued From page 24 Supervisor, Maintenance Director, HR director and Director of Rehab held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to identify any on-going or previously unreported allegations of abuse and/or neglect and to administer posttest to employees to determine understanding of education provided. There were no new policy or procedure changes. 12. The SA validated that all corrective actions were completed as of 4/25/19, and the IJ was removed as of 4/26/19.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to implement their Abuse policy for protection of residents from verbal abuse, failed to protect other residents from abuse, and failed to report an allegation of abuse for one (1) of 24 residents, Resident #14. This was evidenced by allowing a	F 607	F607 1. Resident #14 was interviewed on 5/15/19 by Corporate Clinical Specialist regarding abuse/neglect concerns; Resident #14 denies any other instances of abuse or neglect. LPN#1 was terminated on 4/25/2019.	5/31/19

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F 607	Continued From page 25 staff member to return to work following an incident of witnessed verbal abuse toward Resident #14. The facility also failed to report the allegation of abuse to the required state agencies, per policy, within the two (2) hour timeframe, to ensure appropriate actions were taken. On 4/3/19, at approximately 9:50 PM, (according to written reports) Resident #14 reported an allegation of verbal abuse against Licensed Practical Nurse (LPN) #1. This occurred at the nurse's station. There were witnesses to the events. LPN #3 stated she heard LPN #1 say, "If I'm a bitch, you are a bitch. It takes one to know one". LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was immediately notified by LPN #2 at approximately 10:00 PM, and LPN #1 was suspended on 4/3/19, however, she was allowed to return to work on 4/17/19, and allowed to work on the same assigned hall where Resident #14 resided. This resulted in the resident refusing to take medications from LPN #1, stating he did not trust her and didn't know what she might do. The facility did not report the allegation of abuse until 4/4/19, at approximately 5:20 PM, which was almost 20 hours after the allegation. The failure of the facility to protect residents from verbal abuse by allowing a staff member to return to work in the facility, with the same resident, following an investigation of witnessed verbal abuse; and failure to report the abuse within two (2) hours to the State Designated Agencies, per facility policy, placed Resident #14 and other residents in a situation that was likely to cause serious injury, harm, impairment, or death.	F 607	2.Facility Residents have the potential to be affected by deficit practice. Residents with Brief Interview for Mental Status (BIMS) scores of 12 or higher were interviewed by Director of Nursing/Human Resources/Minimum Data Set Registered Nurses/Staff Development Coordinator/Activity Director/Social Services under the direction of the Administrator and Director of Nursing, on 4/29/19, regarding concerns of abuse or neglect; no concerns noted. Facility staff were interviewed beginning on 4/27/19 by Director of Nursing/Human Resources/Minimum Data Set Registered Nurses/Staff Development Coordinator/Activity Director/Social Services/Business Office Manager/Corporate Clinical Specialist Registered Nurse/Case Mix Specialist Registered Nurse/Regional Vice President, regarding concerns of abuse or neglect; no concerns noted. 3. On 4/26/19,Regional Vice President educated facility Administrator on requirements of abuse/neglect prohibition policy including reporting requirements. Beginning 4/27/19,facility staff participated in abuse/neglect questionnaires to determine knowledge retention on abuse/neglect prohibition training; individuals who could not answer each question correctly were provided one-to-one additional training. Beginning on 4/30/19, facility staff were in-serviced by Corporate Clinical Specialist/Director of Nursing regarding abuse and neglect	

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F 607	Continued From page 26 The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 4/3/19, when the abuse occurred. The facility's Administrator was notified of the IJ and SQC on 4/25/19, at 10:00 AM, and the State Agency (SA) provided the facility with the IJ template. An acceptable credible Removal Plan was provided by the facility on 4/26/19, in which the facility alleged all corrective actions were completed as of 4/25/19, and the IJ was removed on 4/26/19. The State Agency (SA) validated the Removal Plan and determined that the IJ was removed on 4/26/19, prior to exit. Therefore, the scope and severity for IJ and SQC at 42 CFR 483.12(b)(1)-(3); Develop/Implement Abuse/Neglect Policies, was lowered to a "D", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the facility's policy entitled "Abuse Prohibition Policy", Revision: 03/18/2019, revealed Policy: 1. The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property or finances of residents. Review of the facility policy "Abuse Program", Revision 11/2017, revealed ...Investigation: 1. The facility will thoroughly investigate all alleged violations and take appropriate actions. 2. The Abuse Coordinator will report such allegations to the state agency in accordance with state law. The Abuse Coordinator will report all allegations of abuse...within two hours of the allegation...	F 607	prohibition policy, reporting concerns regarding abuse and/or neglect immediately, two hour required reporting timeframe by the facility to the Mississippi State Department of Health, Licensure and Certification, protecting residents immediately following allegation of abuse/neglect. On 5/6/19, representative of the Mississippi Attorney General□s office provided in-service to facility staff in regards to abuse/neglect prevention, reporting, Vulnerable Adults Act, Medicaid Fraud, types of abuse. On 5/22/19,Corporate Support Administrator/Registered Nurse in-serviced facility staff on Abuse and Neglect Prohibition program including but not limited to the requirement to protect residents, if a staff is involved, they will be suspended, facility is required to report to authorities within two (2) hour time frame, facility is required to conduct a thorough investigation and findings of investigation could lead to staff termination. A Quality Assurance Performance Improvement committee meeting was held on 5/22/19 with the Administrator, the Director of Nursing, the Corporate Clinical Specialist and Medical Director to review the statement of deficiencies and plan of correction; no further recommendations were made. 4. Beginning on 5/27/19, facility department heads including Social Services, Activities, Nursing Leadership, Business Office Manager, Minimum Data Set nurses, Lead Certified Nursing Assistant (C.N.A.), Dietary Manager,	

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F 607	Continued From page 27 Protection: 1. All residents will be immediately protected from harm. 2. All allegations involving staff will necessitate suspension without pay, pending investigation. 3. If the allegation is substantiated, the employee will be terminated immediately without pay retroactive to the date of removal from employment. ... Statement of Policy, Regarding the Reporting of Abuse and Associate Acknowledgement ...Remember our policy is all residents and patients of this nursing home are to be treated with dignity and respect at all times, under all circumstances. Mistreatment or abuse of any nature will not be tolerated... During an interview with Resident #14 on 04/22/19, at 04:03 PM, he stated that about two (2) weeks ago, Licensed Practical Nurse (LPN) #1 cursed him and pushed him into a wall, hurting his left foot. He stated "If y'all don't do anything about it, I will". Resident #14 had difficulty recalling exactly what was said but stated that he cursed her and she cursed him back. He also stated that he did not trust LPN #1 and he refused to take any medication or receive any care from her after she returned to work and was re-assigned to his hall. He stated, "No telling what she might do". Review of a written report from the facility, dated 4/5/19, revealed that on 4/3/19 at 9:50 PM, Resident #14 alleged that LPN #1 cursed him and pushed his wheelchair against the wall hurting his toe. Witnesses, LPN #2 and LPN #3 wrote statements and confirmed LPN #1 used profane language toward Resident #14, saying things such as, "Mother Fucker", and Bitch toward or in the presence of Resident #14. LPN #1 was suspended on 4/3/19.	F 607	Admissions Director, will interview residents in their respective facility areas weekly for twelve (12) weeks, in regards to concerns related to care or treatment from staff related to abuse and/or neglect issues; any negative concern will be immediately reported to the Administrator or Director of Nursing for further intervention. Beginning on 5/27/19, the Administrator will review the incident log weekly to ensure reportable events have been investigated and reported as required. Beginning on 5/27/19, the Administrator will review the grievance log weekly to ensure any allegations have been investigated and reported as required. A report will be submitted by the Administrator to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The Administrator is responsible for monitoring and compliance.	

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Record review of the Daily Assignment Sheets for 4/17/19 - 4/21/19, revealed that LPN #1 was assigned to the 300/400 Hall for these dates. LPN #1 was also assigned on the same hall on 4/24/19, prior to being re-assigned to another building to work in Medical Records. Resident #14 resided on the 300 hall and LPN #1 was assigned his care.

On 04/23/19, at 4:30 PM, during an interview with the Administrator, she confirmed that LPN #1 continued to work for the facility after being suspended for verbal abuse from 4/3/19 - 4/17/19, and that LPN #1 was allowed to return to work on 4/17/19, after the investigation was completed. The Administrator stated that abuse could not be substantiated on the part of the facility, per corporate review. Further interview with the Administrator, on 04/24/19, at 8:33 AM, revealed that she did feel that verbal abuse had occurred to Resident #14 by LPN #1, based upon the statements of LPN #2 and LPN #3 that were obtained during the investigation. The Administrator stated she requested for LPN #1 to be terminated for verbal abuse, but was denied by Human Resources. She stated that LPN #1 was brought back and re-assigned to the same halls she worked prior to the suspension; this was the same hall upon which Resident #14 resided. She confirmed that the facility policy was not followed for protection of the resident. She stated that LPN #1 was terminated on 4/24/19, for verbal abuse of Resident #14.

On 04/24/19, at 8:33 AM, during an interview with the Administrator, she stated that she was not aware of the regulation and thought she had 24 hours to report the allegation of abuse by LPN #1 to Resident #14. She confirmed the allegation

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was not reported to the Mississippi State Department of Health, Health Facilities Licensure and Certification within two (2) hours.

Review of a Fax Call Report revealed that the incident of verbal abuse for Resident #14 was reported to the Mississippi State Department of Health Hotline number on 4/4/19, at 5:16 PM, which was almost 20 hours after the incident occurred.

The facility submitted an acceptable Removal Plan on 4/26/19, for the IJ.

Review of the facility's Removal Plan revealed the facility took the following corrective actions to remove the IJ prior to exit:

1. The facility failed to assure the resident was free from verbal abuse and failed to report the abuse within the required two (2) hour reporting period, failing to keep the resident safe. On April 3, 2019, at approximately 10:00 PM, Resident #14 reported an allegation of verbal abuse against Licensed Practical Nurse (LPN) #1. The allegation consisted of the Resident #14 using a derogatory name towards LPN #1. LPN #1 responded to the resident by using the same derogatory name. This occurred around the nursing station. LPN #3 stated she heard LPN #1 say "If I'm a bitch, you are a bitch. It takes one to know one" at the nurses station. LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was immediately notified by LPN #2 at approximately 10:00 PM. LPN #1 was immediately suspended, abuse in-services and the abuse investigation was initiated.

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2. The following parties were notified of the incident:
· Responsible party was notified April 4, 2019 at approximately 10:38 AM.
· Primary Physician was notified April 4, 2019 at 12:50 PM.
· Medical Director was notified April 4, 2019 at 11:44 AM.
· Mississippi State Department of Health was notified April 4, 2019 at 5:20 PM.
· Mississippi State Attorney General was notified April 4, 2019 at 5:01 PM.
· Mississippi State Board of Nursing was notified April 25, 2019 at 9:11 PM.

3. LPN #1 was brought back on April 17, 2019, and received an inservice on abuse, neglect, and exploitation. She was then assigned to Resident #14, thus not protecting the residents in the facility from further abuse and the facility not following their policy for abuse. LPN #1 was subsequently suspended on April 24, 2019, pending an investigation. LPN #1 was terminated on April 25, 2019, for verbal abuse against Resident #14.

4. On April 24, 2019, at approximately 9:00 AM, the Administrator removed LPN #1 from all resident care areas.

5. On April 24, 2019, beginning at approximately 8:00 PM, the Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC), and Assistant DON initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, reporting abuse and/or neglect

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within the required two (2) hour time frame. Focus was placed on immediately removing the resident from the abuse situation; reporting all allegations of abuse, neglect and exploitation to the Administrator immediately; and that any staff member accused of abuse, neglect or exploitation will be suspended immediately pending investigation. No staff member will be allowed to return to work without completing required education. Currently, 76 of 88 staff members have completed required education.

6. On April 24, 2019, beginning at approximately 8:45 PM, the Interim Director of Nursing, Corporate Clinical Specialist, Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) provided posttest to employees in regards to Abuse and Neglect prohibition policy that was initiated on April 24, 2019, to ascertain understanding of Abuse and Neglect prohibition policy training. Any employee that was not able to answer the posttest answers correctly was provided a one-to-one (1:1)re-education at that time. No staff will be allowed to return to work without completing the required education posttest.

7. On April 24, 2019, beginning at approximately 9:15 PM, Social Worker, Human Resource Director, Business Office Manager (BOM), Respiratory Therapist, Assistant BOM, Activities Director, Minimum Data Set nurses, SDC, Registered Nurse (RN) Charge Nurse interviewed forty-five (45) residents in the facility at that time, with a Brief Interview of Mental Status (BIMS) of 12 or higher, in regards to had they ever experienced any verbal or physical abuse. Findings of the interviews were reviewed by the Administrator to determine any on-going or

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previously unidentified allegations of abuse and/or neglect; two (2) residents relayed information from a prior incident, which was investigated and reported. No abuse was substantiated.

8. On April 24, 2019, beginning at approximately 9:00 PM, the Corporate Clinical Specialist, both MDS nurses and the Regional Case Mix Specialist reviewed clinical documentation for Resident #14, to determine any negative changes to daily routines, activity participation, socialization, meal intake; Resident #14 began refusing medication from LPN #1 on April 18, 2019. No other changes where identified with Resident #14.

9. On April 24, 2019 and April 26, 2019, the Chief Operating Officer in-serviced the Director of Field Human Resources on the policy and procedures for Abuse and Neglect.

10. On April 25, 2019 at approximately 12:30 PM, the grievance log, beginning January 1, 2019 through April 25, 2019, and incident log, beginning January 1, 2019 through April 25, 2019, were reviewed by the Administrator to identify potential allegations abuse/neglect for reporting potential. No grievances or incidence were identified as a potential allegation that had not already been reported.

11. On April 25, 2019, at 2:00 PM, the Medical Director, Administrator, interim Director of Nursing, Social Services Director, Activities Director, BOM, SDC, ADON, Dietary Supervisor, Housekeeping Supervisor, Maintenance Director, HR director and Director of Rehab held a Quality Assurance Performance Improvement (QAPI)

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meeting following notification of Immediate Jeopardy to review steps initiated to identify any on-going or previously unreported allegations of abuse and/or neglect and to administer posttest to employees to determine understanding of education provided. There were no new policy or procedure changes.

12. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of April 25, 2019, and the Immediate Jeopardy was removed April 26, 2019.

