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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435073</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/13/2016</b> |
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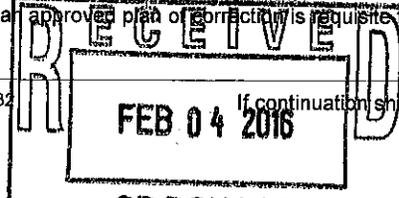
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHESDA HOME OF ABERDEEN</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1224 S HIGH ST<br/>ABERDEEN, SD 57401</b> |
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| F 000         | INITIAL COMMENTS<br><br>Surveyor: 33265<br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/12/16 through 1/13/16. Areas surveyed included abuse policies, procedures, and training. Bethesda Home of Aberdeen was found not in compliance with the following requirement(s): F 223, F 224, and F 226.   | F 000 | * Addendums noted with an asterisk per 2/22/16 per telephone with facility administrator.<br>NK/SDDO/H/EL |  |
| F 223<br>SS=D | 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION<br><br>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.<br><br>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 33265<br>Based on observation, interview, record review, and policy review, the provider failed to ensure one of five sampled residents (1) was kept free from physical and mental abuse. Findings include:<br><br>1. Observation on 1/12/16 at 10:00 a.m. of resident 1 in her room revealed:<br>*She was seated in a geriatric (geri) chair.<br>*She had a blanket covering her entire body and face and she a hat on her head.<br>*When asked why the blanket was over her face she removed the blanket and stated "It is cold." | F 223 |   |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X6) DATE February 3, 2016

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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| F 223  | <p>Continued From page 1</p> <p>*She had not been able to answer any further questions with identifiable words.</p> <p>2. Interview on 1/12/16 at 1:10 p.m. with CNA A revealed:<br/>*On 12/18/15 (Friday) between 1:30 p.m. and 2:00 p.m. CNA B asked if she wanted to see something funny. CNA B brought her into resident 1's room, and then CNA B pinched the resident's nose shut until she got a verbal and physical reaction from the resident.<br/>*She had not thought it was funny and had left the room and had not known what to do. She stated she "was in shock."<br/>*She had worked the weekend and when she had seen resident 1, the resident mentioned the "girl who pinches my nose."<br/>*On 12/21/15 (Monday) she went to her supervisor, sometime between 10:00 a.m. and 1:30 p.m. to report the behavior she had witnessed on Friday.</p> <p>3. Interview on 1/12/16 at 10:43 a.m. with the director of nursing (DON) revealed:<br/>*On 12/21/15 at 1:30 p.m. she was informed of abusive behavior by a staff member towards a resident.<br/>*Certified nursing assistant (CNA) A reported on 12/19/15, she had seen CNA B pinch the nose of resident 1 and hold her nose pinched until the resident started reacting verbally and physically.<br/>-At a later unidentified time on 12/22/15, CNA A wrote out what she had witnessed. She then corrected the date of the event as 12/18/15 between 1:30 p.m. and 2:00 p.m.<br/>*CNA B had asked CNA A if she wanted to see something funny and had taken her into resident 1's room and then pinched the resident's nose shut, so she could not breathe through her nose.</p> | F 223   | <p>F223 (1, 2, 3, 4)</p> <p>This deficiency has the potential to affect all residents.</p> <p>The Director of Nursing has determined that there were no further negative outcomes to Resident #1 regarding the incident.</p> <p>On January 19, 2016, <b>*N. LISDORHEL</b> the local ombudsman, presented education on abuse and resident rights for all staff.</p> <p>The policy "Abuse, Neglect, and Misappropriation of Resident Property" will be reviewed and revised. The policy will include; prevention of abuse, procedures for reporting abuse and keeping the resident safe throughout the investigation process, follow-up and resolution.</p> <p>The 'Code of Conduct' will be revised and revisited.</p> <p>The Administrator, Director of Nursing, Social Services, and Staff Education will provide education to all staff by attending one of six in-services to be held on February 9, 2016 and February 10, 2016. Education will include the review of the "Abuse, Neglect, and Misappropriation of Resident Property" policy and procedures. Education will also include; what constitutes abuse, reporting abuse, and procedures to follow once abuse is reported.</p> |   |

