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S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care	S9999		

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plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, record review and interview, the facility failed to assess a resident's use of side rails, identify side rails as a potential entrapment risk, adequately investigate resident falls, and properly report a serious resident incident involving side rails, resulting in no investigation or amendment to the Plan of Care, for two of 10 residents (R8, R6) reviewed for use of siderails, in a sample of 15. This failure resulted in staff not identifying R8's inability to utilize side rails as an enabler, R8 being found with (R8's) body hanging from the bed and face against the side rail, and continued use of the side rails without concern of the potential for future entrapment. The facility failed to ensure staff safely transferred residents and followed operational Policies and Procedures for transfers, for two of seven residents (R1, R10) reviewed for

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transfers, in a sample of 15. This failure resulted in skin tears to R10's hand, shin, and great toe as well as bruising to the eye.

Findings include:

1. On 3/03/14 at 10:00 a.m. and 2:00 p.m. and on 3/04/14 at 9:10 a.m., R8 was lying in bed with the right side of the bed against the wall and the left half-siderail in the upright position.

On 3/04/13 at 10:35 a.m., E9 (Certified Nursing Assistant) and E8 (Certified Nursing Assistant) provided incontinence care to R8. E8 stated R8 was unable to reposition independently. E8 and E9 had to physically roll R8 from the right to the left side during cares.

A Physician's Order Sheet, dated 3/01/14, documents R8 has the current diagnoses of Anxiety and Cerebral Vascular Accident with right sided weakness. A Minimum Data Set, dated 12/17/13, documents R8 has moderate cognitive impairment, with disorganized thinking, fluctuating altered level of consciousness, psychomotor retardation, and requires the extensive assistance of two staff for transfers and bed mobility. The Minimum Data Set identifies R8 utilizes a bed rail as a physical restraint on a daily basis. A Plan of Care, last updated 8/01/13, documents R8 as high risk for falls with a long history of falls at home and while residing at the facility, often making unsafe transfers, trying to ambulate independently, making poor decisions, and having poor balance control. The Plan of Care instructs staff to utilize bilateral half side rails while R8 is in bed, as an intervention to the falls. A Side Rail Assessment, dated 11/16/10, documents R8 had requested a side rail for

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"enhanced bed mobility" and identified R8 as having a history of weakness, balance deficit, and falls. The Side Rail Assessment documents the side rails are recommended for use when R8 is in bed and is to be assessed in 30 days "or sooner, if there is a significant change in condition." The last documented assessment of R8's ability to use the side rails is dated 8/01/13, and indicates R8 "requests to keep (R8's bilateral) half rails."

A Incident/Accident Report, dated 12/22/13 at 6:30 a.m., documents R8 as "trying to get up to go to (bathroom). (Resident) on knees beside bed, holding on to side rail." The Incident/Accident Report documents R8 sustained "(right) elbow bruises (and) skin abrasions." The Incident/Accident Report instructs staff to conduct visual checks of R8 every 15 minutes as a new intervention to prevent falls. R8's most current Plan of Care (dated 8/01/13) failed to document staff were to monitor R8 every 15 minutes as an intervention.

A Incident/Accident Report, dated 12/27/13 at 1:05 a.m., documents R8 as laying on the floor next to the bed, with the side rails in the upright position. The Incident/Accident Report documents R8 was moved to a room closer to the nurses station, as an intervention to prevent further falls. However, according to E2 (Director of Nursing), on 3/11/14 at 3:00 p.m., R8 was not relocated to a room closer to the nurses station at that time.

Nursing notes, dated 2/18/14 at 2:00 p.m., document, "Housekeeping yelling for C.N.A. (Certified Nursing Assistant). (Resident) attempting to get out of bed. (Resident) sitting on edge of bed (with bilateral lower extremities) dangling. Personal (and) pad alarm intact. (Not)

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sounding. (Resident states) 'I'm going to get my wallet.' C.N.A.s remind (resident)....hasn't had (wallet) for a long time. (E3-Assistant Director of Nursing) notified staff can't hear alarms during the day with (televisions), etc."

Nursing notes, dated 2/18/14 at 2:50 p.m., document, "Alarms sounding. (Resident's) body hanging out of bed (with) face against siderail. (Resident) repositioned. (E3) notified and asked to move (resident) closer to nurses desk or for a low bed."

