| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| {F 226} | Continued From page 18<br>protect other residents from further abuse, and report another incident of abuse to the Administrator as required by the facility policy and procedure. E2, Director of Nursing, was notified of the Immediate Jeopardy on 12/27/10 at 2:40 PM.<br><br>The Facility took the following actions to remove the Immediacy:<br><br>12/17/10 E5 was terminated.<br>12/21/10 Licensed staff was in serviced regarding the policy on what to do when an employee is suspected of abuse.<br>12/22/10 All polices regarding resident abuse and reporting of suspected abuse was reviewed.<br>E3 was suspended for 2 days while an investigation was initiated into allegations of abuse. The allegations were unfounded and she returned to work 12/24/10.<br>12/23/10 An all staff meeting was held to discuss:<br>When, who and how to report alleged abuse.<br>That allegations of abuse had to be reported immediately.<br>The allegation must be documented and given to the administrator and DON<br>The perpetrator must be removed from the facility immediately.<br>staff needed to be careful with their interactions with residents, so not to offend/scare them and be sensitive to their needs. This included the tone of their voice.<br>Abuse Policies have been reviewed.<br>12/28/10 Care plans of residents with behavioral problems have been updated to include at risk of abuse due to particular behaviors. | {F 226} | | |
| F9999 | FINAL OBSERVATIONS | F9999 | | |

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| F9999 | Continued From page 19<br>LICENSURE VIOLATIONS<br><br>300.610a)<br>300.3240a)<br>300.3240b)<br>300.3240d)<br>300.3240e)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse a resident.<br><br>b) A facility employee or agent who becomes aware of abuse of a resident shall immediately report the matter to the facility administrator.<br><br>d) A facility administrator, employee, or agent who becomes aware of abuse of a resident shall also report the matter to the Department.<br><br>e) Employee as perpetrator of abuse. When an | F9999 | | |

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| F9999 | Continued From page 20<br>investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee.<br><br>These regulations are not met, as evidenced by the following:<br><br>Based on record review and interview the facility failed to protect 2 (R3, R28) of 2 residents reviewed from abuse. This failure resulted in E5 throwing a shoe at R3 and hitting her in the chest. E5, with staff knowledge, remained in the facility and then abused R28 while staff was present. This abuse for R28 was not immediately investigated when it was reported the following day.<br><br>Findings include:<br><br>1. The written "Occurrence Report" dated 11/15/10 for R3 documented "(R17) - I was sitting here at the table and saw (E5, Certified Nurse Aide, (CNA) throw (R3's) shoe at her and hit her in the chest, while saying 'Here's your shoe.'" The report states "alleged abuser was sent home and is still off today while the investigation was going on." The report documented on 11/17/10 that E5 was terminated on that date.<br><br>E7, Licensed Practical Nurse, LPN, stated on 12/21/10 that on 11/15/10, after supper around 6:30 PM to 6:45 PM, she was at the nurses station and R3 was at the long table in front of the nurses station. R17 began yelling at E5 that | F9999 | | |

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she (E5) threw a shoe at R3. E5 then went down the hall and E7 called E2, Director of Nursing. E7 stated that when she got off the phone she went down the hall to R28's room where E5 was assisting R28 and she told E5 to leave the premises. When E7 left R28's room, E5 was still in the room finishing up what she was doing before she clocked out. E5 did not clock out until 7:13 PM. E7 stated she did not stay with E5 and did not know what she did prior to clocking out. Review of the time card confirmed that E5 clocked out at 7:13 PM.

E8, CNA, stated on 12/22/10, by phone, that 11/15/10 was her first day to work and she was orienting with E5. E8 was in a room near the dining room and she could hear R3 screaming. E8 stated when E5 came down the hall, they went into R28's room. E8 asked E5 what had happened. E5 stated that R3 had thrown a shoe at her and she had thrown it back. E5 "cussed" at R28 and said the F word and "s...." E5 washed R28's arm pits and let her arm drop "flat down" on the wheelchair handle. R28 was crying. E5 threw a wash cloth at R28 and hit her in the chest with it. E5 told her to wash her face. R28 jumped when she threw the washcloth and R28 started crying again.

E8 stated E7 came to the room and told E5 to leave. E5 left the room but E8 did not see where she went. E8 thought it was about 7:00 PM. E8 stated that she did not tell anyone about the incidents with R28 until the next day. E7 had the other CNA's come to the nurses desk but did not tell her to come so she did not report it that night.