The State Agency (SA) validated the facility's Removal Plan and determined the facility took the following actions to correct the IJ:

1. The SA validated that Resident #14 was not free from verbal abuse and the facility failed to report the abuse within the required two (2) hour reporting period, failed to keep residents safe. On April 3, 2019, at approximately 10:00 PM, Resident #14 reported an allegation of verbal abuse against Licensed Practical Nurse (LPN) #1. The allegation consisted of the Resident #14 using a derogatory name towards LPN #1 and LPN #1 responded to the resident by using the same derogatory name. This occurred around the nursing station. The SA validated through interviews that LPN #3 stated she heard LPN #1 say "If I'm a bitch, you are bitch. It takes one to know one" at the nurses station. LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was notified by LPN #2. LPN #1 was suspended, abuse in-services and the abuse investigation was initiated.

2. The following parties were notified of the incident:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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· The SA validated through interview with the Responsible Party that she was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Primary Physician was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Medical Director that he was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Department of Health was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Attorney General was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Board of Nursing was notified April 25, 2019, of the alleged abuse by LPN #1.

3. The SA validated through interview with LPN #1 and the Administrator and record review that LPN #1 was suspended and was brought back to work on April 17, 2019, and received an inservice on abuse, neglect, and exploitation. She was then assigned to Resident #14, thus not protecting the residents in the facility from further abuse and the facility not following their policy for abuse. LPN #1 was subsequently suspended on April 24, 2019, pending an investigation. The SA validated that LPN #1 was terminated on April 25, 2019, for verbal abuse against Resident #14.

4. The SA validated through interview with the Administrator and LPN #1 and record review, that on April 24, 2019, the Administrator removed

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LPN #1 from all resident care areas and placed her in another building with Medical Records duty.

5. The SA validated through interview with the Administrator, and staff from Nursing, Dietary, Social Services, Therapy, Business Office and Housekeeping/Maintenance and record review that on April 24, 2019, beginning at approximately 8:00 PM, the Administrator, DON, SDC and ADON initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, reporting abuse and/or neglect within the required two (2) hour time frame. Focus was placed on immediately removing the resident from the abuse situation; reporting all allegations of abuse, neglect and exploitation to the Administrator immediately; and that any staff member accused of abuse, neglect or exploitation will be suspended immediately pending investigation. No staff member was allowed to return to work, without completing required education. Currently, 76 of 88 staff members have completed required education.

6. The SA validated through interview with the Administrator and staff from Nursing, Dietary, Social Services, Therapy, Business Office and Housekeeping/Maintenance and record review that on April 24, 2019, beginning at approximately 8:45 PM, the interim Director of Nursing, Corporate Clinical Specialist, Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) provided posttest to employees in regards to Abuse and Neglect prohibition policy that was initiated on April 24, 2019, to ascertain understanding of Abuse and

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Neglect prohibition policy training. Any employee that was not able to answer the posttest answers correctly was provided a one-to-one (1:1) re-education at that time. No staff was allowed to return to work without completing the required education posttest.

7. The SA validated through interview with the Administrator and record review that on April 24, 2019, the Social Worker, Human Resource Director, Business Office Manager (BOM), Respiratory Therapist, Assistant BOM, Activities Director, Minimum Data Set nurses, SDC, Registered Nurse (RN) Charge Nurse interviewed forty-five (45) residents in the facility at that time, with a BIMS of 12 or higher, in regards to had they ever experienced any verbal or physical abuse. Findings of the interviews were reviewed by the Administrator to determine any on-going or previously unidentified allegations of abuse and/or neglect; two (2) residents relayed information from a prior incident, which was investigated and reported. The SA validated no abuse was substantiated.

8. The SA validated through interview with the Administrator, Corporate Clinical Specialist, and one (1) MDS nurse, that on April 24, 2019, the Corporate Clinical Specialist, both MDS nurses and the Regional Case Mix Specialist reviewed clinical documentation for Resident #14, to determine any negative changes to daily routines, activity participation, socialization, meal intake; Resident #14 began refusing medication from LPN #1 on April 18, 2019. No other changes where identified with Resident #14. The SA validated that Resident #14 did receive medication from other nurses.

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9. The SA validated through interview with the Chief Operating Officer, and dated/signed in-service sheets, that the Director of Field Human Resources was educated on the abuse and neglect policy and procedures with emphasis of investigation and to err on the side of the resident.

10. The SA validated through interview with the Administrator and record review that on April 25, 2019, the grievance log, beginning January 1, 2019 through April 25, 2019, and incident log, beginning January 1, 2019 through April 25, 2019, were reviewed by the Administrator to identify potential allegations abuse/neglect for reporting potential. No grievances or incidence were identified as a potential allegation that had not already been reported.

11. The SA validated through interview with the Administrator and record review that on April 25, 2019, at 2:00 PM, the Medical Director, Administrator, interim Director of Nursing, Social Services Director, Activities Director, BOM, SDC, ADON, Dietary Supervisor, Housekeeping Supervisor, Maintenance Director, HR director and Director of Rehab held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to identify any on-going or previously unreported allegations of abuse and/or neglect and to administer posttest to employees to determine understanding of education provided. There were no new policy or procedure changes.

12. The SA validated that all corrective actions were completed as of 4/25/19, and the IJ was removed as of 4/26/19.

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F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to report an allegation of staff to resident abuse within the two (2) hour required timeframe, for one (1) of 24 residents reviewed, Resident #14. On 4/3/19 at approximately 9:50 PM, Resident #4	F 609	F609 1. Resident #14 was interviewed on 5/15/19 by Corporate Clinical Specialist regarding abuse/neglect concerns; Resident #14 denies any other instances of abuse or neglect. LPN#1 was	5/31/19

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F 609	Continued From page 39 and Licensed Practical Nurse (LPN) #1 had a verbal altercation, with subsequent verbal abuse by LPN #1. Resident #14 called LPN #1 derogatory names, such as Bitch, and the LPN responded back that if she was a Bitch, that he was too, because it took one to know one. LPN #1 was also witnessed to use the phrase, "Mother Fucker". Facility administration was notified immediately, however, it was not reported to the required state agencies until 4/4/19, at approximately 5:20 PM. the Mississippi State Attorney General's office was notified on 4/7/2019, at 7:56:48 PM. The State Board of Nursing was not notified until 4/25/19 at approximately 9:11 PM. LPN #1 was allowed to return to work on 4/17/19, and continued to work at the facility, with Resident #14 and other residents, until 4/24/19. The failure of the facility to notify the appropriate state agencies in a timely manner of an allegation of abuse, to ensure proper measures had been addressed; and allowing the staff member to return to work with the same resident and other residents after the verbal abuse of a resident, placed Resident #14 and other residents at risk for the likelihood of serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 4/3/19, when the allegation of abuse occurred. The facility's Administrator was notified of the IJ and SQC on 4/25/19, at 10:00 AM and provided the facility with the IJ template. An acceptable credible Removal Plan was accepted on 4/26/19, in which the facility alleged all corrective actions were completed as of 4/25/19, and the IJ was removed	F 609	terminated on 4/25/2019. The allegation was reported to the appropriate state agencies on 4/4/19 around 5:20 PM by facility Administrator and on 4/4/2019 at 10:38 AM Responsible party resident#14 wife was notified by the facility administrator. 2.Facility Residents have the potential to be affected by failure to report allegation within two (2) hour timeframe. Residents with Brief Interview for Mental Status (BIMS) scores of 12 or higher were interviewed by Director of Nursing/Human Resources/Minimum Data Set Registered Nurses/Staff Development Coordinator/Activity Director/Social Services under the direction of the Administrator and Director of Nursing, on 4/29/19, regarding concerns of abuse or neglect; no concerns noted. Facility staff were interviewed beginning on 4/27/19 by Director of Nursing/Human Resources/Minimum Data Set Registered Nurses/Staff Development Coordinator/Activity Director/Social Services/Business Office Manager/Corporate Clinical Specialist Registered Nurse/Case Mix Specialist Registered Nurse/Regional Vice President, regarding concerns of abuse or neglect; no concerns noted. 3. On 4/26/19,Regional Vice President educated facility Administrator on requirements of abuse/neglect prohibition policy including reporting requirements. Beginning 4/27/19,facility staff participated in abuse/neglect questionnaires to	

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F 609	Continued From page 40 on 4/26/19. The State Agency (SA) validated the Removal Plan and determined that the IJ was removed on 4/26/19, prior to exit. Therefore, the scope and severity for IJ and SQC at CFR 483.12(c)(1)(4) F609, Reporting of Alleged Violations,was lowered to a "D", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's policy entitled "Abuse Prohibition Policy", Revision: 03/18/2019, revealed Policy: 1. The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property or finances of residents. Review of the facility policy "Abuse Program", Revision 11/2017, revealed,....Investigation: 1. The facility will thoroughly investigate all alleged violations and take appropriate actions. 2. The Abuse Coordinator will report such allegations to the state agency in accordance with state law. The Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, exploitation with serious bodily injury, and injuries of unknown source with serious bodily injury immediately or within two hours of the allegation... Protection: 1. All residents will be immediately protected from harm. 2. All allegations involving staff will necessitate suspension without pay, pending investigation. 3. If the allegation is substantiated, the employee will be terminated immediately without pay retroactive to the date of	F 609	determine knowledge retention on abuse/neglect prohibition training; individuals who could not answer each question correctly were provided one-to-one additional training. Beginning on 4/30/19, facility staff were in-serviced by Corporate Clinical Specialist/Director of Nursing regarding abuse and neglect prohibition policy, reporting concerns regarding abuse and/or neglect immediately, two hour required reporting timeframe by the facility to the Mississippi State Department of Health, Licensure and Certification, protecting residents immediately following allegation of abuse/neglect. On 5/6/19, representative of the Mississippi Attorney General□s office provided in-service to facility staff in regards to abuse/neglect prevention, reporting, Vulnerable Adults Act, Medicaid Fraud, types of abuse. On 5/22/19,Corporate Support Administrator/Registered Nurse in-serviced facility staff on Abuse and Neglect Prohibition program including but not limited to the requirement to protect residents, if a staff is involved, they will be suspended, facility is required to report to authorities within two (2) hour time frame, facility is required to conduct a thorough investigation and findings of investigation could lead to staff termination. A Quality Assurance Performance Improvement committee meeting was held on 5/22/19 with the Administrator, the Director of Nursing, the Corporate Clinical Specialist and Medical Director to review the statement of deficiencies and plan of correction; no further recommendations	

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F 609	Continued From page 41 removal from employment. ... Statement of Policy, Regarding the Reporting of Abuse and Associate Acknowledgement,....Remember our policy is all residents and patients of this nursing home are to be treated with dignity and respect at all times, under all circumstances. Mistreatment or abuse of any nature will not be tolerated... Review of a facility investigation revealed that an incident of verbal abuse was alleged by Resident #14 on 4/3/19 around 9:50 PM. The allegation was not reported to the appropriate state agencies until 4/4/19 around 5:20 PM, almost 20 hours after the allegation. On 04/24/19, at 08:33 AM, during an interview with the Administrator, she stated that the allegation of abuse for Resident #14, by LPN #1, was not reported to the Mississippi State Department of Health, Health Facilities Licensure and Certification within two (2) hours. She stated that she was not aware of the regulation and thought she had 24 hours to report. She stated that she had misinterpreted the facility policy for reporting abuse. Record review of the Facility Reported Incident (FRI) dated 4/5/19, and staff written statements concerning an incident of verbal abuse on 4/3/19 by LPN #1, revealed LPN #4 reported that on 4/3/19, at 9:50 PM, Resident #14 was tapping his hand on the counter to get the nurse's attention. Resident #14 asked for a snack and to use the cordless phone, but it was not charged. Resident #14 became agitated and began hitting the nurse's station desk loudly with the palm of his hand. He also grabbed papers from a chart on the desk attempting to read them. Resident #14 cursed LPN #1 who cursed him in return. This	F 609	were made. 4. Beginning on 5/27/19, facility department heads including Social Services, Activities, Nursing Leadership, Business Office Manager, Minimum Data Set nurses, Lead Certified Nursing Assistant (C.N.A.), Dietary Manager, Admissions Director, will interview residents in their respective facility areas weekly for twelve (12) weeks, in regards to concerns related to care or treatment from staff related to abuse and/or neglect issues; any negative concern will be immediately reported to the Administrator or Director of Nursing for further intervention. Beginning on 5/27/19, the Administrator will review the incident log weekly to ensure reportable events have been investigated and reported as required. 4/26/2019-5/26/2019 Grievance log review by Administrator, on 5/26/2019, to ensure all allegations were investigated and reported as required. Beginning on 5/27/19, the Administrator will review the grievance log weekly to ensure any allegations have been investigated and reported as required. A report will be submitted by the Administrator to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The Administrator is responsible for monitoring and compliance.	

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was witnessed by LPN #2 and LPN #3, who stated that LPN#1 used profanity such as "Mother Fucker", and "If I'm a bitch, you are a bitch. It takes one to know one". LPN #1 was suspended pending investigation.

Record review of the Fax Call Report revealed that the incident of verbal abuse for Resident #14 was reported to the Mississippi State Department of Health Hotline number on 4/4/19, at 5:16 PM.

Record review of the Fax Call Report revealed that the facility faxed a copy of the allegation of verbal abuse of Resident #14 (by LPN #1) to the Mississippi State Attorney General on 4/7/2019, at 7:56:48 PM.

Review of records revealed the MS State Board of Nursing was notified of LPN #1's verbal abuse to Resident #14, on 4/25/19 at approximately 9:11 PM.

The facility submitted an acceptable Removal Plan on 4/26/19, for the IJ.

Review of the facility's Removal Plan revealed the facility took the following corrective actions to remove the IJ prior to exit:

1. The facility failed to assure the resident was free from verbal abuse and failed to report the abuse within the required two (2) hour reporting period, failing to keep the resident safe. On April 3, 2019, at approximately 10:00 PM, Resident #14 reported an allegation of verbal abuse against Licensed Practical Nurse (LPN) #1. The allegation consisted of the Resident #14 using a derogatory name towards LPN #1. LPN #1

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responded to the resident by using the same derogatory name. This occurred around the nursing station. LPN #3 stated she heard LPN #1 say "If I'm a bitch, you are a bitch. It takes one to know one" at the nurses station. LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was immediately notified by LPN #2 at approximately 10:00 PM. LPN #1 was immediately suspended, abuse in-services and the abuse investigation was initiated.

