STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035254	A. BUILDING _____ B. WING _____	09/12/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINSLOW CAMPUS OF CARE	826 WEST DESMOND STREET WINSLOW, AZ 86047

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility neglected to ensure one resident (#4) was free from physical abuse involving another resident (#265). The deficient practice has the potential for further abuse resulting in physical harm to residents. Findings include: -Resident #4 was admitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 6, (YEAR) included the resident had short and long term memory problems and was severely impaired with cognitive skills for daily decision making. The MDS also included the resident required extensive to total dependence with activities of daily living. The care plan for behavioral symptoms included the resident has a history of showing verbal and physical aggression. Interventions included cares provided per resident's unique preferences and routines, document any and all behaviors every shift and to report any change in behaviors. Regarding the incident on (MONTH) 22, 2019: Review of a program manager progress note dated (MONTH) 23, 2019 revealed that on (MONTH) 22, 2019, a CNA (Certified Nursing Assistant) heard loud talking in the resident's room. The CNA entered the room, and the resident's roommate (resident #265) was standing next to resident #4 and her covers had been removed. Resident #265 was telling resident #4 to get up and resident #4 then hit the hand of resident #265, then resident #265 hit resident #4 in the chest. A nursing note dated (MONTH) 23, 2019 included that resident #4 had no complaints of acute pain related to hitting roommate's hand and after being shaken and hit by her roommate (resident #265). Regarding the incident on (MONTH) 30, 2019: A physician note dated (MONTH) 30, 2019 included that yelling was heard and a CNA found resident #4 face down next to the bed, with the bolster propped open, and blood was noted on resident #4's head. Resident #4 was awake, readily consoled, was cooperative and was no longer crying. Physical examination included a laceration to the right forehead measuring 2.5 cm (centimeters) to 3 cm, the right eye was swollen shut, right cheek was bruised and swollen, had a right knee bruise and had a periorbital bruise. A fall from the bed landing face down was suspected and the resident was transported to the ED (emergency department). The hospital emergency room documentation dated (MONTH) 30, 2019 included the resident had a fall with laceration and direct blow. The character of symptoms included pain, bleeding, swelling, ecchymosis, abrasion and contusion. Location of the injury was right forehead, face and periorbital eye(s). Physical examination included swelling and ecchymosis, 5.5 cm (centimeters) of full thickness avulsed, stellate laceration of the right eyebrow and right forehead, superficial skin tear to the right dorsal wrist and dorsal swelling of the right wrist with mild deformity. The x-ray of the right wrist revealed a comminuted [MEDICAL CONDITION] distal radius. Impressions included closed head injury, right facial laceration 5.5 cm with complex repair, skin tear to right wrist, comminuted [MEDICAL CONDITION] distal radius, right knee contusion and closed nasal fracture. A nursing note dated (MONTH) 31, 2019 included that resident #4 was heard screaming from her room. Resident #4 was lying face down on the floor next to the bed and was crying. The roommate (resident #265) was standing next to her and was holding the bedding of resident #4. The note also included that resident #4 was bleeding from her head and nose, and was transported to the ED. Another nursing note dated (MONTH) 31, 2019 revealed the report from the hospital included the resident sustained [REDACTED].A physician progress notes [REDACTED]. Per the note, resident #4 stated Mother hit her. The note included the resident had bilateral nasal fractures, the right had sutures over the right eyebrow and the eye was less swollen and she was able to open it. -Resident #265 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. A behavior care plan dated (MONTH) 5, (YEAR) revealed the resident exhibited behaviors of striking out, wandering and refusing medications. A goal was that the resident would not cause harm to self or others. Approaches included the use of a wander guard, documenting behaviors and to make sure all basic needs were met. Regarding the incident on (MONTH) 22, 2019: Review of the physician progress notes [REDACTED].