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| F 223  | <p>Continued From page 2</p> <p>*On 12/21/15 at an unidentified time the DON attempted unsuccessfully to interview resident 1. -Resident 1 had a diagnosis of dementia and was not able to engage in a meaningful discussion.</p> <p>*On 12/22/15 at 2:30 p.m. and at 4:00 p.m. the DON interviewed two other CNAs who regularly worked with CNA B. Both denied witnessing any abusive behavior.</p> <p>*The DON had not interviewed the charge nurse on the wing during the shift when the abusive behavior was to have happened.</p> <p>*On 12/22/15 at an unidentified time during the morning the DON and administrator met with CNA B regarding the above behavior. She did not deny pinching resident 1's nose shut, and she was terminated.</p> <p>*On 12/23/15 at 10:00 a.m. the DON interviewed CNA C who identified two other CNAs who she had also seen pinch resident 1's nose shut. Those were CNAs D and E.</p> <p>*On 12/23/15 at 11:30 a.m. CNA B returned to the facility and requested to meet with management. She denied doing anything to resident 1. She stated she had witnessed CNAs D and E pinching resident 1's nose shut.</p> <p>*On 12/23/15 at 4:00 p.m. the administrator and DON met with CNA D who admitted to pinching resident 1's nose shut until she reacted. She was terminated.</p> <p>*The DON had not attempted to reach CNA E as she was no longer employed as a full time CNA.</p> <p>4. Interview on 1/12/16 at 2:13 p.m. with CNA C regarding resident revealed:<br/>*When questioned about CNA behaviors she reported she had witnessed CNAs D and E pinch resident 1's nose shut until they got a physical and verbal response.<br/>*The CNA D and E had done that individually, not</p> | F 223   | <p>F223 (cont)</p> <p>Education will also include the review of the "Code of Conduct" by all employees. Review of electronic devices and social media will be included.</p> <p>Social Services will audit staff members to inquire as to what abuse is and what they would do if they thought someone was being abused. Five staff members will be interviewed weekly for 4 weeks and then monthly thereafter until the Quality Assurance and Performance Improvement committee advises to discontinue. Social Services will report monthly to the Quality Assurance and Performance Improvement committee and Staff education will report quarterly to the Quality Assurance committee.</p> <p>Social Services will interview four residents weekly assuring that they are being treated properly and that their property is safe. Interviews will continue until the Quality Assurance and Performance Improvement committee advises to discontinue.</p> |                      |   |

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| F 223  | <p>Continued From page 3 together.</p> <p>*The resident would tell them to stop and attempt to push them away.</p> <p>*She "didn't think anything of it", so she had not reported it.</p> <p>*"Didn't realize pinching nose shut was abuse."</p> <p>*When asked what training she had received regarding abuse when she had started her employment she stated "they gave me a piece of paper to read."</p> <p>*She had not witnessed any other residents being treated that way.</p> <p>*When asked why resident 1 was treated this way she said "she's not going to tell anybody."</p> <p>Review of resident 1's medical record revealed she:</p> <p>*Had a diagnosis of intracranial hemorrhage (bleeding in the brain).</p> <p>*Needed total assistance with all care.</p> <p>*Had both short and long term memory problems.</p> <p>Review of the Required Healthcare Facility Event Reporting form dated 12/22/15 and interview with the DON on 1/12/16 at 10:43 a.m. revealed she:</p> <p>*Had no idea why CNA A waited three days to report the incident.</p> <p>*Believed CNA C had not reported the witnessed behaviors until asked, because CNA C was not sure it was abuse.</p> <p>*Agreed the incidents should have been reported immediately.</p> <p>*Did make rounds and observed for inappropriate behavior, but had not documented that monitoring.</p> <p>Review of the provider's undated Code of Conduct revealed:</p> <p>*"Residents have the right to choose what is done</p> | F 223   | <p>F223 (cont)</p> <p>Any negative findings will be reported immediately to administration and then monthly to the QAPI committee and Staff education will report quarterly to the Quality Assurance committee.</p> <p>The Director of Nursing or her designee will monitor residents for any signs and changes in residents that would indicate possible abuse. Audits during resident care will be conducted weekly with a focus on those residents who cannot speak for themselves. At least four residents will be monitored weekly. Audits will continue until the Quality Assurance and Performance Improvement committee advises to discontinue.</p> <p>The Administrator and the Director of Nursing will report monthly to the Quality Assurance and Performance Improvement committee and quarterly to the Quality Assurance committee.</p> | 2/10/16   |