2. The following parties were notified of the incident:
· Responsible party was notified April 4, 2019 at approximately 10:38 AM.
· Primary Physician was notified April 4, 2019 at 12:50 PM.
· Medical Director was notified April 4, 2019 at 11:44 AM.
· Mississippi State Department of Health was notified April 4, 2019 at 5:20 PM.
· Mississippi State Attorney General was notified April 4, 2019 at 5:01 PM.
· Mississippi State Board of Nursing was notified April 25, 2019 at 9:11 PM.

3. LPN #1 was brought back on April 17, 2019, and received an inservice on abuse, neglect, and exploitation. She was then assigned to Resident #14, thus not protecting the residents in the facility from further abuse and the facility not following their policy for abuse. LPN #1 was subsequently suspended on April 24, 2019, pending an investigation. LPN #1 was terminated on April 25, 2019, for verbal abuse against Resident #14.

4. On April 24, 2019, at approximately 9:00 AM, the Administrator removed LPN #1 from all

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F 609	Continued From page 44 resident care areas. 5. On April 24, 2019, beginning at approximately 8:00 PM, the Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC), and Assistant DON initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, reporting abuse and/or neglect within the required two (2) hour time frame. Focus was placed on immediately removing the resident from the abuse situation; reporting all allegations of abuse, neglect and exploitation to the Administrator immediately; and that any staff member accused of abuse, neglect or exploitation will be suspended immediately pending investigation. No staff member will be allowed to return to work without completing required education. Currently, 76 of 88 staff members have completed required education. 6. On April 24, 2019, beginning at approximately 8:45 PM, the Interim Director of Nursing, Corporate Clinical Specialist, Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) provided posttest to employees in regards to Abuse and Neglect prohibition policy that was initiated on April 24, 2019, to ascertain understanding of Abuse and Neglect prohibition policy training. Any employee that was not able to answer the posttest answers correctly was provided a one-to-one (1:1)re-education at that time. No staff will be allowed to return to work without completing the required education posttest. 7. On April 24, 2019, beginning at approximately	F 609		

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9:15 PM, Social Worker, Human Resource Director, Business Office Manager (BOM), Respiratory Therapist, Assistant BOM, Activities Director, Minimum Data Set nurses, SDC, Registered Nurse (RN) Charge Nurse interviewed forty-five (45) residents in the facility at that time, with a Brief Interview of Mental Status (BIMS) of 12 or higher, in regards to had they ever experienced any verbal or physical abuse. Findings of the interviews were reviewed by the Administrator to determine any on-going or previously unidentified allegations of abuse and/or neglect; two (2) residents relayed information from a prior incident, which was investigated and reported. No abuse was substantiated.

8. On April 24, 2019, beginning at approximately 9:00 PM, the Corporate Clinical Specialist, both MDS nurses and the Regional Case Mix Specialist reviewed clinical documentation for Resident #14, to determine any negative changes to daily routines, activity participation, socialization, meal intake; Resident #14 began refusing medication from LPN #1 on April 18, 2019. No other changes where identified with Resident #14.

9. On April 24, 2019 and April 26, 2019, the Chief Operating Officer in-serviced the Director of Field Human Resources on the policy and procedures for Abuse and Neglect.

10. On April 25, 2019 at approximately 12:30 PM, the grievance log, beginning January 1, 2019 through April 25, 2019, and incident log, beginning January 1, 2019 through April 25, 2019, were reviewed by the Administrator to identify potential allegations abuse/neglect for reporting

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potential. No grievances or incidence were identified as a potential allegation that had not already been reported.

11. On April 25, 2019, at 2:00 PM, the Medical Director, Administrator, interim Director of Nursing, Social Services Director, Activities Director, BOM, SDC, ADON, Dietary Supervisor, Housekeeping Supervisor, Maintenance Director, HR director and Director of Rehab held a Quality Assurance Performance Improvement (QAPI) meeting following notification of Immediate Jeopardy to review steps initiated to identify any on-going or previously unreported allegations of abuse and/or neglect and to administer posttest to employees to determine understanding of education provided. There were no new policy or procedure changes.

12. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of April 25, 2019, and the Immediate Jeopardy was removed April 26, 2019.

The State Agency (SA) validated the facility's Removal Plan and determined the facility took the following actions to correct the IJ:

1. The SA validated that Resident #14 was not free from verbal abuse and the facility failed to report the abuse within the required two (2) hour reporting period, failed to keep residents safe. On April 3, 2019, at approximately 10:00 PM, Resident #14 reported an allegation of verbal abuse against Licensed Practical Nurse (LPN) #1. The allegation consisted of the Resident #14 using a derogatory name towards LPN #1 and LPN #1 responded to the resident by using the

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same derogatory name. This occurred around the nursing station. The SA validated through interviews that LPN #3 stated she heard LPN #1 say "If I'm a bitch, you are bitch. It takes one to know one" at the nurses station. LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was notified by LPN #2. LPN #1 was suspended, abuse in-services and the abuse investigation was initiated.

2. The following parties were notified of the incident:
· The SA validated through interview with the Responsible Party that she was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Primary Physician was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Medical Director that he was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Department of Health was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Attorney General was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Board of Nursing was notified April 25, 2019, of the alleged abuse by LPN #1.

3. The SA validated through interview with LPN #1 and the Administrator and record review that LPN #1 was suspended and was brought back to work on April 17, 2019, and received an inservice

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on abuse, neglect, and exploitation. She was then assigned to Resident #14, thus not protecting the residents in the facility from further abuse and the facility not following their policy for abuse. LPN #1 was subsequently suspended on April 24, 2019, pending an investigation. The SA validated that LPN #1 was terminated on April 25, 2019, for verbal abuse against Resident #14.

4. The SA validated through interview with the Administrator and LPN #1 and record review, that on April 24, 2019, the Administrator removed LPN #1 from all resident care areas and placed her in another building with Medical Records duty.

5. The SA validated through interview with the Administrator, and staff from Nursing, Dietary, Social Services, Therapy, Business Office and Housekeeping/Maintenance and record review that on April 24, 2019, beginning at approximately 8:00 PM, the Administrator, DON, SDC and ADON initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, reporting abuse and/or neglect within the required two (2) hour time frame. Focus was placed on immediately removing the resident from the abuse situation; reporting all allegations of abuse, neglect and exploitation to the Administrator immediately; and that any staff member accused of abuse, neglect or exploitation will be suspended immediately pending investigation. No staff member was allowed to return to work, without completing required education. Currently, 76 of 88 staff members have completed required education.

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6. The SA validated through interview with the Administrator and staff from Nursing, Dietary, Social Services, Therapy, Business Office and Housekeeping/Maintenance and record review that on April 24, 2019, beginning at approximately 8:45 PM, the interim Director of Nursing, Corporate Clinical Specialist, Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) provided posttest to employees in regards to Abuse and Neglect prohibition policy that was initiated on April 24, 2019, to ascertain understanding of Abuse and Neglect prohibition policy training. Any employee that was not able to answer the posttest answers correctly was provided a one-to-one (1:1) re-education at that time. No staff was allowed to return to work without completing the required education posttest.

7. The SA validated through interview with the Administrator and record review that on April 24, 2019, the Social Worker, Human Resource Director, Business Office Manager (BOM), Respiratory Therapist, Assistant BOM, Activities Director, Minimum Data Set nurses, SDC, Registered Nurse (RN) Charge Nurse interviewed forty-five (45) residents in the facility at that time, with a BIMS of 12 or higher, in regards to had they ever experienced any verbal or physical abuse. Findings of the interviews were reviewed by the Administrator to determine any on-going or previously unidentified allegations of abuse and/or neglect; two (2) residents relayed information from a prior incident, which was investigated and reported. The SA validated no abuse was substantiated.

8. The SA validated through interview with the Administrator, Corporate Clinical Specialist, and

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one (1) MDS nurse, that on April 24, 2019, the Corporate Clinical Specialist, both MDS nurses and the Regional Case Mix Specialist reviewed clinical documentation for Resident #14, to determine any negative changes to daily routines, activity participation, socialization, meal intake; Resident #14 began refusing medication from LPN #1 on April 18, 2019. No other changes where identified with Resident #14. The SA validated that Resident #14 did receive medication from other nurses.

9. The SA validated through interview with the Chief Operating Officer, and dated/signed in-service sheets, that the Director of Field Human Resources was educated on the abuse and neglect policy and procedures with emphasis of investigation and to err on the side of the resident.

10. The SA validated through interview with the Administrator and record review that on April 25, 2019, the grievance log, beginning January 1, 2019 through April 25, 2019, and incident log, beginning January 1, 2019 through April 25, 2019, were reviewed by the Administrator to identify potential allegations abuse/neglect for reporting potential. No grievances or incidence were identified as a potential allegation that had not already been reported.

11. The SA validated through interview with the Administrator and record review that on April 25, 2019, at 2:00 PM, the Medical Director, Administrator, interim Director of Nursing, Social Services Director, Activities Director, BOM, SDC, ADON, Dietary Supervisor, Housekeeping Supervisor, Maintenance Director, HR director and Director of Rehab held Quality Assurance

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F 609	Continued From page 51 Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to identify any on-going or previously unreported allegations of abuse and/or neglect and to administer posttest to employees to determine understanding of education provided. There were no new policy or procedure changes. 12. The SA validated that all corrective actions were completed as of 4/25/19, and the IJ was removed as of 4/26/19.	F 609		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to prevent further potential abuse and mistreatment from	F 610	F610 1. Resident #14 was interviewed on	5/31/19

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F 610	Continued From page 52 occurring after an allegation of abuse had been made and substantiated for one (1) of 24 residents reviewed, Resident #14. The facility failed to report the allegation of abuse within the required two (2) hour timeframe, and failed to take appropriate corrective action to protect residents from further abuse, by allowing Licensed Practical Nurse (LPN) #1 to continue working with Resident #14, after the witnessed verbal abuse occurred. On 4/3/19 at approximately 9:50 PM, Licensed Practical Nurse (LPN) #1 was witnessed to verbally abuse Resident #14. She used words such as "Mother Fucker" and statements such as, "If I'm a Bitch, then you're a Bitch, because it takes one to know one". Resident #14 also accused LPN #1 of hurting his foot by pushing his wheelchair into the wall. LPN #1 was suspended on 4/3/19, however, she was allowed to return to work on 4/17/19, and continued to work until 4/24/19, on the same unit and was assigned the same room as Resident #14 resided. Resident #14 refused to take medications from the LPN and he made statements such as he wouldn't take medications from her, he didn't trust her, and that he didn't know what she would do. The allegation of abuse was not reported within the two (2) hour timeframe as required, but was reported the next day, almost 20 hours after the incident. The failure of the facility to report the allegation of abuse within the appropriate timeframe and by not protecting residents from further verbal abuse by allowing a staff member to work in the facility following a witnessed verbal abuse to a resident, with a history of profanity in the presence of residents, placed Resident #14 and other	F 610	5/15/19 by Corporate Clinical Specialist regarding abuse/neglect concerns; Resident #14 denies any other instances of abuse or neglect. LPN#1 was terminated on 4/25/2019. 2.Facility Residents have the potential to be affected by deficit practice. Residents with Brief Interview for Mental Status (BIMS) scores of 12 or higher were interviewed by Director of Nursing/Human Resources/Minimum Data Set Registered Nurses/Staff Development Coordinator/Activity Director/Social Services under the direction of the Administrator and Director of Nursing, on 4/29/19, regarding concerns of abuse or neglect; no concerns noted. Facility staff were interviewed beginning on 4/27/19 by Director of Nursing/Human Resources/Minimum Data Set Registered Nurses/Staff Development Coordinator/Activity Director/Social Services/Business Office Manager/Corporate Clinical Specialist Registered Nurse/Case Mix Specialist Registered Nurse/Regional Vice President, regarding concerns of abuse or neglect; no concerns noted. 3. On 4/26/19,Regional Vice President educated facility Administrator on requirements of abuse/neglect prohibition policy including reporting requirements. Beginning 4/27/19,facility staff participated in abuse/neglect questionnaires to determine knowledge retention on abuse/neglect prohibition training; individuals who could not answer each	

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F 610	Continued From page 53 residents at risk for the likelihood of serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 4/3/19, when the allegation of abuse occurred. The facility's Administrator was notified of the IJ and SQC on 4/25/19, at 10:00 AM, and the SA provided the facility with the IJ template. An acceptable credible Removal Plan was provided on 4/26/19, in which the facility alleged all corrective actions were completed as of 4/25/19, and the IJ was removed on 4/26/19. The State Agency (SA) validated the Removal Plan, and determined that the IJ was removed on 4/26/19, prior to exit. Therefore, the scope and severity for IJ and SQC at 42 CFR 482.12(c)(2)-(4), F610, Investigate/Prevent/Correct Alleged Violation, was lowered to a "D", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the facility's policy entitled "Abuse Prohibition Policy", Revision: 03/18/2019, revealed Policy: 1. The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property or finances of residents. Review of the facility policy "Abuse Program", Revision 11/2017, revealed,....Investigation: 1. The facility will thoroughly investigate all alleged violations and take appropriate actions. 2. The Abuse Coordinator will report such allegations to the	F 610	question correctly were provided one-to-one additional training. Beginning on 4/30/19, facility staff were in-serviced by Corporate Clinical Specialist/Director of Nursing regarding abuse and neglect prohibition policy, reporting concerns regarding abuse and/or neglect immediately, two hour required reporting timeframe by the facility to the Mississippi State Department of Health, Licensure and Certification, protecting residents immediately following allegation of abuse/neglect. On 5/6/19, representative of the Mississippi Attorney Generals Office provided in-service to facility staff in regards to abuse/neglect prevention, reporting, Vulnerable Adults Act, Medicaid Fraud, types of abuse. On 5/22/19,Corporate Support Administrator/Registered Nurse in-serviced facility staff on Abuse and Neglect Prohibition program including but not limited to the requirement to protect residents, if a staff is involved, they will be suspended, facility is required to report to authorities within two (2) hour time frame, facility is required to conduct a thorough investigation and findings of investigation could lead to staff termination. All allegation of abuse and neglect since survey exit have been reported. A Quality Assurance Performance Improvement committee meeting was held on 5/22/19 with the Administrator, the Director of Nursing, the Corporate Clinical Specialist and Medical Director to review the statement of deficiencies and plan of correction; no further recommendations were made.	