#265 was frequently hitting staff and trying to elope. Under assessment it included the resident had dementia with behaviors. The care plan for cognitive loss and dementia dated (MONTH) 11, 2019 included the resident had physical and aggressive behavioral symptoms towards other residents and/or staff. The care plan included that others had been hit, struck, kicked, shoved and/or scratched by resident #265. The goal was the resident will not harm self or others. Approaches included avoiding over-stimulation and maintain a calm approach and a calm environment for the resident. A program manager progress note dated (MONTH) 16, 2019 revealed that resident #265 wandered into other resident's rooms and laid on their beds. According to a neurology consultation note dated (MONTH) 18, 2019, the resident continued to have significant behavior issues and ongoing aggressive behaviors of hitting at staff and attempts to elope from the facility. Under assessment it included a [DIAGNOSES REDACTED]. A nursing progress note dated (MONTH) 20, 2019 included the resident continued to wander from room to room and needed constant redirection. Another nursing progress note dated (MONTH) 20, 2019 revealed that resident #265 continued to need redirection and close supervision during interaction with other residents, was wandering/pacing down the hallways and was wandering into other resident's rooms and invading on their privacy. On (MONTH) 21, 2019, a nursing progress note documented the resident was wandering into various rooms and required constant redirection from staff. Resident #265 was refusing assistance and use of the wheelchair, was constantly looking for children and attempted to open all locked doors. A nursing progress note dated (MONTH) 22, 2019 included the resident displayed exit seeking behaviors and had asked staff to open the patio exit, so she could go home. Per the note, the resident verbalized delusions and asked staff where the little boy went and that she was looking for her baby. It also included the resident wandered into other resident rooms to lie down and sleep. Review of a facility's investigative report revealed that on (MONTH) 22, 2019 at 6:22 a.m., a CNA (staff #13) reported that

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

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) she heard yelling from the room of resident #4 and resident #265. The CNA reported that resident #265 pulled off the bed linens of resident #4 and was yelling at the resident to get up. Resident #265 was pulling and shaking resident #4. Resident #4 then hit the hand of resident #265, who then hit resident #4 on the chest. The residents were separated. Further review of the facility's investigative report revealed the facility substantiated abuse and resident #265 was placed on 1:1 supervision. The care plan for cognition loss and dementia was revised on (MONTH) 22, 2019 to reflect the need for 1:1 supervision 24/7. Review of the MAR for (MONTH) 2019 revealed the resident was found hitting and shaking her roommate on (MONTH) 22 and was on 1:1 supervision. A program manager progress note dated (MONTH) 23, 2019 included that on (MONTH) 22, 2019, a CNA witnessed resident #265 shaking resident #4 and telling her to get up. Resident #4 hit the hand of resident #265, who then hit resident #4 back. Resident #265 was directed to her bed and insisted that she needed a match to start a fire. However, there was no further clinical record documentation that resident #265 was provided 1:1 supervision after (MONTH) 22, and there was no documentation of the rationale as to why the 1:1 supervision was discontinued, as the care plan included for 1:1 supervision 24/7. In addition, the documentation included that resident #4 and #265 remained roommates. Continued review of the (MONTH) 2019 MAR indicated [REDACTED]. Regarding the incident on (MONTH) 30, 2019: A social service note dated (MONTH) 23, 2019 included the facility was considering transferring resident #265 to a higher level of care, due to multiple behaviors with a most recent resident to resident occurrence. CNA documentation on (MONTH) 30, 2019 included the resident manifested wandering behaviors, which placed the resident at a significant risk for danger, by intruding on privacy or activity of others. The nursing progress note dated (MONTH) 30, 2019 revealed that resident #265 came out of the room pushing a male resident in his wheelchair and asked staff where the male resident was supposed to go. Another nursing progress note dated (MONTH) 30, 2019 revealed that resident #265 took a female resident's belt alarm and began to push this resident in the hall. Further review of the clinical record revealed there was no evidence that the neurologist was notified regarding the resident's escalating behaviors, as per the neurologist note from (MONTH) 18. Review of the facility's investigative report revealed that at approximately 10:35 p.m. on (MONTH) 30, 2019, resident #4 was found face down on the floor in her room by a CNA (staff #40). The CNA immediately requested the help of a nurse and the medical director who was in the facility at the time of the incident. Resident #265 was found standing over resident #4 and was holding the bed pad of resident #4 in her hands. Review of a written statement from a CNA (staff #40) revealed that on (MONTH) 30, 2019 at approximately 10:35 p.m., he was charting when he heard talking from down the hall which seemed more like short bursts of fairly loud argument and then sounded more like a loud cry. Staff #40 reported that the light was on in the room of