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| F 223  | Continued From page 4<br>to their bodies and by whom."<br>*The provider was to have "assured its employees and agents had sufficient education, licensure, background experience, on the job training and supervision to render services to its residents."<br>**"Any incident of resident mistreatment, neglect or abuse will be reported to the charge nurse, DON or administrator and other officials as required by law."<br>***"Employees and agent will assure each resident is protected from verbal, mental or physical abuse, corporal punishment and involuntary seclusion."<br>****"If an employee or agent knows of or suspects a practice or incident may violate this code of conduct, then he/she must report it to appropriate levels of management."<br><br>Review of the provider's February 2015 Investigation and Reporting of Abuse, Neglect & Misappropriation of Resident Property policy revealed:<br>*Physical abuse included pinching.<br>*Mental abuse included humiliation or harassment.<br>*Mistreatment included willful inappropriate care.<br>*The provider would not permit employees to use verbal, mental, sexual, or physical abuse.<br>*Prevention of abuse included training during orientation and annually.<br>*Any observed incident was to be reported immediately to the charge nurse. The charge nurse was to intervene to maintain resident safety.<br>*Monitoring for abuse was not identified in the policy. | F 223   |   |                      |   |
| F 224  | 483.13(c) PROHIBIT   | F 224   |   |                      |   |

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| F 224<br>SS=D  | <p>Continued From page 5</p> <p><b>MISTREATMENT/NEGLECT/MISAPPROPRIATN</b></p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32331<br/>Based on observation, interview, record review, and policy review, the provider failed to thoroughly investigate the misappropriation of one of one randomly sampled resident's (6) property by two of two certified nursing assistants (CNA) (D and E). Findings include:</p> <p>1. Review of CNA D's employee file revealed:<br/>*A hire date of 1/13/14.<br/>*She had received her CNA training in the facility.<br/>*On 4/23/14 she had become a CNA.</p> <p>Review of CNA E's employee file revealed:<br/>*A hire date of 9/12/13.<br/>*She had received her CNA training in the facility.<br/>*On 11/22/13 she had become a CNA.</p> <p>Review of CNA D and E's employee files revealed:<br/>*A typed letter dated 8/10/15 by registered nurse (RN) K contained the following:<br/>*She had received a call from resident 6's daughter regarding a cord for his iPad(a tablet computer with a multi-touch screen).<br/>*CNAs D and E had borrowed that cord.</p> | F 224   | <p>F224 (1, 2, 3)</p> <p>This deficiency has the potential to affect all residents.</p> <p>On February 2, 2016 Social Services revisited with Resident #6 to ensure there were no further negative outcomes regarding the missing property.</p> <p>On January 19, 2016, <del>_____</del> the local ombudsman, presented education on abuse and resident rights for all staff.</p> <p>The policy "Abuse, Neglect, and Misappropriation of Resident Property" will be reviewed and revised. The policy will include; prevention of abuse, procedures for reporting abuse and keeping the resident safe throughout the investigation process, follow-up and resolution.</p> <p>The 'Code of Conduct' will be revised and revisited.</p> <p>The Administrator, Director of Nursing, Social Services, and Staff Education will provide education to all staff by attending one of six in-services to be held on February 9, 2016 and February 10<sup>th</sup>, 2016. Education will include the review of the "Abuse, Neglect, and Misappropriation of Resident Property" policy and procedures. Education will also include; what constitutes abuse, reporting abuse, and procedures to follow once abuse is reported.</p> |   |

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| F 224  | <p>Continued From page 6</p> <p>*RN K had instructed the CNAs to not take any resident's property.</p> <p>Observation and interview on 1/13/16 at 10:15 a.m. with resident 6 in his room revealed he:</p> <p>*Was seated in his chair with his iPad on his lap.</p> <p>-The iPad was attached to a white power cord plugged into a power strip outlet located next to his chair.</p> <p>-That iPad was turned on.</p> <p>-Stated he was playing a card game on the device.</p> <p>*Stated he enjoyed working with the iPad.</p> <p>*Stated a female staff person had taken his iPad's white power cord "a while back."</p> <p>-That staff person had taken his power cord, because "her [cord] had been shorting out."</p> <p>-She had needed to use his cord to charge her personal device.</p> <p>*Stated she could borrow it, however, he had expected her to have brought it back "in a short time."</p> <p>*Stated there was at "least one time I could not use it [iPad] because my cord was missing."</p> <p>-Had needed that cord to power his iPad.</p> <p>*Stated his power cord had not been returned for "at least several days."</p> <p>*Did not think she worked there anymore, because he had "not seen her for a while."</p> <p>Review of resident 6's 9/3/15 and 11/24/15 quarterly Minimum Data Set assessments revealed he:</p> <p>*Had a Brief Interview for Mental Status (BIMS) score of:</p> <p>-Fourteen on 9/3/15.</p> <p>-Fifteen on 11/24/15.</p> <p>*A BIMS score of thirteen to a fifteen indicated his memory was intact (okay).</p> | F 224   | <p>F224 (cont)</p> <p>Education will also include the review of the "Code of Conduct" by all employees. Review of electronic devices and social media will be included.</p> <p>A policy and procedure for "Lost Item/Personal Property Damage Report" will be developed.</p> <p>Missing property reports will be brought to the attention of staff at the Monday-Friday stand-up meeting. Stand-up meeting includes, Administrator, Director of Nursing, Social Services, Charge Nurses, Resident Care Coordinator, Staff Education and various other supervisors.</p> <p>Social Services will review all missing property reports and determine if it is Misappropriation of Resident property and report to Administration and Department of Health as necessary.</p> <p>Social Services will report monthly to the Quality Assurance and Performance Improvement committee and Staff education will report quarterly to the Quality Assurance committee.</p> | 2/10/16   |