On 3/04/14 at 3:17 p.m., E7 (Licensed Practical Nurse) stated (E7) was caring for R8 on the afternoon of 2/18/14. E7 stated R8 was restless, trying to get out of the bed, and exhibiting unusual behavior. E7 stated R8 was found with (R8's) body scooted down the bed, (R8's) body was on the far left side of the bed with (R8's) feet just over the edge. E7 stated R8's face was pressed up against the half-side rail at the midpoint of the rail. E7 stated, "The side rail was preventing (R8) from falling." E7 stated, since R8's feet were not touching the floor, E7 did not consider the incident a "fall." E7 stated it was conveyed to E3 that R8 was acting unusual and repeatedly trying to get out of bed. E7 stated (E7) discussed with E3 putting R8 into a low bed or moving R8 closer to the nurses station. E7 stated the facility had "no low beds available" and "would have loved to put (R8) in a low bed", but R8 was moved to another room to be more closely monitored.

On 3/04/14 at 4:01 p.m., E3 stated E7 did report to (E3) on 2/18/14 that R8 was "anxious and wanting to climb out of bed." E3 stated (E3) was unaware of R8's position in the bed, with (R8's) face against the siderail. E3 stated the incident should have been accurately reported and

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investigated. E3 concluded R8 originally had half-side rails for bed mobility. However, E3 stated R8 now has the half-side rails as a safety measure to prevent (R8) from "falling out of bed", as (R8's) condition has declined.

On 3/04/14 at 3:44 p.m., E2 (Director of Nursing) stated E7 did not explain to (E2) how R8 was found with (R8's) face against the siderail and body positioned. E2 stated, had the incident been properly reported, an investigation would have been completed and the side rails would have been evaluated. E2 stated that all restraints and side rails are to be assessed on a quarterly basis, at least.

On 3/05/14 at 3:00 p.m., E17 (Medical Director) stated (E17) was unaware of the 2/18/14 incident with R8's face in the side rail. E17 stated, had the nurse who found (R8) reported the incident, "I'm sure a change in the Plan of Care would have occurred." E17 further stated, "accidents happen" and the facility has "only so many low beds." E17 stated, "To me, it sounds like that side rail kept (R8) from falling." E17 concluded, by stating, "Maybe I need some education on the regulation and what options are available besides side rails, to prevent falls."

The facility's "Consent for Use of Side Rails" form, documents "....the use of side rail(s) may involve risks such as: getting caught in the rails, getting caught between the rail and mattress, strangulation, hitting against the rail(s) causing skin tears and/or bruising and crawling over the top of a rail risking a fall from a higher level with a risk for greater injury or death. It is the policy of this facility to use side rail(s) only after assessment and care planning deem it appropriate to treat the resident's medical

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symptoms and assist the resident in attaining or maintaining his or her highest practicable physical and psychosocial well-being, and other methods or interventions are in adequate. In all instances, the least restrictive device, which is effective, will be used. The facility will monitor the resident's status and adjust care, as necessary. The facility will have a systematic and gradual process to reduce the use of side rail(s) to ensure the resident's safety while treating the resident's medical condition."

On 3/04/14 at 5:09 p.m., the measurable width between the lower half of R8's side rail and the mattress was 4 and 3/4 inches at the widest point.

2. R6's current POS (Physician Order Sheet) dated 3/01/14 shows R6 has diagnoses of Dementia, Depression, and a history of a closed fracture of the left femur. R6's MDS (Minimum Data Set) assessment dated 2/12/14 indicates R6 requires extensive assistance of one for transfers and hygiene. R6's MDS assessment also states R6's BIMS (Brief Interview for Mental Status) score is three, indicating R6 has severe cognitive impairment.

On 3/03/14 at 10:00 a.m., R6 was lying in bed with the bed positioned at standard height and both side rails in the raised position. R6 was confused and had a personal alarm in place. On 3/03/14 at 2:30 p.m., R6 was sleeping soundly with the bed positioned at standard height and both side rails raised.

R6's care plan dated 11/20/13 states, "Makes poor decisions. Intermittent confusion, weakness. At risk for falls, Score of 10. Use of

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antidepressant and (history of) falls. (R6) tends to move the edge of the bed and causes risk for falls." No new interventions have been added to R6's fall care plan since 11/20/13.