resident #265 and resident #4, and he found resident #4 face down on the floor. He reported that resident #265 was holding a bed pad and was standing over resident #4, and the bed bolster was standing against the wall near the bed. It also included that the pillow from the bed of resident #4 was on the bed of resident #265. He reported that he then noticed the head of resident #4 was in a puddle of blood. The statement also included that the nurse and physician arrived on the scene and 911 was called. A written statement from a licensed practical nurse (LPN/staff #136) included that on (MONTH) 30, 2019 at 10:45 p.m., staff #40 asked for assistance and when she rushed to the room, resident #4 was face down on the floor next to her bed and she was screaming. Staff #136 reported there was blood on the floor and her face was bloody. She reported that resident #265 was just walking around the room carrying the bed pad of resident #4. A statement from another LPN (staff #148) revealed that at approximately 10:45 p.m., staff #40 informed him that someone was seriously injured. He and the physician went into the room and found resident #4 face down on the floor next to her bed and there was a pool of blood on the floor. The resident was bleeding from a laceration to the right side of her face and forehead. Further review of the facility's investigative report revealed that resident #4 and #265 were interviewed and both residents could not tell what happened. The report also included that the allegation of physical abuse was unable to be substantiated based on the results of the resident interviews, and that the incident was unwitnessed. A nursing progress note dated (MONTH) 31, 2019 included that resident #265 was believed to have pulled her roommate (resident #4) off the bed onto the floor, while she was sleeping. Resident #4 sustained serious injuries to the head and face and was sent to the emergency room . The note also included that resident #265 was now placed on 1:1 observation until the resident could be transferred to a higher level of care. A physician's orders [REDACTED]. Per the documentation on the MARs, the resident was provided 1:1 supervision 24/7 until discharged . A program manager note dated (MONTH) 1, 2019 revealed that resident #265 was discharged to home with family. An attempt was made to conduct an interview with resident #4 on (MONTH) 11, 2019 at 8:34 a.m., however, she was unable to respond to questions appropriately. An interview was conducted on (MONTH) 11, 2019 at 11:24 a.m., with a CNA (staff #40 who found resident #4 on the floor). He stated that he was working the night shift when he heard someone crying out and went into the room of resident #4 and #265 who were roommates. He stated the bed of resident #4 was in lowest position and resident #4 was crying and sobbing loudly and she was on the floor face down. He stated that he could not remember if there was blood on the floor. He said resident #265 was holding the bed pad of resident #4 and she was standing over resident #4. He said the resident was sent to the hospital because of a large open wound in the forehead and right temple. Regarding resident #265, staff #40 stated that resident #4 and #265 had been roommates for at least a month or more and had altercations in the past, but the altercation had not happened on his shift. He said resident #265 had behaviors such as resistive to care and could be aggressive. He stated that prior to the incident, resident #265 was not acting different from the ordinary, but ordinary was on the aggressive side. An interview with a LPN (staff #136) was conducted on (MONTH) 11, 2019 at 12:15 p.m. She stated the night of the incident on (MONTH) 30, staff #40 reported there was something going on in the room of resident #4 and #265. She stated when she went into the room, resident #4 was on the floor crying, but she could not tell her what happened. Staff #40 said there was blood on the floor and the resident was bleeding from her nose all over her face. She stated resident #4 was sent to the hospital and resident #265 was placed back to bed on 1:1, meaning someone was with the resident all the time. In an interview with a registered nurse (RN/staff #76) conducted on (MONTH) 11, 2019 at 1:46 p.m., she stated that all staff in the unit are involved with the supervision of residents. She said residents are parked in their wheelchair in the hallway, so the nurse can supervise the residents while the CNA's are providing cares. She stated when a resident is on 1:1, it means any staff in the hall is responsible in providing 1:1 when able, and there is no specific staff assigned to a resident who requires 1:1 supervision. She further stated the only occasion when the administrator assigns one person per shift for 1:1, is when a resident is verbally and physically aggressive. An interview was conducted on (MONTH) 12, 2019 at 7:06 a.m. with the CNA (staff #13 who reported the incident on (MONTH) 22, 2019). She stated that she heard resident #265 yelling and when she entered the room, resident #265 took the blanket off