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| F 224  | <p>Continued From page 7</p> <p>*The above scores on his BIMS evaluations had indicated he was alert and able to answer questions.</p> <p>Review of resident 6's 8/12/15 social service designee's progress note revealed:<br/>*She had spoken with him and his granddaughter regarding the missing iPad cord.<br/>*The resident had stated "someone brought him a new cord."<br/>*The iPad was charged and in working condition.</p> <p>Interview on 1/13/16 at 10:50 a.m. with the licensed social worker (LSW) regarding the above concerns revealed:<br/>*She worked full-time in the facility.<br/>*She had been unaware resident 6's power cord for his iPad had been missing.<br/>*The provider's resident caseload was divided up by the LSW and the social service designee.<br/>*The social service designee worked with resident 6.</p> <p>Interview on 1/13/16 at 11:05 a.m. with the social service designee regarding the above concerns revealed:<br/>*She worked full-time in the facility.<br/>*She recalled resident 6's power cord for his iPad had been missing.<br/>*She offered to replace the power cord.<br/>*The power cord had been returned on 8/12/15.<br/>*The social services department was responsible for investigating misappropriation of resident's property.<br/>*That department kept two separate binders of information regarding:<br/>-Lost items and a follow-up to those items.<br/>*There had been no investigation by her department on why the power cord had been</p> | F 224   |   |                      |   |

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| F 224 | <p>Continued From page 8</p> <p>missing or any further follow-up with resident 6, RN K, CNA D, and CNA E regarding the above.</p> <p>Interview on 1/13/16 at 1:50 p.m. with the LSW revealed the provider had no policy on residents' missing property.</p> <p>Interview on 1/13/16 at 3:00 p.m. with the administrator and the director of nursing (DON) regarding the above concerns revealed:<br/>*The administrator and the DON were unaware CNAs D and E had taken resident 6's personal property.<br/>*The social services department was responsible for investigating misappropriation of resident's property.<br/>*Both confirmed resident 6's personal property was not to have been taken by CNAs D and E.<br/>*Both agreed a resident's personal property was not to have been taken by any staff person.</p> <p>Review of the provider's 9/12/13 job description for CNA E and the provider's 1/20/14 job description for CNA D revealed:<br/>*Residents were to have been treated fairly, and with kindness, dignity, and respect.<br/>*They were to have reported all misappropriation of resident property.</p> <p>Review of the provider's March 2013 Admission and Social Service Coordinator and Admission and Social Service Assistant job descriptions revealed they:<br/>*Promoted residents' rights.<br/>*Reported suspected abuse or neglect.</p> <p>Review of the provider's undated Code of Conduct policy revealed the provider's employees shall respect the property rights of others.</p> | F 224 |  |  |
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| F 224  | Continued From page 9  | F 224   |  |                      |   |
| F 226<br>SS=E  | <p>Review of the provider's February 2015 Investigation and Reporting of Abuse, Neglect, and Misappropriation of Resident Property policy revealed the resident had the right to be free from misappropriation of resident property.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 33265<br/>A. Based on interview and policy review, the provider failed to ensure seven of seven sampled employees (certified nursing assistant [CNA] A, C, F, G, H, I and registered nurse [RN] J) recognized a possible abusive situation. Findings include:</p> <p>1a. Interview on 1/12/16 at 1:10 p.m. with CNA A revealed:<br/>*On 12/18/15 (Friday) between 1:30 p.m. and 2:00 p.m. CNA B asked her if she wanted to see something funny. CNA B brought her into resident 1's room, and then CNA B pinched the resident's nose shut until she got a verbal and physical reaction from the resident.<br/>*CNA A had not thought it was funny and left the room. She had not known what to do. She stated she "was in shock."</p> | F 226   | <p>F226<br/>A, B) This deficiency has the potential to affect all residents.</p> <p>On January 19, 2016, <del>XXXXXXXXXX</del> <i>*KNZISDDH/EL</i> the local ombudsman, presented education on abuse and resident rights for all staff.</p> <p>The policy "Abuse, Neglect, and Misappropriation of Resident Property" will be reviewed and revised. The policy will include; prevention of abuse, procedures for reporting abuse and keeping the resident safe throughout the investigation process, follow-up and resolution.</p> <p>The Administrator, Director of Nursing, Social Services, and Staff Education will provide education to all staff by attending one of six in-services to be held on February 9, 2016 and February 10<sup>th</sup>, 2016. Education will include the review of the "Abuse, Neglect, and Misappropriation of Resident Property" policy and procedures. Education will also include; what constitutes abuse, reporting abuse, and procedures to follow once abuse is reported.</p> |                      |   |