The incident with R28 was not immediately reported to Administration or the Department on

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| F9999 | Continued From page 22<br>11/15/10. E8 did not report the incident with R28 until 11/16/10. The original "Occurrence Report" for R3 was sent to the Department on 11/16/10 and only identified the incident with R3. On 11/17/10 the Department was sent a follow up report that documented under "Injury Cause or Staff Comments" for E8 stated "(E5) told me that she threw the shoe at (R3) after (R3) had thrown it at (E5), (E5) said that she did not have to put up with that. (E5) was then seen throwing a wash cloth at another resident telling her to wash her own face. (E5) also was seen holding a residents arm up to wash underneath and just let it drop hitting the arm of her wheelchair. (E5's) attitude was terrible after (R17) had yelled at her." The report does not name R28 as the resident that E5 threw the washcloth at or let her arm drop. E2 confirmed on 12/21/10 that the incident report for R28 was not sent to the department.<br><br>The " Occurrence Report" with "Type" of "Alleged Abuse" for R28 dated for 11/15/10 documented on 11/16/10 that E8 had come into work the next day, 11/16/10 at 4:30 PM, and reported that "she saw (E5) throw a washcloth at (R28) telling her to wash her face. (E8) also said that (E5) had lifted (R28's) left arm and let is (it) fall down onto the wheelchair. (she has no control of this arm due to past CVA (cerebral vascular accident)." The "Witness Statement" by E8 noted "(E5) came down the hall and said that she did throw the shoe at (R3) because (R3) had thrown it at her and that she did not have to put up with that. After that happened (E5's) attitude only got worse. She was cursing on the hall saying s*** and F***. She was rude with the residents. (R28) was crying and (E5) threw a wash cloth at her and told her to wash her face. (E5) then lifted | F9999 | | |

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R28's arm and let it fall onto the arm of the wheelchair." The incident report for R28 was not sent to the Department. E2 provided the report to the surveyor on 12/21/10. The report noted that the physician and power of attorney were not notified until 11/17/10.

Other incidents of alleged abuse include:

A. According to 2 confidential resident interviews, R3 was pushed into the main dining room on 11/15/10 by E5, Certified Nurse Aide (CNA). Both residents stated E5 was jumping at R3, saying "Boo" and scaring her. One interview stated other staff were in the dining room and laughed at E5 scaring R3. One confidential interview stated that E5 threw a shoe at R3 and hit her in the chest. E3 was present and saw the incident. One resident stated E5 had also "kneed" R3 in the back prior to this incident. The confidential interview stated that E5 and E3, CNA's were both "mean" and "rough" with some of the residents especially R3. The confidential interview stated they had heard slapping noises and screaming when E3 was in a room with R3. E2, Director of Nursing, confirmed on 12/22/10 that she was only aware of E5 throwing the shoe.

B. E4, CNA, stated on 12/21/10 that E5 was "hateful and rude" and "rough" with the residents. E4 stated she had seen E5 scare R3 before and throw wash cloths at residents, especially R3. E4 had seen E5 grab R3's arm when R3 was swinging at her. E4 stated E5 liked to "torment" the residents. E4 stated she told E2, Director of Nursing (DON), about all the incidents she had seen after the incident on 11/15/10 when E5 threw the shoe at R3. E4 had worked at the facility approximately 1 and a half months when

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the 11/15/10 shoe incident occurred. There were no abuse investigations provided for any of the allegations except for the 11/15/10 incident.

C. E6, CNA, stated on 12/22/10 that she had seen E3 throw one of R3's baby dolls over the nurses station. E6 stated R3 thinks the dolls are real and R3 was very upset and crying. E2, DON, confirmed on 12/22/10 that she was not aware of that incident. E6 also stated that R10 had said "that girl (pointing at E3) pinches me on my sides." This occurred approximately 4 weeks ago. The information was reported to E11, Assistant Director of Nursing. There were no abuse investigations provided for either incidents.

D. E9, CNA, stated on 12/22/10 that she was working in the room across from R10. E3 was in the room with R10 with the door shut and she could hear them both screaming. E9 went over and knocked on the door to see if E3 needed assistance. E3 told her she did not need any help and as she left E9 heard additional screaming. E9 stated she told E12, LPN, who told her to tell E2 in the morning. E2 did not recall any staff reporting the incident.

E. E10, CNA, stated on 12/22/10 that recently R3 was hitting E7, Licensed Practical Nurse (LPN), with her doll she holds. They got the doll away from her, R3, and either E7 or E3 took the doll and threw it over the nurses station. R3 thinks her dolls are babies. R3 got irate and thought they were hurting her baby. E2, Director of Nursing, was not aware of the incident on 12/22/10.

The facility policy and procedure titled "Resident Abuse Prevention Program" states "Any witness

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| F9999 | Continued From page 25<br>to abuse must be reported to the administrator immediately". It further states "Any incidences observed by staff or reported by resident will be reported to supervisor immediately and action to ensure residents safety will be initiated." The policy also states "When the incident or suspected incident of abuse is reported, the Administrator, or the party designated by the Administrator, will investigate the incident, and notify the (Department) within 24 hours of the initial report."<br><br>(A) | F9999 | | |