resident #4. She stated the bed of resident #4 was in low position and resident #265 was standing over her bed. She said resident #265 was asking resident #4 to get up and help find her kids/babies. She stated that she redirected resident #265 out of the room and she stayed in the hall for the rest of the shift. She said resident #4 went back to sleep and resident #265 was watched closely and placed on every 15 minute checks. However, she stated the 15 minute checks she conducted were not documented because there was no place to document them any where in the clinical record. Regarding resident #265, staff #13 stated the behaviors of resident #265 included resisting cares, refusing medications, could be combative with staff or other residents and could be verbally and physically aggressive to staff and other residents. She said resident #265 would yell at other residents who would then yell back and that resident #265 had a tendency to hit residents. She stated that resident #265 would not sleep for 2-3 days and then would sleep for one whole day and then would be awake again for 2-3 days. She stated if the resident did sleep at night, it was usually only for 45 minutes and then she would be awake the entire time. She stated that during the night time, resident #265 is the only resident wandering in the hallway, so staff can closely monitor her. She stated after the incident on (MONTH) 22, 2019, resident #265 was on close watch and every 15 minute checks, but there was no specific staff assigned to resident #265 for

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) 1:1, until after the second incident that resulted in the transfer of resident #4 to the hospital. She further stated that both residents remained as roommates after the incident on (MONTH) 22. Regarding resident #4, staff #13 stated the resident was sweet and did not have any temperament and would just keep to herself. She stated that she has not seen resident #4 to have any behaviors and had not seen resident #4 provoke resident #265 or any other residents. During an interview with the Director of Nursing (DON/staff #98) conducted on (MONTH) 12, 2019 at 1:24 p.m., she stated that on (MONTH) 22, 2019 it was reported to her that resident #265 pulled the blanket off of resident #4 and tried to wake her up and had swatted resident #4, who then swatted her back. She said the facility substantiated the allegation of abuse on (MONTH) 22 because the CNA (staff #13) witnessed the incident. She stated that resident #4 and #265 continued to be roommates after this incident, because she did not think it was abuse because both residents had dementia and they did not know what they were doing. She stated resident #265 was care planned for and was placed on 1:1 supervision, meaning there was one staff assigned to care for resident #265 the entire shift starting (MONTH) 22, and that the assigned staff changes after every shift. She said when resident #265 was redirected, she became aggressive and would hit staff or other residents. However, she could not find documentation that 1:1 supervision was provided after (MONTH) 22, 2019. During the above interview, the clinical record was reviewed with the DON and the Assistant Director of Nursing (staff #47 who later joined the interview). Staff #47 provided documentation of resident #265 being on 15 minute checks from (MONTH) 23-30, 2019. The DON stated that resident #265 was placed on 1:1 supervision on (MONTH) 22. However, both staff #98 and #47 stated that they could not find documentation that resident #265 was provided 1:1 supervision after (MONTH) 22, as care planned. Regarding the incident on (MONTH) 30, 2019, staff #98 stated she was not at the facility when the incident happened and she learned about the incident the next day. She stated facility unsubstantiated the allegation because the facility really did not know if resident #265 did something to resident #4 or if resident #4 just rolled out of bed and resulted in injury. She said the bed of resident #4 was in the low position, meaning it was approximately one and a half feet from the floor. She said because resident #4 has a [DIAGNOSES REDACTED]. She said resident #4 was found on the floor and resident #265 was holding the incontinent pad also known as bed pad from the bed of resident #4. She said the bed pad is usually placed on top of the sheet of a resident's bed. She stated that the medical director was at the facility at the time of the incident and assessed resident #4 and ordered the transfer to the hospital. Staff #98 continued to say that she reviewed the video surveillance on the date and time of the incident and stated that prior to the incident, the video showed that resident #265 pushed her wheelchair out of her room, re-entered her room and came out later with either a blanket or a pillow and was placing these items on her wheelchair. She stated there were no other persons seen in the video entering their room other than resident #265, until staff #40 entered the room at the time of the incident. Review of the policy on Behavior Management revealed