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F 610	Continued From page 54 state agency in accordance with state law. The Abuse Coordinator will report all allegations of abuse,...within two hours of the allegation... Protection: 1. All residents will be immediately protected from harm. 2. All allegations involving staff will necessitate suspension without pay, pending investigation. 3. If the allegation is substantiated, the employee will be terminated immediately without pay retroactive to the date of removal from employment. ... Statement of Policy, Regarding the Reporting of Abuse and Associate Acknowledgement,....Remember our policy is all residents and patients of this nursing home are to be treated with dignity and respect at all times, under all circumstances. Mistreatment or abuse of any nature will not be tolerated... During an interview with Resident #14 on 04/22/19, at 4:03 PM, he reported everything was fine except with that woman who still worked at the facility and named LPN #1. He stated that about two (2) weeks ago, LPN #1 cursed him and pushed him into a wall, hurting his left foot. He stated "If y'all don't do anything about it, I will". Resident #14 had difficulty recalling exactly what was said but stated that he cursed her and she cursed him back. He also stated that he did not trust LPN #1 and he refused to take any medication or receive any care from her after LPN #1 returned to work and was re-assigned to his hall stating, "No telling what she might do". Review of the facility's investigative report, dated 4/5/19, revealed on 4/3/19 at 9:50 PM, Resident #14 reported he was tapping his hand on the desk to get the nurse's attention. He stated the nurse got up and pushed his wheelchair down the hall and hit his toe on the wall. He stated he cursed the nurse and she cursed him back. The	F 610	4. Beginning on 5/27/19, facility department heads including Social Services, Activities, Nursing Leadership, Business Office Manager, Minimum Data Set nurses, Lead Certified Nursing Assistant (C.N.A.), Dietary Manager, Admissions Director, will interview residents in their respective facility areas weekly for twelve (12) weeks, in regards to concerns related to care or treatment from staff related to abuse and/or neglect issues; any negative concern will be immediately reported to the Administrator or Director of Nursing for further intervention. Beginning on 5/27/19, the Administrator will review the incident log weekly to ensure reportable events have been investigated and reported as required. Beginning on 5/27/19, the Administrator will review the grievance log weekly to ensure any allegations have been investigated and reported as required. A report will be submitted by the Administrator to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The Administrator is responsible for monitoring and compliance.	

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investigation documented interviews from LPN #2 and LPN #3, confirming LPN #1 cursed the Resident, making statements such as, "Mother Fucker" and "If I'm a Bitch, you are a Bitch. It takes one to know one". The report documented another resident was around the desk, but interview revealed she could not recall profanity used. LPN #1 was suspended at that time.

On 04/23/19, at 8:16 PM, in a phone interview with LPN #2, she stated that on 4/3/19, around 8:15-8:20 PM, she walked to the nurse's station from the 200 Hall where LPN #1 sat at the desk working on charting and Resident #14 was sitting across from LPN #1 in his wheelchair at the nurse's station. She stated that Resident #14 was hitting the top of the desk with the palm of his hand very loudly. LPN #2 stated that she asked Resident #14 to stop and he stopped. She stated that LPN #1 had told her that Resident #14 was pulling orders out of charts and looking at them and she had to move everything. LPN #2 stated that she proceeded through the nurse's station toward the 500 Hall to the treatment cart when she overheard LPN #1, say "Bitch, I got your bitch, you Mother Fucker". She stated that LPN #1 left the facility a few minutes later (no more than 5 minutes) and that she called the Administrator to report the incident and also reported it to Resident #14's charge nurse, LPN #4.

On 04/23/19, at 4:30 PM, in an interview with the Administrator, she confirmed that LPN #1 was suspended, then allowed to return to work at the facility on 4/17/19, and was assigned to the 300/400 Hall on which Resident #14 resided. Assignment sheets verified LPN #1 worked from 4/17/19-4/21/19 on the 300/400 hallway.

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During a further interview with the Administrator, on 04/24/19, at 8:33 AM, she stated that she felt Resident #14 was verbally abused based upon the statements of LPN #2 and LPN #3, obtained during the investigation. She stated that Human Resources had denied her request to terminate LPN #1. She stated that LPN #1 was suspended from 4/3/19 - 4/17/19, and that she was allowed to return to the facility on 4/17/19, after the investigation was completed. The Administrator stated that LPN #1 had been re-assigned to Resident #14, since that was the hall that she was assigned to before she was suspended, so she was reassigned to that hall upon return on 4/17/19. The Administrator confirmed the policy was not followed for protection of the resident when LPN #1 returned to work after verbally abusing Resident #14. The Administrator stated that LPN #1 was issued a "Final Warning" upon return, due to a previous Verbal Warning at a sister facility for using profanity in the common area.

Review of a documented e-mail, dated 4/8/19, by the Administrator, revealed a request to terminate LPN #1, based on the statements from two (2) LPNs. "Attached is an allegation of verbal abuse investigation that was reported to the state and AG. The LPN is (LPN #1's name)."

Review of LPN #1's personnel file revealed a "Corrective Action Plan", dated 6/27/18, for a verbal warning of using profanity in the common area of the facility. A "Disciplinary Action Record", dated 4/24/19, that documented LPN #1 was suspended on 4/3/19, for using profanity in the presence of residents. A further "Disciplinary Action Record" dated 4/25/19, documented LPN

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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#1 was terminated related to the 4/3/19 incident of using profanity in the presence of residents.

During an interview, on 4/24/19, at 11:10 AM, LPN #1 revealed that she had been assigned to Resident #14 upon return to the facility on 4/17/19, until this morning (4/24/19), when she was removed from the 300/400 Hall and told to go to Medical Records, which is in a separate building. She stated that Resident #14 took medication from her on 4/17/19, but began refusing on 4/18/19, telling her, "I don't want to take it, I don't trust you". LPN #1 denied verbally abusing Resident #14 on 4/3/19.

Record review of Progress Notes revealed, "4/18/19 14:05, Type: Gen Nurses Notes - narrative, Note Text: Writer approached the resident to give him his medication and he stated 'I am not taking them for you', writer in return asked DON who was standing at the nurses station and she gave the resident his medication, he took his medication just fine for me yesterday. Author: (Proper Name) LPN#1 [e-SIGNED]".

Record review of Progress Notes revealed, "4/19/2019 14:45, Type: Gen Nurses Notes - narrative, Note Text: The resident continues to refuse to take his medications from me, other nurses have been giving him his medications for me, writer continues to maintain a professional level with him, he is sating to other staff and residents that he don't trust me and stating that I pushed him into the wall which is not true. No acute distress noted, will continue to medicate and monitor per MD orders as the resident will allow. Author: (Proper Name) LPN #1 [e-signed]".

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Record review of the Daily Assignment Sheets dated 4/17/19 - 4/21/19, revealed that LPN #1 was assigned to the 300/400 Hall. She was also initially assigned on 4/24/19, and was moved to another building for Medical Records. Resident #14 resided on the 300 Hall.

The facility submitted an acceptable Removal Plan on 4/26/19, for the IJ.

Review of the facility's Removal Plan revealed the facility took the following corrective actions to remove the IJ prior to exit:

1. The facility failed to assure the resident was free from verbal abuse and failed to report the abuse within the required two (2) hour reporting period, failing to keep the resident safe. On April 3, 2019, at approximately 10:00 PM, Resident #14 reported an allegation of verbal abuse against Licensed Practical Nurse (LPN) #1. The allegation consisted of the Resident #14 using a derogatory name towards LPN #1. LPN #1 responded to the resident by using the same derogatory name. This occurred around the nursing station. LPN #3 stated she heard LPN #1 say "If I'm a bitch, you are a bitch. It takes one to know one" at the nurses station. LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was immediately notified by LPN #2 at approximately 10:00 PM. LPN #1 was immediately suspended, abuse in-services and the abuse investigation was initiated.

2. The following parties were notified of the incident:
· Responsible party was notified April 4, 2019 at approximately 10:38 AM.
· Primary Physician was notified April 4, 2019 at

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12:50 PM.
· Medical Director was notified April 4, 2019 at 11:44 AM.
· Mississippi State Department of Health was notified April 4, 2019 at 5:20 PM.
· Mississippi State Attorney General was notified April 4, 2019 at 5:01 PM.
· Mississippi State Board of Nursing was notified April 25, 2019 at 9:11 PM.

3. LPN #1 was brought back on April 17, 2019, and received an inservice on abuse, neglect, and exploitation. She was then assigned to Resident #14, thus not protecting the residents in the facility from further abuse and the facility not following their policy for abuse. LPN #1 was subsequently suspended on April 24, 2019, pending an investigation. LPN #1 was terminated on April 25, 2019, for verbal abuse against Resident #14.

4. On April 24, 2019, at approximately 9:00 AM, the Administrator removed LPN #1 from all resident care areas.

5. On April 24, 2019, beginning at approximately 8:00 PM, the Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC), and Assistant DON initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, reporting abuse and/or neglect within the required two (2) hour time frame. Focus was placed on immediately removing the resident from the abuse situation; reporting all allegations of abuse, neglect and exploitation to the Administrator immediately; and that any staff

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member accused of abuse, neglect or exploitation will be suspended immediately pending investigation. No staff member will be allowed to return to work without completing required education. Currently, 76 of 88 staff members have completed required education.

6. On April 24, 2019, beginning at approximately 8:45 PM, the Interim Director of Nursing, Corporate Clinical Specialist, Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) provided posttest to employees in regards to Abuse and Neglect prohibition policy that was initiated on April 24, 2019, to ascertain understanding of Abuse and Neglect prohibition policy training. Any employee that was not able to answer the posttest answers correctly was provided a one-to-one (1:1)re-education at that time. No staff will be allowed to return to work without completing the required education posttest.

7. On April 24, 2019, beginning at approximately 9:15 PM, Social Worker, Human Resource Director, Business Office Manager (BOM), Respiratory Therapist, Assistant BOM, Activities Director, Minimum Data Set nurses, SDC, Registered Nurse (RN) Charge Nurse interviewed forty-five (45) residents in the facility at that time, with a Brief Interview of Mental Status (BIMS) of 12 or higher, in regards to had they ever experienced any verbal or physical abuse. Findings of the interviews were reviewed by the Administrator to determine any on-going or previously unidentified allegations of abuse and/or neglect; two (2) residents relayed information from a prior incident, which was investigated and reported. No abuse was substantiated.

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8. On April 24, 2019, beginning at approximately 9:00 PM, the Corporate Clinical Specialist, both MDS nurses and the Regional Case Mix Specialist reviewed clinical documentation for Resident #14, to determine any negative changes to daily routines, activity participation, socialization, meal intake; Resident #14 began refusing medication from LPN #1 on April 18, 2019. No other changes where identified with Resident #14.

9. On April 24, 2019 and April 26, 2019, the Chief Operating Officer in-serviced the Director of Field Human Resources on the policy and procedures for Abuse and Neglect.

10. On April 25, 2019 at approximately 12:30 PM, the grievance log, beginning January 1, 2019 through April 25, 2019, and incident log, beginning January 1, 2019 through April 25, 2019, were reviewed by the Administrator to identify potential allegations abuse/neglect for reporting potential. No grievances or incidence were identified as a potential allegation that had not already been reported.

11. On April 25, 2019, at 2:00 PM, the Medical Director, Administrator, interim Director of Nursing, Social Services Director, Activities Director, BOM, SDC, ADON, Dietary Supervisor, Housekeeping Supervisor, Maintenance Director, HR director and Director of Rehab held a Quality Assurance Performance Improvement (QAPI) meeting following notification of Immediate Jeopardy to review steps initiated to identify any on-going or previously unreported allegations of abuse and/or neglect and to administer posttest to employees to determine understanding of

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education provided. There were no new policy or procedure changes.

12. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of April 25, 2019, and the Immediate Jeopardy was removed April 26, 2019.

The State Agency (SA) validated the facility's Removal Plan and determined the facility took the following actions to correct the IJ:

1. The SA validated that Resident #14 was not free from verbal abuse and the facility failed to report the abuse within the required two (2) hour reporting period, failed to keep residents safe. On April 3, 2019, at approximately 10:00 PM, Resident #14 reported an allegation of verbal abuse against Licensed Practical Nurse (LPN) #1. The allegation consisted of the Resident #14 using a derogatory name towards LPN #1 and LPN #1 responded to the resident by using the same derogatory name. This occurred around the nursing station. The SA validated through interviews that LPN #3 stated she heard LPN #1 say "If I'm a bitch, you are bitch. It takes one to know one" at the nurses station. LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was notified by LPN #2. LPN #1 was suspended, abuse in-services and the abuse investigation was initiated.

2. The following parties were notified of the incident:
· The SA validated through interview with the Responsible Party that she was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the

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Administrator and record review that the Primary Physician was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Medical Director that he was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Department of Health was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Attorney General was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Board of Nursing was notified April 25, 2019, of the alleged abuse by LPN #1.

3. The SA validated through interview with LPN #1 and the Administrator and record review that LPN #1 was suspended and was brought back to work on April 17, 2019, and received an inservice on abuse, neglect, and exploitation. She was then assigned to Resident #14, thus not protecting the residents in the facility from further abuse and the facility not following their policy for abuse. LPN #1 was subsequently suspended on April 24, 2019, pending an investigation. The SA validated that LPN #1 was terminated on April 25, 2019, for verbal abuse against Resident #14.

4. The SA validated through interview with the Administrator and LPN #1 and record review, that on April 24, 2019, the Administrator removed LPN #1 from all resident care areas and placed her in another building with Medical Records duty.

5. The SA validated through interview with the

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Administrator, and staff from Nursing, Dietary, Social Services, Therapy, Business Office and Housekeeping/Maintenance and record review that on April 24, 2019, beginning at approximately 8:00 PM, the Administrator, DON, SDC and ADON initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, reporting abuse and/or neglect within the required two (2) hour time frame. Focus was placed on immediately removing the resident from the abuse situation; reporting all allegations of abuse, neglect and exploitation to the Administrator immediately; and that any staff member accused of abuse, neglect or exploitation will be suspended immediately pending investigation. No staff member was allowed to return to work, without completing required education. Currently, 76 of 88 staff members have completed required education.