A Side Rail Assessment dated 2/20/14 states "(R6) continues to use (siderails) for mobilities". There is no documentation indicating R6's siderail use was assessed after R6's fall on 2/27/14. An Incident/Accident Report, dated 2/18/14 at 9:45 a.m., states R6 fell and was found partially off the bed. A Resident Accident and Incident Investigation Report dated 2/18/14 recommends R6 be toileted every two hours and the call light be kept within R6's reach. An Incident/Accident Report, dated 2/27/14 at 4:15 a.m., states R6 was found on the floor beside R6's bed and between the bed and the window. A Resident Accident and Incident Investigation Report dated 2/27/14 recommends discontinuing R6's air mattress "Due to concerns about it causing (R6) to slide out of bed no pressure areas. Consider pad alarm."

3. R10's current POS (Physician Order Sheet) dated 3/01/14 shows R10 has a diagnosis of CVA (Cerebral Vascular Accident - Stroke). R10's MDS (Minimum Data Set) assessment dated 1/01/14 indicates R10 is total dependent on two staff for transfers. R10's MDS assessment also states R10's BIMS (Brief Interview for Mental Status) score is five, indicating R10 has severe cognitive impairment. R10's Care Plan dated 1/07/14 states "All transfer with (mechanical) lift, gait belt, and two assist."

On 3/03/14 at 1:50 p.m., R10 was sitting in a wheelchair next to R10's bed. R10 had a lap cushion in place and a personal alarm. E21(CNA

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- Certified Nursing Assistant) and E22 (CNA) entered R10's room to transferred R10 from a wheelchair to the bed. E21 (CNA) and E22 (CNA) secured the mechanical lift sling positioned under R10 to the mechanical lift and transferred R10 from the wheelchair to the bed.

An Accident/Incident Log entry for R10 dated 8/04/13 states, "CNAs (Certified Nursing Assistants E18 and E19) using lift with two assist, slid out of lift hitting right shoulder in wheelchair and sliding to floor on right side. ROM (Range of Motion) per usual, skin tears noted to left hand, right shin, and great toe. Right outer corner of eye bruised." An Incident/Accident Report completed by E20 (RN - Registered Nurse) dated 8/04/14 at 6:45 p.m. states, "Using lift with assist, slid out of lift hitting right shoulder in wheelchair and sliding to floor on right side." A Resident Accident and Incident Investigation Report completed by E2 (DON - Director of Nursing) at 7:00 p.m. states, "The lift and sling were checked and all was in working order at the time. Instructed staff to check and double check everything when using a lift. Called to assess resident after the incident... When questioning staff about the incident , they said it happened so quickly that they aren't sure of what or how it happened. They stated they hooked the lift up as usual, and as they were lifting (R10) out of the wheelchair, (R10) slid out of the wheelchair and onto the floor. The lift was in low position at the time, so (R10) did not fall."

On 3/10/14 at 4:15 p.m., regarding R10's fall from the lift on 8/04/13, E18 (CNA - Certified Nursing Assistant) stated, "(E19 CNA) was hooking (R10) up to the lift. I'm assuming, but not sure because (R10) likes to move things around, but when we were getting him up the sling was still on and

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(R10) was hooked up to the machine. But it was off (the sling loop not connected to the lift arm) or not all the way on....(R10's) really grabby and I was trying to watch (R10) from grabbing me... (R10) was probably off the wheelchair an inch and the sling came off at the bottom and (R10) slid out of the bottom. We tried to catch (R10). I happened quick. I'm pretty sure (R10) hit (R10's) head on the wheelchair and slid to the floor." E18 (CNA) verified R10 fell to the floor during the transfer on 8/04/13 at 6:45 p.m. and received injuries.

On 3/10/14 at 4:05 p.m., E19 (CNA) stated on 8/04/13 R10 was hooked up to the mechanical lift and "(R10) grabbed a hold of the sling and unhooked it while we were lifting (R10) up. (R10) will do that sometimes. We've caught (R10) doing it even since then. (E18 CNA) was in front. I was in back. From my angle it looked like it was connected... (R10) was just above the wheelchair 3 inches and (E18 CNA) gasped. I guess that's what you'd call it. I tried to catch (R10) but couldn't get to him fast enough. (R10) fell and landed into the wheelchair, hit the chair and then we eased (R10) to the floor." E19 verified the incident resulted in R10 falling and receiving injuries.