the facility takes a cautionary and safe approach in treating and caring for individuals who exhibit challenging behaviors that may pose a threat to the health or safety of the resident or other individuals in the facility. Review of the Abuse Prevention policy revealed the facility will take appropriate steps to prevent the occurrence of abuse. It also stated, Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm pain or mental anguish. Physical Abuse includes hitting, slapping, pinching and kicking. The policy also included that the IDT (Interdisciplinary Team) will attempt to identify residents whose personal histories may render them at risk for abusing other residents and develop intervention strategies to prevent occurrences and monitor changes that would trigger abusive behavior. Additionally, the IDT team will attempt to identify those residents whose personal histories may render them at risk for abuse and develop intervention strategies to protect them. The policy further included the facility makes reasonable efforts to determine the cause of the alleged violation and takes corrective action consistent with the investigation findings and to eliminate any ongoing dangers to the resident. It also stated that appropriate steps are taken by the facility to prevent recurrence of abuse. If a suspected violation occurs, the facility shall take immediate action to stop the alleged or suspected abuse, neglect or exploitation of a resident. If the suspected perpetrator is another resident, the DON or designee separates the residents so they do not have access to each other until the circumstances of the alleged incident can be determined.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility failed to implement their policy regarding reporting allegations of abuse involving two residents (#4 and #265). The deficient practice could result in the appropriate State agencies not being notified as required. Findings include: -Resident #4 was admitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. -Resident #265 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Regarding an incident on (MONTH) 22, 2019: Review of the facility's investigative report revealed that on (MONTH) 22, 2019 at 6:22 a.m., a CNA (staff #13) reported that she heard yelling from the room of resident #4 and resident #265. The CNA reported that resident #265 pulled the bed pad off of resident #4's bed and was yelling at the resident to get up and resident #265 was pulling and shaking resident #4. Resident #4 then hit the hand of resident #265, who then hit resident #4 on the chest. Continued review of the facility's investigative report revealed the facility substantiated abuse. However, further review of the facility's investigation revealed there was no evidence that the incident of physical abuse was reported to APS. Regarding an incident on (MONTH) 30, 2019: Review of the facility's investigative report revealed that at approximately 10:35 p.m. on (MONTH) 30, 2019, resident #4 was found face down on the floor in her room by a CNA (staff #40). The CNA immediately requested the help of a nurse and the medical director who was in the facility at the time of the incident. Resident #265 was found standing over resident #4 and was holding the bed pad of resident #4 in her hands. Review of a written statement from the CNA (staff #40) revealed that on (MONTH) 30, 2019 at approximately 10:35 p.m., he was charting when he heard talking from down the hall which seemed more like short bursts of fairly loud argument and then sounded more like a loud cry. Staff #40 went to the room of resident #265 and resident #4, and resident #4 was face down on the floor. He reported that resident #265 was standing over resident #4 and the head of resident #4 was in a puddle of blood. The statement also included that the nurse and physician arrived on the scene and 911 was called. A written statement from a licensed practical nurse (LPN/staff #136) included that on (MONTH) 30, 2019 at 10:45 p.m., staff #40 asked for assistance and when she rushed to the room, resident #4 was face down on the floor next to her bed and she was screaming. Staff #136 reported there was blood on the floor and her face was bloody. A statement from another LPN (staff #148) revealed that at approximately 10:45 p.m., staff #40 informed him that someone was seriously injured. He and the physician went into the room and found resident #4 face down on the floor next to her bed and there was a pool of blood on the floor. The resident was bleeding from a laceration to the right side of her face and forehead. Further review of the facility's investigative report revealed that resident #4 and #265 were interviewed and both residents could not tell what happened. The report included that the allegation of physical abuse was unable to be substantiated based on the results of the resident interviews, and that the incident was unwitnessed. The investigative report also included that the incident was not reported to the State Agency until (MONTH) 31, 2019 at 1:30 a.m., which was more than 3 hours after the allegation was made. There was also no evidence that this incident was reported to APS. An interview with the Director of Nursing (DON/staff #98) was conducted on (MONTH) 12, 2019 at 1:24 p.m. During the interview, the investigative reports for the incidents on (MONTH) 22 and (MONTH) 30 were reviewed. Staff #98 stated she could not find any documentation that both incidents were reported to APS and that she did not know why. She also stated that based on the documentation, the incident on (MONTH) 30 was reported to the State Agency on (MONTH) 31 at 1:30 a.m., which was approximately 3 hours after the incident. She stated their policy was to report any incident with serious injury