6. The SA validated through interview with the Administrator and staff from Nursing, Dietary, Social Services, Therapy, Business Office and Housekeeping/Maintenance and record review that on April 24, 2019, beginning at approximately 8:45 PM, the interim Director of Nursing, Corporate Clinical Specialist, Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) provided posttest to employees in regards to Abuse and Neglect prohibition policy that was initiated on April 24, 2019, to ascertain understanding of Abuse and Neglect prohibition policy training. Any employee that was not able to answer the posttest answers correctly was provided a one-to-one (1:1) re-education at that time. No staff was allowed to

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return to work without completing the required education posttest.

7. The SA validated through interview with the Administrator and record review that on April 24, 2019, the Social Worker, Human Resource Director, Business Office Manager (BOM), Respiratory Therapist, Assistant BOM, Activities Director, Minimum Data Set nurses, SDC, Registered Nurse (RN) Charge Nurse interviewed forty-five (45) residents in the facility at that time, with a BIMS of 12 or higher, in regards to had they ever experienced any verbal or physical abuse. Findings of the interviews were reviewed by the Administrator to determine any on-going or previously unidentified allegations of abuse and/or neglect; two (2) residents relayed information from a prior incident, which was investigated and reported. The SA validated no abuse was substantiated.

8. The SA validated through interview with the Administrator, Corporate Clinical Specialist, and one (1) MDS nurse, that on April 24, 2019, the Corporate Clinical Specialist, both MDS nurses and the Regional Case Mix Specialist reviewed clinical documentation for Resident #14, to determine any negative changes to daily routines, activity participation, socialization, meal intake; Resident #14 began refusing medication from LPN #1 on April 18, 2019. No other changes where identified with Resident #14. The SA validated that Resident #14 did receive medication from other nurses.

9. The SA validated through interview with the Chief Operating Officer, and dated/signed in-service sheets, that the Director of Field Human Resources was educated on the abuse

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F 610	Continued From page 66 and neglect policy and procedures with emphasis of investigation and to err on the side of the resident. 10. The SA validated through interview with the Administrator and record review that on April 25, 2019, the grievance log, beginning January 1, 2019 through April 25, 2019, and incident log, beginning January 1, 2019 through April 25, 2019, were reviewed by the Administrator to identify potential allegations abuse/neglect for reporting potential. No grievances or incidence were identified as a potential allegation that had not already been reported. 11. The SA validated through interview with the Administrator and record review that on April 25, 2019, at 2:00 PM, the Medical Director, Administrator, interim Director of Nursing, Social Services Director, Activities Director, BOM, SDC, ADON, Dietary Supervisor, Housekeeping Supervisor, Maintenance Director, HR director and Director of Rehab held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to identify any on-going or previously unreported allegations of abuse and/or neglect and to administer posttest to employees to determine understanding of education provided. There were no new policy or procedure changes. 12. The SA validated that all corrective actions were completed as of 4/25/19, and the IJ was removed as of 4/26/19.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		5/31/19

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F 623	Continued From page 67 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30	F 623		

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F 623	Continued From page 68 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F 623		

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F 623	Continued From page 69 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, and staff interview, the facility failed to provide the Resident Representative (RR) a written notification of a resident's transfer to an acute care hospital for two (2) of three (3) residents reviewed for discharge or transfer to an acute hospital, Resident #8 and Resident #61. Findings include: Review of an undated facility document, titled, "Discharge Tracking Information", as provided and signed by the Administrator, revealed that the facility is to notify the resident and the resident's representative of the transfer or discharge in writing and in a language and manner they understand. The facility document was provided when asked for a facility policy regarding the practice of issuing a written notification to the resident and RR. Resident #8	F 623	F623 1. On 5/21/19, a letter was mailed to Resident #8□s Resident Representative by Social Services regarding transfer on 2/28/19. On 5/21/19, a letter was mailed to resident #61□s resident representative by social services regarding transfer on 3/31/19. 2. Residents who are transferred from the facility are potentially affected. On 5/21/19,Social Service Director conducted an audit of transfers, back to 3/1/19, letters were mailed to fifty-four (54) resident representatives informing them of their respective residents transfer, reason for transfer, where resident was transferred and Ombudsman□s contact information. 3. On 4/24/19, Social Services Director was educated by Business Office	

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THE BLUFFS REHABILITATION AND HEALTHCARE CENTER	2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180

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F 623	Continued From page 70 Review of Resident #8's clinical record titled, "Progress Notes," dated 4/25/2019, revealed that on 2/28/2019 at 2:36 PM, during communication with the physician, an order was given to transfer Resident #8 to the Emergency Room (ER). The clinical record also revealed that on 12/14/2018 at 09:36 AM, a Health Status Note was entered, which indicated that Resident #8 was sent out to an acute care hospital to have outpatient surgery. The clinical record further revealed that on 10/28/2018 at 6:45 PM, a Health Status Note was entered, which indicated that the On Call Physician gave an order to send Resident #8 to the ER for further evaluation. Review of Resident #8's clinical records, dated 4/25/2019, revealed that the Minimum Data Set (MDS) Discharge Tracking records indicated that Resident #8 was assessed as being discharged with return anticipated on 2/28/2019, 12/14/2018, and 10/28/2018. During an interview, on 4/23/2019 at 11:00 AM, the Administrator revealed that the facility did not issue a written notice to the resident or the resident's representative of transfers to the hospital for Resident #8. The Administrator stated that they were aware of the regulation. Resident #61 Record review of the Skilled Nursing Facility/Nursing Facility to Hospital Transfer form, dated 3/31/19, revealed Resident #61 was transferred to the local hospital Emergency Room for evaluation due to tan/brown secretions, temperature 100.6 degrees Fahrenheit axillary, decreased oxygen saturation of 79-86% on 28% oxygen, and congestion to bilateral lobes. On 4/23/19, at 11:00 AM, an interview with the	F 623	Manager, on requirement of written notification related to transfer, reason for transfer, and Ombudsman□s contact information and will be responsible for mailing letter on next business day and logging mailing of letter on the transfer letter tracking log. Beginning on 5/20/19 Staff Development Coordinator provided in-service to licensed nurses regarding requirement for written notification to be presented/mailed to resident or resident representative following a resident□s transfer from the facility, in a language that is easily understood, regarding reason for transfer, where the resident was transferred to, and information on contacting the Ombudsman. On 5/22/19 Corporate Support Administrator/Registered Nurse in-serviced facility staff on requirement of facility to provide written notice to the resident/resident representative for every transfer, information that includes where the resident is transferred to, why and information to contact the Ombudsman. 4. Beginning on 5/27/19, the Business Office Manager will conduct an audit weekly for four (4) weeks, then monthly for three (3) months to determine for each transfer that a letter was mailed and logged on transfer letter tracking log. The Business Office Manager will report findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Administrator is responsible for monitoring and compliance.	

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F 623	Continued From page 71 Administrator, revealed that the facility did not issue a written notice to the family or Resident #61 of the transfer to the hospital. She stated that they were aware of the regulation, but had not issued the notice. During an interview, on 4/24/2019 at 10:00 AM, Regional Nurse #1 revealed that the facility had not been participating in the practice of sending a written notification of transfer to the resident and the resident's representative when the resident is transferred to an acute care hospital. Regional Nurse #1 stated that the facility now has a form they will be using for the written notification, and that the notifications will be started as of today. Regional Nurse #1 also stated that the staff had been educated on the practice of written transfer notifications. During a follow-up interview, on 4/25/2019 at 5:15 PM, the Administrator, revealed the task of the written notification of a resident's transfer to an acute care hospital will now be the responsibility of the Social Services Director (SSD). During an interview on 04/25/2019 at 5:44 PM, the Social Services Director (SSD) revealed that she had been given the responsibility of providing a written notification of transfer to an acute care hospital to be sent to a resident's representative. The SSD stated that she had been given an in-service and was educated on the process by RN #4. The SSD stated that she would be starting the letters immediately.	F 623		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment	F 636		5/31/19

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F 636	Continued From page 72	F 636		

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff

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F 636	Continued From page 73 members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to complete an annual Minimum Data Set (MDS) assessment in a timely manner for one (1) of 27 records reviewed, Resident #3. Findings include: Review of the facility policy entitled "MDS (Minimum Data Set) Completion and Submission Timeframes", revised October 2010, revealed: 1. The Assessment Coordinator or designee shall be responsible for ensuring that resident assessments are submitted to CMS (Center for Medicare Services) QIES (Quality Improvement and Evaluation System) Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. 2. The following timeframes will be observed by this	F 636	F636 1. Annual Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 3/12/19 for Resident # 3 was modified and submitted by MDS Registered Nurse on 4/25/19 and accepted on 5/1/19. 2. Residents who reside in the facility for a year may be affected. On 5/21/19, an audit was conducted by MDS Coordinator Registered Nurse to determine how many annual MDS assessments need to be submitted to attain compliance which revealed eight (8) annual assessments need to be submitted for compliance. 3. On 5/17/19, in-service was conducted	

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F 636	Continued From page 74 facility: Assessment Type, Annual (Comprehensive) MDS Completion Date, ARD (+ 14 calendar days...". Record review of the MDS Assessment Summary, printed 4/25/19, revealed the status for the Annual Assessment, with an Assessment Reference Date of 3/12/19, for Resident #3, was "In Progress". On 04/25/19, at 4:00 PM, interview with Registered Nurse #5 (RN), MDS Nurse, revealed there were three (3) more sections of the Annual Assessment left to do for Resident #3. She stated the assessment was not closed yet, but it was scheduled for 3/12/19. She stated she hadn't had time to get to Resident #3 yet; "Don't have enough time to get to all of them".	F 636	with MDS RNs by Regional Case Mix Registered Nurse in regards to requirements to complete and submit annual assessments per requirements of Resident Assessment Instrument (RAI) manual. On 5/22/19, Corporate Administrator/Registered Nurse in-serviced facility staff on requirement of the facility to perform annual MDS assessments for residents who reside in the facility for a year. 4. Beginning 5/27/19, Regional Case Mix Registered Nurse will complete an audit weekly for four (4) weeks to determine compliance with completion and submission of annual MDS assessments. A report will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months by MDS Coordinator for further review and recommendations. The Administrator is responsible for monitoring and compliance.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review and staff interview, the facility failed to complete the Quarterly Minimum Data Set (MDS) in a timely manner for two (2) of three (3) Quarterly MDS's	F 638	F638 1. Quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 3/15/19 for Resident #2	5/31/19

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F 638	Continued From page 75 reviewed. This affected Resident #2 and Resident #8. Findings include: Review of the facility's policy titled, "MDS Completion and Submission Timeframes," dated October 2010, revealed that it is the policy of this facility that the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. The facility policy states that a Quarterly (Non-Comprehensive) Minimum Data Set (MDS) assessment will be completed by the Assessment Reference Date (ARD) plus (+) 14 calendar days. The facility policy also documented that the assessment must be transmitted, to the Centers for Medicare & Medicaid Services (CMS), by the completion date of the MDS plus (+) 14 calendar days. Resident #2 Review of the Quarterly MDS for Resident #2, with an ARD of 3/15/19, indicated that the current status is noted to still be "In Progress". Resident #2's Quarterly MDS also indicated that this assessment is currently 26 days overdue, and has not been completed, closed, or transmitted. Resident #8 Review of the Quarterly MDS for Resident #8, with an ARD of 3/20/19, indicated that the current status is noted to still be "In Progress". Resident #8's Quarterly MDS also indicated that this assessment is currently 22 days overdue, and has not been completed, closed, or transmitted. During an interview on 4/24/19 at 2:30 PM, Registered Nurse (RN) #3/MDS Coordinator,	F 638	was completed and submitted by the MDS Registered Nurse (RN) on 4/26/19 and accepted on 5/1/19. Quarterly MDS assessment with ARD of 3/20/19 for resident #8 was completed and submitted by the MDS RN on 4/26/19 and accepted on 5/1/19. 2. Residents of the facility have the potential to be affected. On 5/21/19, an audit was conducted by MDS Coordinator RN to determine how many quarterly MDS assessments need to be submitted to attain compliance which revealed forty-one (41) quarterly assessments to submit. 3. On 5/17/19, in-service was conducted with MDS RNs by Regional Case Mix Registered Nurse in regards to requirements to complete and submit quarterly assessment per requirement of the Resident Assessment Instrument (RAI) manual. On 5/22/19, Corporate Administrator/Registered Nurse in-serviced facility staff on requirement of the facility to complete and submit MDS assessments on a quarterly basis for residents of the facility. On 5/22/19, the Quality Assurance Performance Improvement committee developed a plan to complete the forty-one (41) quarterly assessments to attain and sustain compliance. 4. Beginning on 5/27/19, Regional Case Mix Registered Nurse will complete an audit weekly for four (4) weeks to determine compliance with completion	

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F 638	Continued From page 76 revealed that the MDS's are to be completed by the 14th day following the ARD entry. RN #3 confirmed that the MDS for Resident #2 with an ARD of 3/15/19, and the MDS for Resident #8, with an ARD of 3/20/19, were both late. RN #3 stated that the MDS team is trying to catch all the MDS's up to the correct date and time. During an interview on 4/25/219 at 12:25 PM, Interim Director of Nursing (DON) #1 confirmed that the MDS's should be completed by the 14th day following the ARD entry. Interim DON #1 stated that she was aware that there were several late MDS's, but she was unsure of exactly how many.	F 638	and submission of quarterly MDS assessments. A report will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months by MDS Coordinator for further review and recommendations. The Administrator is responsible for monitoring and compliance.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) for one (1) of (27) MDS assessments reviewed, Resident #103. Findings include: Review of the facility's policy, titled "MDS Completion and Submission Timeframes", dated October 2010, revealed that a comprehensive assessment of a resident's needs shall be made following the guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Manual (RAI	F 641	F641 1. Resident #103 discharged from the facility on 3/6/19. The discharge Minimum Data Set (MDS) assessment was modified and submitted on 4/26/19 by the MDS Registered Nurse (RN). 2. On 5/21/19, and audit was conducted by Assistant Director of Nursing on one hundred and two (102) discharged tracking MDS assessments for residents that have discharged from the facility back to 3/1/19 to determine if the MDS assessment was coded to reflect accurate discharge status, with 7 identified	5/31/19