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| F 226  | <p>Continued From page 10</p> <p>b. Interview on 1/12/16 at 2:13 p.m. with CNA C revealed:<br/>*When questioned about CNA behaviors she reported she had witnessed CNA D and CNA E pinch resident 1's nose shut until they got a physical and verbal response.<br/>*The resident would tell them to stop and attempt to push them away.<br/>*She "didn't think anything of it" so she didn't report it.<br/>*"Didn't realize pinching nose shut was abuse."<br/>*When asked what training she received regarding abuse when she started her employment she stated "they gave me a piece of paper to read."<br/>*When asked why resident 1 was treated this way she said "she's not going to tell anybody."</p> <p>Initial interview on 1/12/16 at 10:43 a.m. with the director of nursing (DON) revealed she believed CNA C had not reported the witnessed behaviors until asked because CNA C was not sure it was abuse.</p> <p>c. Interview on 1/13/16 at 9:10 a.m. with CNA F revealed a resident's sudden change in behavior (from being calm to yelling and pushing staff away) was not identified as a sign of possible abuse.</p> <p>d. Interview on 1/13/16 at 9:13 a.m. with CNA G revealed a resident's sudden change in behavior was not identified as a sign of possible abuse.</p> <p>e. Interview on 1/13/16 at 9:16 a.m. with CNA H revealed a resident's sudden change in behavior was not identified as a sign of possible abuse.</p> <p>f. Interview on 1/13/16 at 9:25 a.m. with CNA I</p> | F 226   | <p>F226 (cont)</p> <p>Education will also include the review of the "Code of Conduct" by all employees. Review of electronic devices and social media will be included.</p> <p>The Director of Nursing or her designee will monitor residents for any signs and changes in residents that would indicate possible abuse. Audits during resident care will be conducted weekly with a focus on those residents who cannot speak for themselves. At least four residents will be monitored weekly. Audits will continue until the Quality Assurance and Performance Improvement committee advises to discontinue.</p> <p>C) The Education Director will revise and elaborate the education on abuse. Face to face education will include such topics as abuse prevention, identification of direct and indirect abuse, reporting abuse, and stress management.</p> <p>The Education Director will also review all the material in the NATP.</p> <p>Abuse Education will be provided during orientation, at quarterly staff meetings, annually, and at any time deemed necessary.</p> |                      |   |