On 3/10/14 at 9:05 p.m., E7 (LPN - Licensed Practical Nurse) verified (E7 LPN) and E20 (RN - Registered Nurse) assessed R10 on 8/04/13 but neither E7 or E20 witnessed R10's transfer. E7 (LPN) stated, "I got this from them (E18 and E19 CNAs). (R10) was having behaviors that day and somehow (R10) had unhooked the lift sling. (R10) had to have done it before they started the lift. I would say (R10) has done it before but they've never lifted him without putting it back on. (E2 DON - Director of Nursing) knows about it

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cause (R10's) done it right in front of (E2) when (E2) was on the floor. I don't believe it's one of the behaviors we chart on."

On 3/10/14 at 11:10 a.m., E2 (DON) stated, "(R10's) good hand is everywhere. (R10's) grabbing at them or something all the time. It should be on the care plan." The current Behavior Flow sheet for R1 dated 3/01/14 does not include behaviors regarding R10's transfers. R10's Care Plan dated 1/07/14 does not include interventions regarding R10's behaviors during transfers or safety interventions for staff providing R10's care.

4. A Minimum Data Set, dated 2/10/14, documents R1 requires the extensive assist of two people to transfer. A Plan of Care, dated 2/10/14, documents R1 has the current diagnoses of Epilepsy and Osteoporosis, and identifies R1 as having cognitive loss with periods of lethargy.

On 3/04/14 at 9:55 a.m, R1 was wheeled into a community bathroom located adjacent to the Activity Room/Dining Room, by E11 (Certified Nursing Assistant). E11 pivot transferred R1 independently, from the wheelchair to the toilet, without using a gait belt and holding R1 under the arm.

On 3/04/14 at 10:00 a.m., E11 stated R1, "does o.k. with out using a gait belt."

The facility policy, titled "Transfer or Gait Belt", documents, "Purpose: To promote patient safety when walking or making a transfer." The "Transfer or Gait Belt" policy instructs staff to "fasten the transfer belt securely around the patient so that the belt does not slide up the

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S9999	Continued From page 11 patient's body" and "using the transfer belt, pivot the patient to the bed or chair." (A) 300.610a) 300.1210b) 300.3240a) 300.3240e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:	S9999		

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S9999	Continued From page 12 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) e) Employee as perpetrator of abuse. When an 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. (Section 3-611 of the Act) These requirements were not met as evidenced by: Based on observation, record review and interviews, the facility failed to report allegations of abuse to the state agency for three incidents involving three of three residents(R10, R15, and R18) reviewed for abuse on the sample of 15. The facility failed to thoroughly investigate allegations and failed to provide protection for all 57 residents residing in the facility as those staff involved E5 C.N.A. (Certified Nurse Aide) and E6 C.N.A. were allowed to continue to work after witnessed allegations of verbal, mental and physical abuse were made and reported. The facility failed to report to the state agency an abuse by R18 towards R15. Findings include: (A) The facility's "Abuse Prohibition and	S9999		

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Prevention Policies and Procedures" under the heading titled "E. Investigation" states "Any employee suspected of committing the above will be suspended pending the outcome of the investigation" and "Employees of the facility who have been accused of resident abuse will be suspended until the results of the investigation have been concluded." On 3/3/14 at 2:00pm E2, Director of Nursing, stated that the facility had "only one allegation of abuse" during the past 12 months.

A facility "Incident/Accident Report"prepared by E2, Director of Nursing dated 11/7/13 documents a witnessed allegation of physical and verbal abuse occurred on 11/7/13 at approximately 1:30pm identifying E5, Certified Nurse Aid (CNA)as the perpetrator of the abuse. This Incident/Accident Report identifies R10, a cognitively impaired 81 year old resident as the recipient of the abuse and E12, CNA and E13, CNA are identified as the witnesses to the alleged abuse.

R10's medical record documents that R10 has diagnoses which include Cerebral Vascular Accident and Dementia; Chronic Obstructive Pulmonary Disease, Anxiety and Aphasia. R10's Annual Minimum Data Set dated 1/1/14 documents R10's Brief Interview for Mental Status (BIMS) score of 5 indicating R10 has significant cognitive impairment and that R10 requires extensive assistance with transfers, dressing, bathing and all activities of daily living.