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F 641	Continued From page 77 Manual). A record review of the MDS, with an Assessment Reference Date (ARD) of 03/06/19, revealed Resident #103's discharge assessment-return not anticipated was coded incorrectly in the A1800 section of the MDS. The MDS was incorrectly coded to indicate that the resident was discharged to an Acute Hospital. The MDS should have been coded to indicate that the resident was discharged to the community/private home. Record review of the nurse's notes, dated 2/19/19, revealed the resident was discharged home with his medication and family. The resident's discharge was planned by the resident and the Social Worker. During an interview on 4/24/19 at 11:25 AM, the Social Worker revealed the resident was discharged home with medication and medical supplies. The family transferred Resident #103 home. During an interview on 04/25/19 at 03:36 PM, RN #3 revealed the resident was discharged home. RN #3 said that she made a mistake and hit the wrong button and coded the resident's MDS wrong.	F 641	corrections. 3. On 5/17/19, in-service was conducted by the Regional Case Mix Registered Nurse with MDS RNs on requirement to accurately code MDS discharge assessments per the Resident Assessment Instrument (RAI) manual. On 5/22/19 the Corporate Administrator/Registered Nurse in-serviced facility staff on requirement for facility to completed and submit an MDS assessment to reflect residents discharge from the facility that accurately reflects where the resident discharges to. 4. Beginning on 5/27/19, an audit will be conducted weekly for four (4) weeks, then monthly for three (3) by Regional Case Mix Registered Nurse on discharge tracking MDS assessments to review accuracy of coding the discharge MDS assessment. A report of audit findings will be submitted by MDS Coordinator to the Quality Assurance Performance Improvement committee monthly for three (3) months for further review and recommendations. The Administrator is responsible for monitoring and compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		5/31/19

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F 656	Continued From page 78 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, the facility failed to initiate a	F 656	F656 1. Comprehensive care plan was	

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F 656	Continued From page 79 comprehensive care plan for Resident #75 for areas that were triggered; and, failed to follow the care plan for Resident #32, for incontinent care and number of staff required for care. This affected two (2) of 27 residents reviewed for care plans. Findings include: Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered" dated December 2016, revealed, "A Comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Care plan interventions are derived from a thorough analysis of the information gathered as a part of the comprehensive assessment. The comprehensive, person centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS)". Resident #75 A Record Review of Resident #75's Admission Assessment revealed the facility admitted Resident #75 on 2/18/19. Review of Resident #75's Comprehensive Care Plan, dated 2/25/19, revealed Resident #75 did not have a complete Comprehensive Care Plan addressing current areas of care including: Active Diagnosis, urinary incontinence, bowel incontinence, Pain Assessment, At Risk for Pressure Ulcer, Medications, communication, Activity of Daily Living (ADL) function, Falls, Daily preferences, Activities, and mobility, based on MDS triggers.	F 656	developed and reviewed by the interdisciplinary team for Resident # 75 on 5/22/19. Comprehensive care plan was reviewed and revised to reflect current status for Resident # 32 related to assistance needed in regards to incontinent care on 5/16/19 by interdisciplinary team. 2. All residents have the potential to be affected. On 5/23/19 an audit was conducted by Registered Nurses for residents currently in the facility to determine if a comprehensive care plan was completed. Ninety-nine (99) Resident Comprehensive Care Plan were reviewed in the Audit, with (33) thirty-three Comprehensive Care Plan changes. 3. On 5/22/19, the interdisciplinary team members were educated by Corporate Clinical Specialist in regards to requirement of each resident having comprehensive care plan that is developed by the interdisciplinary team based on assessments of resident specific care needs. On 5/22/19 Corporate Support Administrator/Registered Nurse in-serviced facility staff regarding requirement of facility to develop, implement and revise a comprehensive care plan for that addresses each residents specific care needs. 4. Beginning 5/27/19, an audit will be conducted weekly for four (4) weeks, then monthly for three (3) months by the	

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F 656	Continued From page 80 Review of the Interim Care Plan, dated 2/25/19, for Resident #75, revealed the needs for Resident #75 that were identified on the Interim Care Plan were not transferred to the Comprehensive Care Plan. An interview on 04/25/19 at 03:15 PM, with RN #5/Care Plan Nurse, revealed, "I just haven't gotten to Resident #75's Care Plan, I guess because of staffing issues". An interview on 04/26/19 at 12:25 PM, with Interim DON #3, revealed, "What was triggered on the MDS should have been on the care plan. The Care Plan Coordinator should have created a care plan based on the resident's comprehensive needs". After viewing the Care Plan for Resident #75, DON #3 revealed, "The care plan is incomplete based on the MDS you've shown me". Resident #32 Review of the current care plan revealed Resident #32 had a history of Urinary Tract Infections (UTI). Interventions included to check at least every two (2) hours for incontinence, and encourage good hygiene practices. The care plan also documented the resident has an Activities of Daily Living self care performance deficit related to intellectual deficits. Interventions: personal hygiene; the resident requires extensive assistance by (2) staff with personal hygiene and oral care. During an observation on 04/24/19 at 09:54 AM, of incontinent care with Certified Nursing Assistant (CNA) #8, revealed the resident's legs were contracted really tight. CNA #8 took a wet wipe and wiped between Resident #32's legs	F 656	Director of Nursing/Assistant Director of Nursing to review completion and accuracy of the comprehensive care plan for three (3) residents. A report will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months by the Director of Nursing for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance.	

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F 656	Continued From page 81	F 656		

three (3) times. This surveyor was unable to see what part of the resident's body was cleaned with the wet wipe.

During an interview on 04/24/19 at 09:55 AM, CNA #8 revealed she was trained to clean the resident from front to back. CNA #8 also said she don't know how to get to the resident's perineal area without sticking her hands between Resident #32's legs and wiping the perineal area. CNA #8 said because the resident is contracted and unable to open her legs, she has to feel with the wipes. CNA #8 was asked if she was going to clean the resident without assistance? CNA #8 stated that she always cleans the resident without assistance. CNA #8 said that resident #32 can be turned without help.

During an interview on 04/24/2019 at 3:30 PM, Registered Nurse (RN) #4 confirmed Resident #32 is a two (2) person extensive assist with hygiene and oral care. RN #4 said the CNA should have turned the resident onto her side and cleaned her from the back because you can see her vaginal area better.

Review of the facility's face sheet revealed the facility admitted Resident #32 on 03/1/18, with diagnoses, which included Urinary Tract Infection, Diabetes Mellitus, Pressure Ulcer and Anemia.

Review of Resident #32's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/10/2019, revealed Resident #32's Brief Interview for Mental Status (BIMS) could not be completed and/or scored 99, which indicated the resident is severely cognitively impaired.

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F 656	Continued From page 82 An interview on 04/25/19 at 12:15 PM, with Interim Director of Nursing (DON) #1, revealed "If a care plan is in place, I expect the staff to follow the care plan". An interview on 04/25/19 at 03:15 PM, with RN #5/Care Plan Nurse, revealed, "If we create a care plan on a resident, I absolutely expect staff to follow it.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		5/31/19

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F 690	Continued From page 83 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to provide incontinent care in a manner to clean the resident thoroughly and prevent the possible spread of infection for one (1) of three (3) incontinent care observations, Resident #32. Findings include: Review of the facility's policy, entitled, "Perineal Care", revealed the purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. The staff should wash the perineal area from front to back. Separate the labia and wash area downward from front to back. wash perineum moving from inside outward to the thighs. During an observation on 04/24/19 at 9:54 AM, of incontinent care with Certified Nursing Assistant (CNA) #8, revealed Resident #32's legs were contracted tightly. CNA #8 took a wet wipe and wiped between Resident #32's legs three (3) times. The surveyor was unable to see what part of the resident's body was cleaned with the wet wipe. CNA #8 did not spread the labia and clean the resident thoroughly.	F 690	F690 1. Resident # 32 was evaluated by Corporate Clinical Specialist on 4/27/19 regarding amount assistance needed for incontinent care. Resident #32□s care plan was reviewed and revised by the interdisciplinary team on 5/16/19 in regards to the number of staff to provide incontinent care. Resident #32 was assessed on 4/27/2019 by Corporate Clinical Specialist with No S/S of infection, No negative findings. On 4/24/2019, CNA#8 was in-serviced on Incontinent care, infection control related incontinent care and assistance with Incontinent care by Lead Certified Nursing Assistant and Corporate Clinical Specialist. 2. On 5/19/19 care plans and Kardexes for Residents who are dependent on staff for incontinent care, were evaluated to determine if they accurately reflected the number of staff members needed to deliver incontinent and were updated by the Minimum Data Set Registered Nurses and Corporate Clinical Specialist. 3. Residents who require Incontinent care have the potential to be affected.	

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F 690	Continued From page 84 During an interview on 04/24/19 at 9:55 AM, CNA #8 revealed she didn't know how to get to the resident's perineal area without sticking her hands between Resident #32's legs and wiping the perineal area. CNA #8 confirmed because the resident is contracted and unable to open her legs, she has to feel with the wipes. CNA #8 stated that she always cleaned the resident without assistance. During an interview on 04/24/219 at 3:30 PM, Registered Nurse (RN) #4 confirmed Resident #32 is a two (2) person extensive assist with hygiene. RN #4 stated that CNA should have gotten assistance and turned the resident onto her side and cleaned her from the backside, so that her vaginal area could be seen better and cleaned better. Review of the facility's "Incontinent Care Skills" log revealed Certified Nursing Assistant (CNA) #8 was trained on how to provide appropriate incontinent care, dated 3/6/2019. Review of the care plan revealed Resident #32 had a history of Urinary Tract Infections (UTI). Interventions included good hygiene practices. Review of the facility's face sheet revealed the facility admitted Resident #32 on 03/1/18, with diagnoses which included Urinary Tract Infection, Diabetes Mellitus, Pressure Ulcer and Anemia. A review of Resident #32's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/10/2019, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident is severely cognitively impaired and/or was unable to complete the BIMS.	F 690	Facility Certified Nursing Assistants and licensed nurses were in-serviced on 5/16/19 by Staff Development Coordinator in regards to following residents care plans which will reflect the care needs and amount of support needed to provide care and on reporting resident care changes in order for care plan to be reviewed and revised. Beginning on 5/20/19 Certified Nursing Assistants were in-serviced on and performed return demonstration for hand washing and incontinent care to the Staff Development Coordinator/Lead C.N.A. On 5/22/19 Corporate Administrator/Registered Nurse in-serviced facility staff on requirement to have a comprehensive care plan for each resident that accurately reflects resident care needs and care needed to be provided by staff and to report changes in resident care needs. 4. Beginning 5/27/19, the Director of Nursing/Staff Development Coordinator/Assistant Director of Nursing will conduct care observations on three (3) residents weekly for four (4) weeks, then monthly for three (3) months to determine if care is provided per the comprehensive care plan and determine if comprehensive care plan accurately reflects care needs; Beginning 5/27/19, Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Registered Nurses will perform incontinent care observations with three (3) Certified Nursing Assistants weekly for four (4) weeks, then monthly	

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F 690	Continued From page 85	F 690	for three (3) months,concerns will be discussed with interdisciplinary team. A report will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and further recommendations by the Staff Development Coordinator. The Director of Nursing is responsible for monitoring and compliance.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to ensure respiratory therapy treatments were provided by the appropriate licensed personnel, designated in the plan of care, and as ordered for one (1) of (27) residents reviewed, Resident #65. Findings include: Review of Resident #65's current care plan revealed a problem with shortness of breath. One (1) intervention revealed to administer medications as ordered. This intervention was documented for the Licensed Nurse (LN) or Respiratory Therapist (RT) to implement.	F 695	F695 1. Resident #65 was evaluated by Licensed Nurse and assessed by Registered Nurse for any adverse reactions on 4/22/19; no concerns identified. Nebulizer mask was discarded and replaced with a new mask on 4/22/19, by Director of Nursing. Certified Nursing Assistant #1 was provided one-to-one education on 4/22/19, by Corporate Clinical Specialist and Director of Nursing regarding removing nebulizer masks being the responsibility of the licensed nurse or respiratory therapist and concerns should be reported to immediate	5/31/19

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F 695	Continued From page 86 Review of the facility's policy titled, "Administering Medications", dated December 2012, revealed Medications shall be administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. Medications must be administered in accordance with the orders, including any required time frame. The individual administering the medication will record in the resident's medical record the signature and titled of the person administering the medication. A review of the document titled, "Standard 14: Nurse Aide Scope of Practice" provided by https://secure.in.gov, revealed the Nurse Aide will not administer any medications, perform treatment or apply or remove any dressings. A review of the facility's policy titled, "Departmental (Respiratory Therapy) Prevention of Infection", dated November 2011, revealed, "The following information should be recorded in the resident chart : the date and time the respiratory therapy was performed, the type of respiratory treatment performed, the name and title of the individual who perform the respiratory therapy, if the resident refused therapy, the reason why and what was done as a result and the signature of the person recording the information". A review of Resident #65's Medication Administration Record (MAR) revealed Resident #65 received Albuterol Sul Nebulizer every six (6) hours as needed for Chronic Obstructive Pulmonary Disease.	F 695	supervisor; Physician/Medical Director was notified. Licensed Nurse #5 was provided one-to-one education by Corporate Clinical Specialist and Director of Nursing on 4/22/19, regarding remaining within line of sight of residents receiving nebulizer treatments, documentation requirements, cleaning and storage. 2. On 5/10/19, an audit was conducted by Medical Records Nurse related to residents of the facility with orders for nebulizer treatments. There are twenty-two (22) residents who have physician orders for nebulizer treatments and are at risk related to this deficient practice. 3. On 5/20/19, facility Certified Nursing Assistants were in-serviced by Staff Development Coordinator in regards to not removing nebulizer or oxygen masks and to report concerns regarding nebulizers or other care concerns to licensed nurse or respiratory therapist; removing nebulizer mask is not in the scope of practice for a Certified Nursing Assistant. Beginning on 5/20/19 Licensed Nurses will complete return demonstration of administration of nebulizer treatments with Staff Development Developer/Respiratory Therapist of three (3) residents with orders for nebulizer treatments, weekly for four (4) weeks, then monthly for three (3) months. On 5/20/19, Medical Records Nurse began in-servicing licensed nurses on entering nebulizer treatment orders into electronic	

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F 695	Continued From page 87 An observation on 04/22/19 at 9:25 AM, revealed Resident #65 sitting in the hallway close to the nurse's station in her wheelchair. Resident #65 appeared anxious and wheezing when she took a breath. A by-passing staff member turned and faced the nursing station toward Licensed Practical Nurse (LPN) #5 and said, "She wants a breathing treatment," and pointed to Resident #65. An observation on 04/22/19 at 9:49 AM, revealed Resident #65 sitting in her wheelchair in the doorway of her room with the nebulizer mask on her face and the nebulizer machine was turned on. LPN #5 was standing at the medication cart approximately 40 feet down from Resident #65's room. Resident #65 was yelling and trying to roll herself to the door in her wheelchair. CNA #1 was attempting to pull the resident's wheelchair back into the room since she had the nebulizer mask on. CNA #1 removed the nebulizer mask from the Resident #65's face. LPN #5 began walking toward Resident #65's room. CNA #1 told LPN #5, she removed the nebulizer mask because the resident wasn't doing right. LPN #5 asked CNA #1 if the breathing treatment was finished and CNA #1 stated, "No, but she ain't gonna do right". LPN #5 turned around and walked off from Resident #65's room back to the medication cart. When asked if the resident's breathing treatment was finished, CNA #1 stated, that it was not. After removing the nebulizer mask from Resident #65's face, CNA #1 placed the mask on the night stand in Resident #65's room. The Nebulizer mask was lying on the nebulizer machine itself, not in a bag. Observation,at this time, revealed the nebulizer machine and it had fluid in the holding chamber. LPN #5 was asked if she had placed the nebulizer on Resident #65 and she stated, "Yes".	F 695	health record system and completing documentation with each new order. On 5/22/19 Corporate Administrator/Registered Nurse in-serviced facility staff in regards to Certified Nursing Assistants not removing nebulizer masks, reporting care concerns to licensed nurse, licensed nurses administering nebulizer treatments per orders, staying within line of sight of resident during administration of nebulizer and appropriately documenting nebulizer administration. 4. Beginning on 5/27/19, the Staff Development Coordinator/Respiratory Therapy Manager will conduct an audit by observation of three (3) residents with orders for nebulizer treatments, weekly for four (4) weeks, then monthly for three (3) months to validate nebulizer masks are cleaned and stored appropriately. The Staff Development Coordinator will report findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance.	