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| F 226  | <p>Continued From page 11</p> <p>revealed a resident's sudden change in behavior was not identified as a sign of possible abuse.</p> <p>g. Interview on 1/13/16 at 9:30 a.m. with RN J revealed a resident's sudden change in behavior was not identified as a sign of possible abuse.</p> <p>h. Interview on 1/13/16 at 3:00 p.m. with the DON and the administrator regarding the above interviews of the five random employees revealed they agreed the interviewed employees had not recognized a sign of a possible abusive situation.</p> <p>Review of the provider's undated Code of Conduct revealed the provider was to have "assured its employees and agents had sufficient education, licensure, background experience, on the job training and supervision to render services to its residents."</p> <p>Review of the provider's February 2015 Investigation and Reporting of Abuse, Neglect &amp; Misappropriation of Resident Property policy revealed:<br/>*Physical abuse included pinching.<br/>*Mental abuse included humiliation or harassment.<br/>*Mistreatment included willful inappropriate care.</p> <p>B. Based on interview, record review, and policy review, the provider failed to ensure two of two sampled employees (certified nursing assistants [CNA] A and C) would immediately report possible abusive behavior. Findings include:</p> <p>1. Interview on 1/12/16 at 1:10 p.m. with CNA A revealed:<br/>*On 12/18/15 (Friday) between 1:30 p.m. and 2:00 p.m. CNA B asked if she wanted to see</p> | F 226   | <p>F226 (cont)</p> <p>All incident reports will be brought to the attention of staff at the Monday-Friday stand-up meeting. Stand-up meeting members include; Administrator, Director of Nursing, Social Services, Charge Nurses, Resident Care Coordinator, Staff Education and various other supervisors. Incidents will be investigated by the appropriate staff, care plans will be reviewed, and corrective action taken as needed.</p> <p>D) The Personnel Policy outlines the process for disciplinary action. The Director of Human Resources will review the policy with Department Supervisors on Monday, February 8, 2016. Protocols for conducting employment background checks and reference checking will also be reviewed.</p> <p>The Administrator and the Director of Nursing will report monthly to the Quality Assurance and Performance Improvement committee and quarterly to the Quality Assurance committee.</p> | 2/10/16              |

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| F 226  | <p>Continued From page 12</p> <p>something funny. CNA B brought her into resident 1's room, and then she pinched the resident's nose shut until she got a verbal and physical reaction from the resident.</p> <p>*She had not thought it was funny, had left the room, and had not known what to do. She stated she "was in shock."</p> <p>*She had worked the weekend and when she had seen resident 1, the resident mentioned the "girl who pinches my nose."</p> <p>*On 12/21/15 (Monday) she went to her supervisor, sometime between 10:00 a.m. and 1:30 p.m. to report the behavior she had witnessed on Friday.</p> <p>2. Interview on 1/12/16 at 2:13 p.m. with CNA C regarding resident revealed:</p> <p>*When questioned about CNA behaviors she reported she had witnessed CNAs D and E pinch resident 1's nose shut until they got a physical and verbal response.</p> <p>*The resident would tell them to stop and attempt to push them away.</p> <p>*She "didn't think anything of it", so she had not reported it.</p> <p>*When asked what training she had received regarding abuse when she had started her employment she stated "they gave me a piece of paper to read."</p> <p>Review of the Required Healthcare Facility Event Reporting form dated 12/22/15 and interview with the DON on 1/12/16 at 10:43 a.m. revealed she:</p> <p>*Had no idea why CNA A waited three days to report the incident.</p> <p>*Believed CNA C had not reported the witnessed behaviors until asked, because CNA C was not sure it was abuse.</p> <p>*Agreed the incidents should have been reported</p> | F 226   |   |   |

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| F 226  | <p>Continued From page 13 immediately.</p> <p>Review of the provider's undated Code of Conduct revealed:<br/>*The provider was to have "assured its employees and agents had sufficient education, licensure, background experience, on the job training and supervision to render services to its residents."<br/>*"Any incident of resident mistreatment, neglect or abuse will be reported to the charge nurse, DON or administrator and other officials as required by law."<br/>*"If an employee or agent knows of or suspects a practice or incident may violate this code of conduct, then he/she must report it to appropriate levels of management."</p> <p>Review of the provider's February 2015 Investigation and Reporting of Abuse, Neglect &amp; Misappropriation of Resident Property policy revealed:<br/>*Physical abuse included pinching.<br/>*Mental abuse included humiliation or harassment.<br/>*Mistreatment included willful inappropriate care.<br/>*Any observed incident was to be reported immediately to the charge nurse. The charge nurse was to intervene to maintain resident safety.</p> <p>C. Based on interview and policy review, the provider failed to ensure measures including policy, training, monitoring, and investigation were in place to prevent abusive behaviors towards one resident (1) by three of three sampled certified nursing assistants (CNAs B, D, and E). Findings include:</p> | F 226   |   |   |