The description of the allegation included in the Incident/Accident Report and Investigation dated 11/7/13 documents the following occurred on 11/7/13 at 1:30pm:
While changing R10's clothes, with E12, E5

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"grabbed R10's nose and twisted it" after R10 "made inappropriate sexual statement" to E5. Two witnesses, E12 and E 13, documented in separate written witness statements dated 11/7/13 that after the mechanical lift transfer of R10 to R10's bed, E5 sat in R10's wheelchair with the mechanical lift handheld controller and continued to lower the metal bar on the mechanical lift into R10's abdomen. After being told to stop lowering the mechanical lift three times by the two other CNA's assisting in the transfer, E5 continued to lower the metal bar into R10's abdomen and stated that she should have " lowered the bar into (R10)'s chest in order to crush (R10), after what R10 said to me". E12, CNA also documented in the written statement dated 11/7/13, that after the transfer to R10's bed, while "picking up R10's room", E5 "said (E5) hates that f---ing bastard" and when R10 asked E5 for some chocolate milk E5 stated "(E5) was not giving that f---er nothing."

A written statement by E3, Registered Nurse/Assistant Director of Nursing (RN/ADON), dated 11/7/13 documents that E3 was notified by E25, Licensed Practical Nurse (LPN), at 1:45pm on 11/7/13 that "E12, E13 and E5(CNA's) were in R10's room putting him to bed when E5 sat in R10's chair with the mechanical lift control in her hand pushing the down button."E12 told E5 three times to stop lowering the mechanical lift arm "before E5 finally stopped." "When she was pushing the button the (mechanical lift arm) was going down on (R10's) abdomen. After (E13) heard E5 tell E12 that E5 should have put it on his chest to crush him because he had told her early in the day to "suck his d--k and called her a b---h. E13 heard R10 ask for something E5 told R10 to "Shut the f--k up". E3, RN/ADON, documents that E3 notified E2, (Director of

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S9999	Continued From page 15 Nursing). A document included in the investigation of the 11/7/13 incident titled "Timeline of (E5)" included in the Investigation packet for the abuse allegation of 11/7/13 involving E5 states "(E2) spoke with (E5) at 2:50pm, one and one-half hours later, on 11/7/13 at the facility explaining that an incident had been reported involving (R10) that had to be investigated." Also included in the same "Timeline on (E5)" is documentation by E2, Director of Nursing (DON), that E5 worked the following day from 7:00am to 12:00 noon on 11/8/13 for before being put on suspension. The facility's "CNA SCHEDULE" dated October 27, 2013 to November 9, 2013 documents that E5 was scheduled to work the 7am to 3 pm shift on 11/7/13 and on 11/8/13 from 7 am to 12 pm. The facility's Time Card for E5 documents that E5 worked on 11/7/13 from 7:01am through 3:14pm and on 11/8/13 from 7:01 through 12:08pm. On 3/4/14 at 1:00pm E2, Director of Operations verified that E5 did continue to work on 11/7/13 until "approximately 2:45pm" when E2 was notified of the allegation and arrived at the facility to begin the investigation of the allegation and E2 verified that E5 did work in resident care on 11/8/13 from 7am to 12pm. On 3/6/14 at 6:00pm, E2 verified that E5 should not have been allowed to work after the allegation of abuse on 11/7/13 was made.	S9999		

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(B) R10's current POS (Physician Order Sheet) dated 3/01/14 shows R10 has a diagnoses of CVA (Cerebral Vascular Accident - Stroke), Anxiety, and Depression. R10's MDS (Minimum Data Set) assessment dated 1/01/14 indicates R10 is total dependent on staff for hygiene, dressing, and transfers. R10's MDS assessment also states R10's BIMS (Brief Interview for Mental Status) score is five, indicating R10 has severe cognitive impairment. R10's behavior flow sheet dated 3/01/14 shows R10 is monitored for the following behaviors: Actively engaged; One to one socialization; Sexually inappropriate to staff (verbally or physically); cursing; and Will not speak to staff.

On 3/03/14 at 1:50 p.m., R10 was confused and sitting in a wheelchair next to R10's bed. R10 had a lap cushion in place and a personal alarm. E21 (CAN - Certified Nursing Assistant) and E22 (CNA) entered R10's room and transferred R10 from a wheelchair to the bed with a mechanical lift.

An Accident/Incident Log dated 2013 documents on 9/15/13 at 2:50 p.m., R10 stated, "That girl that was just here (E6 CNA) twisted my left wrist." An Incident/Accident Report dated 9/15/13 at 2:50 p.m., indicates R10 reported to E7 (LPN - Licensed Practical Nurse), "That girl that was just in here (E6 CNA) twisted my left wrist." A Resident Accident and Incident Investigation Report dated 9/15/13 E7 (LPN) indicated R10 complained of left wrist discomfort at 2:50 p.m. and denied pain by 2:55 p.m.