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When ask what was in the nebulizer, LPN #5 confirmed it was Albuterol.

An observation on 04/25/19 10:10 AM revealed medication still in chamber of nebulizer machine and mask still lying on the machine not bagged.

An observation on 04/22/19 at 2:50 PM, revealed the nebulizer medication was still present in the holding chamber of the nebulizer mask and the mask still lying on the nebulizer machine itself, not in a bag.

An interview on 04/22/19 at 02:55 PM, with LPN #5, revealed she walked to the door to see what was happening and why the resident was yelling. She stated she saw the nebulizer off the resident and asked the CNA if the breathing treatment was finished; she said, "No, she ain't gonna do right." LPN #5 stated she thought Resident #65 took the nebulizer off and didn't realize CNA #1 had taken it off. At this time, LPN #5 was ask to go into Resident #65's room and check the nebulizer. LPN #5 looked in the nebulizer holding compartment and confirmed there was medication still present in the container at this time. LPN #5 took a plastic cup and poured the medication from the machine into the cup and left out of the room and destroyed the medication by throwing the cup into the garbage on the medication cart. Medication was not finished nor attempted to be finished by LPN #5. LPN #5 verified the nebulizer mask was not in a bag upon entry to the room, but rather placed across the nebulizer machine itself. LPN #5 left Resident #65's room and returned with a bag. LPN #5 placed the nebulizer mask in the bag.

An interview on 04/22/19 at 3:05 PM, with CNA

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#1, revealed she recalled taking the nebulizer mask off of Resident #65. She stated the only reason she removed the mask was to prevent the resident from dragging the tubing because she was rolling towards the door. She stated she laid the mask on the table.

An interview on 04/25/19 at 8:50 AM, with Lead CNA #5, revealed if a nebulizer is lying around, the nurse was to be notified. She stated it should be stored in a clear bag. CNA #5 stated that CNA #1 removing the nebulizer mask from Resident 65's face is not in the scope of the CNA practice. CNA #5 stated the CNA's could not mess with medications. CNA #5 stated during the Orientation Process, the different department heads come in and speak to the new CNAs and tells them what they can and cannot do within their scope of practice. She stated the information is also in the orientation packet.

An interview on 04/25/19 at 9:18 AM, with Registered Nurse (RN) #4 revealed, "The CNA's are provided with a checklist in orientation of what they can or cannot do in a facility. It is not within the scope of the CNA's practice for CNA #1 to do anything with medication".

An interview on 04/25/19 at 12:30 PM with Interim Director of Nursing (DON) #1 revealed "the CNA did not act within the scope of her practice by removing the nebulizer mask with medication in it".

During an interview on 04/25/19 at 12:33 PM, Interim DON #1 revealed the LPN not ensuring that the resident received the full breathing treatment is not following the physician's order. She stated the LPN should have followed up with

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F 695	Continued From page 90	F 695		

the breathing treatment medication not being given, and she should have notified the physician that the medication wasn't completely given.

Review of Resident #65's Medication Administration Record (MAR) revealed LPN #5 did not sign the MAR on 4/22/19, for the resident's Albuterol treatment being administered.

An interview on 04/25/19 at 4:23 PM, with LPN #5, revealed, "I put Albuterol in the nebulizer and placed the nebulizer on the Resident #65's face". LPN #5 stated, when asked why she didn't try to complete the breathing treatment for Resident #65, "She would have got combative if I had tried to put it back on her. That's just the way she is". When LPN #5 was ask why she didn't sign the Medication Administration Record for the Albuterol Medication, LPN #5 stated, "It wasn't signed? I guess I just forgot but it was really crazy here that day."

An interview on 04/26/19 at 4:38 PM, with the Administrator, revealed she wasn't aware that LPN #5 was down the hall from the nebulizer treatment that was in progress. She stated she wasn't aware that she did not sign the MAR until now. She stated that LPN #5 should have signed the MAR that she administered the medication and notified the RN Supervisor and the physician when it was removed from the resident and not finished.

An interview on 04/26/19 at 12:15 PM, with Interim DON #3, revealed, "It is not in the Scope of Practice for CNA #1 to remove a nebulizer mask from Resident #65. CNA #1 should have went and got the nurse for assistance. LPN #5 should have evaluated the resident and then

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F 695	Continued From page 91 notified the Registered Nurse Supervisor for an assessment and then notify the physician regarding the issue. At that point the physician could make a call as to whether another treatment was necessary at that time based on the assessment. Interim DON #3 stated that LPN #5 should not have been down the hall, she should have stayed with the resident during medication administration of the breathing treatment.	F 695		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, record review, and staff interview, the facility failed to obtain a physician's order before drawing a laboratory specimen from a Peripherally Inserted Central Catheter (PICC) line for a peak and trough level, related to medication administration, for one (1) of 24 medical records reviewed for lab, Resident #4. Findings include:	F 773	F773 1. Resident #4 is followed by an Infectious Disease provider and has continued on antibiotic treatment since 4/26/19 related to various infectious processes; Peripherally Inserted Central Catheter (PICC) line was discontinued on 5/3/19. Registered Nurse #1 was provided one-to-one education on 4/26/19 by Corporate Clinical Specialist in regards to	5/31/19

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F 773	Continued From page 92 Review of the facility's policy titled, "Medication and Treatment Orders", dated July 2016, revealed that it is the policy of this facility that orders for medications and treatments will be consistent with principles of safe and effective order writing. The facility policy states that verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date, and the time of the order. The facility policy also states that verbal orders must be signed by the prescriber at his or her next visit. During an observation on 4/23/19 at 11:35 AM, Registered Nurse (RN) #1 drew a laboratory blood specimen from Resident #4's PICC line. Review of Resident #4's medical records, "Order Summary Report," dated 4/25/19, revealed that there was no Physician's order for the facility to draw blood from a PICC line for laboratory testing, as it related to the peak and trough of an antibiotic (Tobramycin) on 4/23/19. Review of Resident #4's medical record documentation, revealed a laboratory test result for a Tobramycin Trough level that was collected on 4/23/19. During an interview on 4/23/19 at 11:55 AM, with Registered Nurse (RN) #1/ Unit Supervisor, she stated that the resident had a physician's order to draw blood before and after each administration of the Intravenous (IV) therapy of the Tobramycin from a PICC line. (Review of the medical record revealed no order for the lab).	F 773	procedure for obtaining lab test specimen via PICC and on following physician orders for laboratory tests. No negative outcome for Resident #4. 2. On 4/28/19, one (1) resident had orders for Peripherally Inserted Central Catheter (PICC) line, Resident #4. No other residents have the potential to be affected. 3. On 5/20/19, Registered Nurses were in-serviced in regards to procedure for obtaining blood specimens from central venous catheters by Staff Development Coordinator. On 5/20/19, Licensed Nurses were in-serviced in regards following physician orders. On 5/22/19, Corporate Support Administrator/Registered Nurse in-serviced facility staff, including Licensed Nurses, on requirement to obtain and follow physician orders for laboratory tests, and Registered Nurses on following procedures for obtaining blood specimen via PICC/central venous access. 4. Beginning 5/27/19, Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator will observe PICC line care weekly for four (4) weeks, then monthly for three (3) months to monitor for care/flushes/lab draws performed per policy if there is a resident in the facility with orders for PICC/central venous line. The Director of Nursing will report findings of observations to the Quality Assurance Performance Improvement committee monthly for three	

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F 773	Continued From page 93 During an interview on 4/25/19 at 12:41 PM, Interim Director of Nursing (DON) #1 revealed that the nurse should have obtained a lab order before obtaining blood for a laboratory test. During an interview, on 4/26/19 at 9:15 AM, RN #1/ Unit Supervisor revealed that the laboratory testing for the Peak and Trough levels for the current antibiotic therapy, Tobramycin, was not written. RN #1 stated that it was her intention to write the order, but she got distracted and forgot. RN #1 stated that the pharmacy had called her and told her they would not send the medication until peak and trough levels were done. RN #1 stated that was the reason that she drew the blood before she went to write the order. RN #1 stated that she had given the results to the doctor, so he must have wanted one. RN#1 stated that she would get it clarified by the doctor today. Review of the Face Sheet revealed the facility admitted Resident #4 on 9/14/16, and re-admitted on 9/8/17, with diagnoses to include Osteomyelitis, Paraplegia, and Urinary Tract Infection.	F 773	(3) months for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		5/31/19

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§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when

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F 842	Continued From page 95 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to have an accurate medical record for one (1) of 24 records reviewed, Resident #65, for failure to document the respiratory treatment on the Medication Administration Record (MAR) for medication initiation/completion. Findings include: Review of the facility's policy titled, "Administering Medications", dated December 2012, revealed, "Medications should be administered in a safe and timely manner and as prescribed. As required or indicated for a medication, the individual administering the medication will record in the residents medical record the signature and title of the person administering the drug". An observation on 04/22/19 at approximately 9:49 AM, revealed Resident #65 sitting in her	F 842	F842 1. On 5/10/19, Medical Records licensed nurse reviewed orders for Resident #65 and corrected order entry for respiratory treatment in the electronic medication administration record. 2. Resident with respiratory treatments have the potential to be affected. On 5/10/19, Medical Records licensed nurse reviewed respiratory orders for twenty-two (22) residents in regards to order being entered correctly in electronic medication administration record, corrections were made as indicated. 3. On 5/20/19, licensed nurses were in-serviced by Medical Records Nurse, on required components for entering respiratory orders into electronic medication administration record and	

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F 842	Continued From page 96 wheelchair in the doorway of her room with the nebulizer mask on her face and the nebulizer machine was turned on. Licensed Practical Nurse (LPN) #5 was standing at the medication cart approximately 40 feet down from Resident #65's room. LPN #5 confirmed she had placed the nebulizer on Resident #65 and confirmed the medication in the nebulizer was Albuterol. Review of Resident #65's Medication Administration Record (MAR) revealed LPN #5 did not sign the MAR on 4/22/19, for the Resident's Albuterol treatment being initiated/administered. There was no documentation that the medication had not been completed after it was initiated, or the reason why it was not completed. An interview on 04/25/19 at 4:23 PM, with LPN #5, revealed, "I put Albuterol in the nebulizer and placed the nebulizer on the resident". LPN #5 confirmed the medication was not completed during the treatment. When asked why she didn't try to complete the breathing treatment for Resident #65, LPN #5 stated the resident would have become combative if she had attempted, stating, "That's just the way she is". When LPN #5 was asked why she didn't sign the Medication Administration Record (MAR) for any part of the breathing treatment that Resident #65 received, she stated, "It wasn't signed? I guess I just forgot, but it was really crazy here that day." An interview on 04/25/19 at 12:33 PM, with Interim Director of Nursing (DON) #1, revealed if LPN #5 gave the Albuterol, then LPN #5 should have signed the MAR for the medication. An interview on 04/26/19 at 4:38 PM, with	F 842	requirement to complete documentation with each treatment and how to document by exception. 4. Beginning on 5/27/19, the Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Respiratory Therapist will conduct observations of licensed nurse completing administration of nebulizer treatments and review of documentation after treatment to ensure administration of nebulizer treatments is being documented correctly; observations will be conducted on three (3) residents weekly for four (4) weeks. The Director of Nursing will report findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance.	