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| F 226  | <p>Continued From page 14</p> <p>1. Review of the February 2015 Investigation and Reporting of Abuse, Neglect &amp; Misappropriation of Resident Property policy and CNA E's employment application with the DON on 1/13/16 at 8:20 a.m. revealed:</p> <p>*There was only one policy on abuse.</p> <p>*There was no policy on prevention of abuse.</p> <p>*There was a section in the February 2015 policy titled prevention that included statements on:</p> <p>-Education of the staff at orientation and annually.</p> <p>-All prospective employees were to complete the employment application and provide references.</p> <p>*The DON stated she tried to get three references for each potential employee. She would try to get professional references (former employers) first and then personal references.</p> <p>*Regarding CNA E's 8/31/13 employment application the DON agreed:</p> <p>-CNA E had only one personal reference listed.</p> <p>-The application had not been completely filled out.</p> <p>Interview on 1/13/16 at 3:00 p.m. with the administrator and DON regarding the abuse policy revealed:</p> <p>*They were not aware the most recent policy (February 2015) was not the policy in the notebooks on the units for the charge nurses to use when dealing with an incident.</p> <p>*The policy in the books on the units was dated 2/16/12.</p> <p>*They were not aware the February 2015 policy had not identified the steps necessary to notify the Department of Health. The 2/16/12 policy had identified steps.</p> <p>*They were not aware the most recent policy (February 2015) identified the need to protect the resident only if they believed there was an immediate jeopardy (danger) to the resident. The</p> | F 226   |   |                      |   |

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| F 226  | <p>Continued From page 15</p> <p>2/16/12 policy had identified what to do to protect the resident in cases where there was and was not an immediate jeopardy.</p> <p>3. Interview on 1/13/16 at 9:35 a.m. with registered nurse (RN) L regarding training of staff and interviews of selected and random staff revealed:</p> <ul style="list-style-type: none"> <li>*She was in charge of training the staff.</li> <li>*She was the primary instructor for the nurse aide training program (NATP) at the facility.</li> <li>*Training newly hired staff on abuse during orientation consisted of her reading the February 2015 policy to the staff in training.</li> <li>*No other activities regarding how to identify signs of abuse or what to do if abuse was questioned were done.</li> <li>*She believed the NATP had a section on abuse but could not locate it in the on-line educational materials when first asked to.</li> <li>-She had not reviewed all the material in the course.</li> <li>*The annual abuse training consisted of watching a video.</li> <li>*No other activity to identify signs of abuse or what to do if abuse was questioned were done.</li> <li>*There had been no monitoring following the educational offerings through observation, interview, or skill testing regarding the recognition of signs of abuse or what to do if abuse was questioned.</li> <li>*She agreed from the interviews of selected and random staff the staff were not aware of all signs of abuse.</li> </ul> <p>4. Interview on 1/13/16 at 8:20 a.m. with the DON regarding monitoring of employees to ensure care was provided without abuse revealed:</p> <ul style="list-style-type: none"> <li>*The DON and all nurses observed and watched</li> </ul> | F 226   |   |   |

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| F 226  | <p>Continued From page 16 for stressed or overwhelmed staff and visited with them.<br/>*There had been no documentation of the above mentioned monitoring.<br/>*The DON agreed the documentation of monitoring should have been completed.</p> <p>Surveyor: 32331<br/>5. Interview on 1/13/16 at 3:00 p.m. with the administrator and the DON regarding incidents and investigations revealed:<br/>*The administrator, DON, social service designee, licensed social worker, and the rest of the Quality Assurance and Performance Improvement (QAPI) team discussed all incidents at a monthly QAPI meeting.<br/>*Both agreed all incidents should have had a thorough investigation and corrective action as needed to prevent reoccurrence.</p> <p>Surveyor: 35625<br/>D. Based on record review, interview, and policy review, the provider failed to maintain a safe environment for all residents by allowing one of one employee (E) who had repeated abuse violations to continue employment. Findings include:</p> <p>1. Review of certified nursing assistant (CNA) E's employee file revealed:<br/>*She had a hired date of 9/12/13.<br/>*An email on 8/6/15 at 1:07 a.m. from the north station nurse stated CNA E had left the building during her shift and had been found outside talking with friends.<br/>-No disciplinary actions had occurred as a result of that incident.<br/>*On 8/10/15 she received a letter of reprimand for the following incidents:</p> | F 226   |   |   |