An Accident/Incident Log dated 2013 states on 9/15/13 at 2:50 p.m., indicates R10 had no obvious injury and reports E6 CNA stated, " I did not touch (R10's) hand, wrist, or arm. I used the

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pad to turn and reposition (R10)." A Resident Accident and Incident Investigation Report dated 9/15/13 at 3:00 p.m. includes a summary hand written by E2 (DON - Director of Nursing) stating, "Questioned (E6 CNA) and (E6) stated that (E6) did not touch (R10) or twist (R10's) wrist. (R10) may have thought (E6) did when (E6) turned (R10) with the pad. I explained to (E6 CNA) to always have two people in the room when taking care of (R10) because of (R10's) confusion and history of inappropriate measures with the staff. It protects everyone that way. When questioning (R10), (R10) had forgotten that (R10) had said anything about (E6 CNA)."

On 3/10/14 at 9:05 a.m., E7 (LPN - Licensed Practical Nurse) stated, "I went in right away to (R10) and asked right at the first. (R10) told me someone twisted (R10's) arm. There was nothing visible on the arm. (R10) just said it was the girl that was just in (R10's) room (E6 CNA). It would have been the end of (E6's) shift because it was during last rounds and (E6 CNA) leaves at 3:00 p.m. I wrote what (E6 CNA) told me." E7 (LPN) indicated if an allegation of abuse occurs both the resident and the accused are to be questioned and the information reported to (E2 DON - Director of Nursing). Regarding staff being sent home after an allegation of abuse, E7 (LPN) stated, "That would be up to (E2 DON)."

On 3/10/14 at 9:20 a.m., E6 (CNA) stated, "It was during 2:30 p.m. rounds. I was going in to change (R10's) pad real quick. I went in and I was rolling (R10) over trying to talk to (R10). You have to be careful what you say to (R10). (R10) gets sexual." E6 (CNA) stated, "(E7 LPN) and Z1 (R10's POA - Power of Attorney) called me back into the room and told me (R10's) wrist was hurting. I told them I didn't know anything about

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it." When asked if E6 (CNA) gave a written statement to E2 (DON) or E7 (LPN), E6 stated, "No, not that I recall." When ask if (E6 CNA) worked the following day (9/16/13).

(C) Upon request to review the facility allegations of abuse at 1:00 pm on 3/3/14, E2 (DON/Director of Nursing) stated , "We haven't had any allegations of abuse."

The facility incident log was reviewed and noted to include a 7/19/13 at 9:00 am unwitnessed injury. Results include: Bruise noted to (right upper extremity, two bruises to right side abdomen origin unknown.

At 1:00 pm on 3/5/14, E2 (DON/Director of Nursing) provided an incident for the above occurrence. The report states, "On 7/19/13 at 9:00 am, (R15) states, 'Bruise on my arm. I made a smart comment to female (R18). (R18) hit me. As for other bruise, I am not sure what I have done'. (R18) became excited "horseplay". (R15) on Coumadin therapy." The facility investigation report includes: Who Involved: (R15) Date: 7/19/ 13 Injuries: Bruises times three. Right outer abdomen 4 (centimeters) x 2 cm and 2cm x 1 cm. Right upper extremity 3cm x 2 cm. Resident account: (R15) "Received punch from (R18) after I made a remark." E2 documents, "Told both residents its okay for them to have fun, but explained to (R18) that (R18) cannot hit anyone. The bruises on the abdomen are probably from....." There is no further information on the investigation. There are no statements from R18.

E2 (DON) was asked at 2:10 pm on 3/5/14 why this allegation of abuse was not reported to the state agency. E2 stated, " I made the

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S9999	Continued From page 19 determination myself that it was not abuse. Therefore, it does not have to be reported." The facility policy titled ABUSE PROHIBITION AND PREVENTION POLICIES AND PROCEDURES no date, includes the following: E. Investigation: A thorough investigation will be conducted by the administrator or representative. 1. The investigation shall consist of: a. A review of the complaint. b. Interviews with person reporting c. Interviews with any witnesses f. An interview with staff members on all shifts having contact with the residents during the period of the alleged incident h. A review of the circumstances surrounding the incident. Protection: Appropriate action will be taken to protect a resident from harm during the investigation The resident census and condition report, dated 3/03/14, documents there are 57 residents in the facility. (A)	S9999		