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F 842	Continued From page 97 Administrator, revealed that she wasn't aware that LPN #5 did not sign the MAR. She stated, "She should have signed the MAR that she administered the medication and notified the Registered Nurse (RN) Supervisor and the physician when it was removed from the resident and not finished".	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		5/31/19

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F 880	Continued From page 98 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed	F 880	F880	

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F 880	Continued From page 99 to prevent the possible spread of infection while drawing a blood specimen from a Peripherally Inserted Central Catheter (PICC) line for Resident #4; failed to prevent the possible spread of infection during incontinent care for (1) of (3) incontinent care observations for Resident #56, and failed to prevent the possible spread infection during medication administration for (2) of (3) medication pass observations for Residents #19 and #29; and failed to ensure a nebulizer mask was bagged and stored properly for Resident #65. This affected five (5) of 24 residents reviewed. The facility also failed to prevent the possible spread of infection, as evidenced by over-filled sharp containers for four (4) of six (6) medication carts. Findings include: Review of the facility's policy titled, "Guidelines for Preventing Intravenous Catheter-Related Infections," dated August 2014, indicated that it is the purpose of this procedure to maximally reduce the risk of infection associated with indwelling intravenous (IV) catheters. The facility policy stated that the aseptic technique shall be observed at all times when working with IV equipment, such as injection/ access caps, and if contaminated, must be changed. Review of the facility's policy titled, "Sharps Disposal," dated January 2012, indicated that it is the policy of this facility that this facility shall discard contaminated sharps into designated containers. The facility policy states these designated containers must be impermeable and capable of maintaining impermeability through final waste disposal. The facility task also states that designated individuals will be responsible for	F 880	1. Resident #4 is followed by an Infectious Disease provider and has continued on antibiotic treatment since 4/26/19 related to various infectious processes; Peripherally Inserted Central Catheter (PICC) line was discontinued on 5/3/19. Registered Nurse #1 was provided one-to-one education on 4/26/19 by Corporate Clinical Specialist in regards to procedure for obtaining lab test specimen via PICC. Resident #56 has been prescribed an antibiotic since 4/3/19 for chronic urinary tract infection, receives in and out catheterization and has diagnosis Hydronephrosis; no negative outcome per MD assessment on 4/25/2019. License Practical Nurse/treatment nurse was provided one-to-one education in regards to infection control issues with medication pass and not stacking cups on top of each other. Education was provided by Staff Development on 5/24/19. Resident #65 was evaluated by Registered and licensed nurses for any adverse reactions on 4/22/19; no concerns identified. Nebulizer mask was discarded and replaced with a new mask on Director of Nursing on 4/22/19. Certified Nursing Assistant #1 was provided one-to-one education on 4/22/19, by Corporate Clinical Specialist and Director of Nursing regarding removing nebulizer masks is the responsibility of the licensed nurse or respiratory therapist and concerns should be reported to immediate supervisor; Physician/Medical Director was notified. Licensed Nurse #5 was provided	

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F 880	Continued From page 100 sealing and replacing containers when they are 75 percent (%) to 80% full to protect employees from punctures, and/ or needle sticks, when attempting to push sharps into the container. Review of an undated facility document on the facility's letterhead, revealed that the sharps containers will be checked by Central Supply daily and emptied when necessary. The document was signed by Registered Nurse (RN) #2, the facility's Infection Control Nurse. The document was provided by the Administrator when asked who is responsible for monitoring and the disposal of sharps containers that are full. Review of the facility's policy titled, "Infection Control Plan", dated May 15, 2013, revealed the facility will maintain a Infection Control Plan to provide systematic management of infection control issues for residents and employees in the facility. It is the facility's plan to establish policies and procedures for investigating, controlling, and preventing infection transmission in the facility. Resident #4 During an observation on 4/23/2019 at 11:35 AM, of a blood specimen draw from Resident #4's Peripherally Inserted Central Catheter (PICC) line, Registered Nurse (RN) #1/ Unit Supervisor placed all the supplies to withdraw a blood sample on Resident #4's bedside table. RN #1 did not clean the bedside table, nor did she place any type of barrier on the table. RN #1 removed the cap from the PICC line Lumen, and placed the cap on the unclean bed side table. RN #1 tore open the alcohol swab packaging and toss the packaging onto the bed side table, where the packaging landed on top of the Lumen cap. RN #1 was then observed to retrieve the	F 880	one-to-one education by Corporate Clinical Specialist and Director of Nursing on 4/22/19 regarding remaining within line of sight of residents receiving nebulizer treatments and responding to resident care needs. On 4/25/19 RN #1 was provided one-to-one education in regards to safe practice and replacing sharps containers when they reach the fill line by Corporate Clinical Specialist. On 4/25/19 licensed nurses on duty at time checked sharps containers throughout the facility and replaced those that were at or above the fill line. 2. Resident with orders for PICC lines have the potential to be affected by the deficient practice, no other residents with PICC lines. Residents who are dependent on staff for incontinent care have the potential to be affected by the deficient practice. MDS Coordinator audit 97 Resident to identify 35 resident potentially affected. Corporate Clinical Specialist verified the Kardex was accurate. Residents who received medication pass from licensed nurse/treatment nurse LPN#6 on 4/26/2019 have the potential to be affected by the deficient practice. Twenty- two (22)Residents who have physician orders for nebulizer treatments have the potential to be impacted by the deficient practice. All staff and residents have the potential to be impacted by overfilled sharps containers.	

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F 880	Continued From page 101 contaminated cap and reapply it to the Lumen. RN #1 also did not clean the cap before reusing it on the PICC line port. During an interview on 04/23/2019 at 11:55 AM, Registered Nurse (RN) #1/Unit Supervisor stated that she had forgotten to clean the bedside table and place a barrier before laying the supplies down on the table before drawing blood from Resident #4. RN #1 confirmed that she removed the cap from the PICC line Lumen and placed it on the unclean bedside table. RN #1 confirmed she tossed the alcohol swab packaging onto the bedside table after opening, and it had landed on the Lumen cap. RN #1 that stated she knows that is an infection control issue. During an observation, on 4/23/2019 at 12:18 PM, of the disposal of the biohazard waste, it was observed that RN #1 attempted to push a small clear plastic biohazard bag, containing the vial of Resident #4's blood inside, into a sharps container. It was then observed, that after the second attempt, RN #1's hand broke the plane of the protective guard to complete the task of waste disposal. Concurrent observation of the medication and wound carts revealed four (4) out of six (6) designated sharps containers attached to each medication and each wound cart were filled above the fill line, indicating that they should be replaced. During an interview, on 4/23/2019 at 12:26 PM, RN #1/ Unit Supervisor, indicated that she was aware that the sharps container, on the medication cart for the 300 Hall, was over-filled and needed to be replaced. RN #1 confirmed that she had attempted to drop a bio-hazard bag into the container. RN #1 confirmed that there was a	F 880	3. On 5/22/19, facility staff, including licensed nurses, Certified Nursing Assistants, were in-serviced in regards to infection control practices, including but not limited providing incontinent care following infection control standards, hand washing before, and after resident care, and after removing gloves. Licensed nurses were in-serviced in regards to infection control practices during medication pass, including but not limited to, not stacking graduated cups, changing sharps containers before or at fill line, cleaning and storing nebulizer mask in a manner that decreases risk of infection; in-services provided by Corporate Support Administrator/Registered Nurse. Beginning on 5/20/19, licensed nurses were in-serviced on maintaining infection control practices during medication pass including but not limited to not stacking graduated cups by the Staff Development Coordinator. Beginning on 5/20/19 Certified Nursing Assistants were in-serviced on and performed return demonstration for hand washing and incontinent care to the Staff Development Coordinator/Lead C.N.A. Beginning on 5/20/19 Registered Nurses were educated by Staff Development Coordinator on following infection control technique while providing PICC care/obtaining laboratory specimen. 4. Beginning 5/27/19, the Director of Nursing/Assistant Director of Nursing will conduct an observation weekly, if there is a resident with a physician order for	

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F 880	Continued From page 102 vial, half filled with a sample of resident's blood inside the bio-hazard bag. RN #1 stated that she did try to push the small plastic biohazard bag into in sharps container, but her hand did not break the plane of the protective guard. RN #1 also stated that pushing an object into a sharps container is a serious risk hazard. During an interview, on 4/23/2019 at 5:05 PM, RN #2/ Infection Control Nurse, confirmed that the actions taken by RN #1, while performing the blood draw using a PICC line, were an infection control concern. RN #2 stated that RN #1 should have cleaned the bed side table and placed a barrier down on the table before starting the procedure. RN #2 also stated that it is an infection control concern to allow an unclean surface, like the alcohol swab packaging to touch the lumen cap, and then recap the PICC line port (without cleaning). During a follow-up interview, on 04/25/2019 at 9:05 AM, RN #2/ Infection Control Nurse stated that no one should ever force anything into a sharps container. RN #2 stated, "Having to force something into a sharps container could cause injury and increase the risk of acquiring a serious transmitted disease." RN #2 also stated that the night shift is designated to monitor the sharps containers and change them out when they are greater than 75% full. During an interview, on 4/25/2019 at 12:25 PM, Interim Director of Nursing (DON) #1 revealed that placing your hand into the sharps container, to push something into it, should never happen. Interim DON #1 stated that not cleaning the bed side table before placing the supplies to draw the blood specimen for a laboratory test and how RN	F 880	Peripherally Inserted Central Catheter (PICC) line flushes/lab/care in the facility, of Registered Nurses performing PIC line flushes/lab/care weekly for four (4) weeks, then monthly for three (3) months. Beginning 5/27/19, Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Registered Nurses will perform incontinent care observations with three (3) Certified Nursing Assistants weekly for four (4) weeks, then monthly for three (3) months. Beginning 5/27/19, Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Registered Nurses will perform observations of three (3) licensed nurses during medication administration to observe for infection control practices being followed, weekly for four (4) weekly, then monthly for three (3) months. Beginning 5/27/19, the Maintenance Director/Assistant Maintenance Director will conduct rounds to check on sharps containers being routinely changed weekly for four (4) weeks, then monthly for three (3) months. The Director of Nursing will monitor outcomes of observations and report findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and further recommendations. The Director of Nursing is responsible for on-going monitoring and compliance.	

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#1 handled the lumen cap were both infection control issues. Interim DON #1 also stated that it is the policy of this facility that the sharps containers are monitored and replaced when that containers have reached the indicated full line.

During an interview, on 4/25/2019 at 12:30 PM, Interim Director of Nursing (DON) #3 stated that the sharps containers are supposed to be changed out at 75% filled.

Review of the Face Sheet revealed Resident #4 was admitted by the facility on 9/14/2016, and re-admitted on 9/8/2017, with diagnoses to include Osteomyelitis, Paraplegia, and Urinary Tract Infection.

Resident #19
An observation on 04/26/19 at 9:25 AM, revealed Licensed Practical Nurse (LPN) #6 placed two (2) 30 cubic centimeter (cc) medication cups on top of the medication cart without a barrier and put Resident #19's medications into one (1) of the cups. LPN #6 then picked up the empty 30 cc medication cup and placed (stacked) it on top of the medications in the first cup, and went to Resident #19's room, and administered medications.

Resident #29
An observation on 04/26/19 at 9:45 AM, revealed revealed LPN #6 placed two (2) 30 cc medication cups on top of the medication cart without a barrier and put Resident #29's medications into one (1) of the cups. LPN #6 then picked up the empty 30 cc medication cup and placed (stacked) it on top of the medications in the first cup and went to Resident #29's room and administered medications.

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An interview on 04/26/19 at 12:04 PM, with LPN #6 revealed, "I didn't have a barrier on the medication cart and I did put the medication cups on top of the cart to pull up the pills. I did stack them together "

An interview on 04/26/19 at 12:08 PM, with Interim Director of Nursing (DON) #3, revealed, "Not having a barrier on the medication cart and placing the medication cups directly on the cart and then placing the cups on top of each other is a infection control issue".

Resident # 56
A review of facility policy titled, "Perineal Care" dated February 18,2019, revealed the purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. The steps include to wash and dry your hands thoroughly before and after providing perineal care and to don and change gloves during care.

An observation on 04/23/19 at 05:22 PM, revealed CNA #4 set up to provide incontinence care in Resident #56's room . The wash basin was placed on the bedside table, without a barrier under the basin. CNA #4 did not wash her hands before gloving. CNA #4 provided incontinent care to Resident #56 using the same gloves throughout the procedure. CNA #4 placed a dirty wash cloth on the over-bed table. CNA #4 took the wash basin to the sink and poured the dirty water into the sink after initially providing the care. CNA #4 still had the same gloves on as she did when she began the pericare. CNA #4 filled the basin with water and returned the basin to the

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bed side table. CNA #4 still had dirty gloves on. CNA #4 wet a wash cloth and wiped the residents buttocks and anal area. CNA #4 placed the cloth in the clear bag. CNA #4 got two (2) wipes and wiped the residents buttocks and anal area and then discarded the wipes into the clear bag. CNA #4 then begin to apply a clean brief with the same gloves on as she had applied when she started the procedure. CNA #4 applied the brief and then walked to the resident's closet to obtain clothes for the resident. CNA #4 still had dirty gloves on. CNA #4 approached the resident and applied Resident #56's clean clothes. CNA #4 then took the basin into the bathroom and dumped the water into the sink. CNA #4 removed her gloves and got a paper towel and walked back over to Resident #56's over-bed table and wiped the table with the paper towel. CNA #4 then walked out of the room and never washed her hands. CNA #4 never changed gloves nor washed her hands through the entire process.

An interview on 04/23/19 at 05:35 PM, with CNA #4 revealed, "I knew that I didn't change gloves or wash my hands. I knew to do all of that, but I was nervous with you watching me".

An interview on 04/23/19 at 05:40 PM, with Interim Director of Nursing (DON) #1, revealed, "CNA #4 not washing her hands or changing her gloves does not support our Infection Control Policy".

An interview on 04/26/19 at 12:20 PM, with Interim DON #3 revealed, "CNA #4 not washing her hands and not changing her gloves during pericare is a infection control issue".

An interview on 04/26/19 at 04:33 PM, with the

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facility's Administrator, revealed CNA #4 should have washed her hands and changed her gloves during pericare.

Resident #65
A review of facility policy titled, "Departmental (Respiratory Therapy) Prevention of Infection", revealed the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Infection Control Considerations related to medication nebulizers includes storing the circuit in plastic bag, marked with date and residents name, between uses.

An observation on 04/22/19 at approximately 09:49 AM, revealed CNA #1 removed the nebulizer mask from Resident #65's face. After removing the nebulizer mask from Resident #65 face, CNA #1 placed the mask on the night stand in Resident #65's room. The Nebulizer mask was lying across the nebulizer machine, but not in a bag.

An observation on 04/25/19 at 10:10 AM, revealed the nebulizer mask, for Resident #65, lying across nebulizer machine, not bagged.

An observation on 04/22/19 at approximately 02:50 PM, revealed the nebulizer mask continued lying across the nebulizer machine and not in a bag

An interview on 04/25/19 08:50 AM, with Lead Certified Nurse Aide (CNA) #5, confirmed if a nebulizer mask is lying around, you are supposed to call the nurse and get the nurse to put it in a bag; it's supposed to be stored in a clear bag.

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F 880	Continued From page 107 Interview on 04/25/19 at 09:00 AM, with RN #2/Infection Control Nurse, revealed the nebulizer mask should be bagged and labeled with the resident's name on the bag. She stated that being laid on the bed side table, without placing it in a bag, was a infection control issue.	F 880		