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| F 226  | <p>Continued From page 17</p> <ul style="list-style-type: none"> <li>-Leaving the building during her shift while not on break for personal reasons.</li> <li>-Using resident's personal property.</li> <li>-Lying on a resident's bed during her work shift.</li> <li>-Rude and inappropriate communication with staff while using the walkie-talkies.</li> <li>-No disciplinary action was put into place with the letter of reprimand.</li> <li>*On 8/20/15 she met with the administrator, compliance officer, and medical records officer to discuss the following concerns:             <ul style="list-style-type: none"> <li>-She was told it was not in her duties to request staff come in to work.</li> <li>-She was advised it was not appropriate to use social media to contact staff at home and ask about resident care.</li> <li>-She was not to use her cell phone at work.</li> <li>-No disciplinary action was taken at that meeting.</li> </ul> </li> <li>*On 9/2/15 she met with the administrator and the director of nursing (DON) regarding her job performance.             <ul style="list-style-type: none"> <li>-She would be working the day shift for at least six months, so her performance could be evaluated.</li> <li>-Her annual salary adjustment was to be held pending improved performance.</li> <li>-No follow-up to the meeting was in her employee file.</li> </ul> </li> <li>*The provider had allowed her to resign her prn (as needed) position on 12/22/15.</li> </ul> <p>Interview on 1/13/16 at 3:00 p.m. with the administrator and the director of nursing regarding employee E revealed:<br/>*On 12/22/15 she was allowed to resign.<br/>*She had not worked full-time at the facility since leaving for another employer in November 2015 but had remained prn at the facility until her resignation.</p> | F 226   |   |                      |   |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435073</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/13/2016</b> |
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| F 226  | <p>Continued From page 18</p> <p>*They acknowledged many of the situations outlined in her employee file constituted abuse or misappropriation of property.</p> <p>*They acknowledged no corrective action had been taken prior to the meeting on 9/2/15.</p> <p>Review of the provider's undated Investigation and Reporting of Abuse, Neglect, and Misappropriation of Resident Property policy revealed: "Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, volunteer staff of other agencies serving the individual, family members, legal guardians, friends or other individuals."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 4, revealed, "The American Nurses Association Standards of Professional Performance describe a competent level of behavior in the professional role. These standards provide objective guidelines for nurses to be accountable for their actions, their patients, and their peers."</p> <p>E. Based on record review, interview, and policy review, the provider failed to follow-up and resolve abuse allegations involving CNAs D and E for three incidents involving two of two (6 and 7) randomly reviewed residents. Findings include:</p> <p>1a. Review of CNA E's employee filed revealed:<br/>*On 8/6/15 at 1:07 a.m. an e-mail by the north station nurse was sent to the DON and medical records officer regarding a verbal warning that was given to CNAs D and E during the previous evening.<br/>*They were unable to be located for an</p> | F 226   |   |                      |   |

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| F 226  | <p>Continued From page 19</p> <p>undetermined length of time and had been found outside visiting with friends.</p> <p>b. On 8/10/15 the DON met with resident 7 regarding the following inappropriate behavior by CNA E:<br/>*CNA E came into the resident's room the evening before and laid down on her bed.<br/>*She became argumentative with the resident when asked to get up and leave the room.<br/>*She removed clothing from the resident's room without consent.</p> <p>c. On 8/10/15 the social services department was notified CNAs D and E had borrowed an electronic device cord from resident 6 and had not returned it in a timely manner.<br/>*The family of resident 6 had expressed concerns that his property was not returned.<br/>*The nurse on duty verbally instructed the two CNAs to not take any resident's property.</p> <p>d. On 8/10/15 CNA E was given a written letter of reprimand, and no further disciplinary actions or follow-up was documented.</p> <p>e. Review of CNA D's employee file revealed:<br/>*On 8/10/15 she had received a written letter of reprimand for the two incidents listed above, and no further disciplinary actions were documented.<br/>*No additional information was found regarding follow-up with the residents involved.</p> <p>Interview on 1/13/16 at 10:50 a.m. with the social services designee revealed she:<br/>*Was the primary social service individual in charge of resident 6.<br/>*Verbalized resident 6 now had a cord for his electronic device.</p> | F 226   |   |                      |   |

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| F 226  | <p>Continued From page 20</p> <p>*Had no additional information available regarding resident 6's property being used by staff.</p> <p>Interview on 1/13/15 at 3:00 p.m. with the administrator and director of nursing revealed:<br/>*Employees were not allowed to use or borrow residents' items.<br/>*They acknowledged the situation regarding resident 6's electronic cord was unacceptable.<br/>*No further information was offered regarding follow-up and resolution of the above incidents.</p> <p>Review of the provider's undated Investigation and Reporting of Abuse, Neglect, and Misappropriation of Resident Property policy revealed no information regarding follow-up and resolution of incidents of abuse.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 4, revealed, " The ANA Standards of Professional Performance describe a competent level of behavior in the professional role. These standards provide objective guidelines for nurses to be accountable for their actions, their patients, and their peers."</p> | F 226   |   |                      |   |