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) to the State Agency within 2 hours. Review of the Abuse Prevention policy revealed it is the responsibility of all employees to immediately report any suspected or alleged violation of abuse, neglect, injuries of unknown source and/or misappropriation of resident property. It also included the facility will take appropriate steps to ensure that all suspected or alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown source, exploitation and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegations is made to the Administrator and to other officials including the State Survey Agency and APS where State law provides for jurisdiction.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policy review, the facility failed to ensure that allegations of abuse involving resident (#4) and resident (#265) were reported to the State Agency and to Adult Protective Services (APS), within two hours after the allegation was made. The deficient practice could result in the appropriate State agencies not being notified of allegations of abuse as required. Findings include: -Resident #4 was admitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. -Resident #265 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Regarding an incident on (MONTH) 22, 2019: Review of the facility's investigative report revealed that on (MONTH) 22, 2019 at 6:22 a.m., a CNA (staff #13) reported that she heard yelling from the room of resident #4 and resident #265. The CNA reported that resident #265 pulled the bed pad off of resident #4's bed and was yelling at her to get up and was pulling and shaking resident #4. Resident #4 then hit the hand of resident #265, who then hit resident #4 on the chest. Continued review of the facility's investigative report revealed the facility substantiated abuse. However, further review of the facility's investigation revealed there was no evidence that the allegation of abuse was reported to APS. Regarding an incident on (MONTH) 30, 2019: Review of the facility's investigative report revealed that at approximately 10:35 p.m. on (MONTH) 30, 2019, resident #4 was found face down on the floor in her room by a CNA (staff #40). The CNA immediately requested the help of a nurse and the medical director who was in the facility at the time of the incident. Resident #265 was found standing over resident #4 and was holding the bed pad of resident #4 in her hands. Review of a written statement from a CNA (staff #40) revealed that on (MONTH) 30, 2019 at approximately 10:35 p.m., he was charting when he heard talking from down the hall which seemed more like short bursts of fairly loud argument and then sounded more like a loud cry. Staff #40 went to the room of resident #265 and resident #4, and resident #4 was face down on the floor. He reported that resident #265 was standing over resident #4 and the head of resident #4 was in a puddle of blood. The statement also included that the nurse and physician arrived on the scene and 911 was called. A written statement from a licensed practical nurse (LPN/staff #136) included that on (MONTH) 30, 2019 at 10:45 p.m., staff #40 asked for assistance and when she rushed to the room, resident #4 was face down on the floor next to her bed screaming. Staff #136 reported there was blood on the floor and her face was bloody. A statement from another LPN (staff #148) revealed that at approximately 10:45 p.m., staff #40 informed him that someone was seriously injured. He and the physician went into the room and found resident #4 face down on the floor next to her bed and there was a pool of blood on the floor. The resident was bleeding from a laceration to the right side of her face and forehead. Further review of the facility's investigative report revealed that resident #4 and #265 were interviewed and both residents could not tell what happened. The report included that the allegation of physical abuse was unable to be substantiated based on the results of the resident interviews, and that the incident was unwitnessed. The investigative report also included that the incident was not reported to the State Agency until (MONTH) 31, 2019 at 1:30 a.m., which was more than 3 hours after the allegation was made. There was also no evidence that the incident was reported to APS. An interview with the Director of Nursing (DON/staff #98) was conducted on (MONTH) 12, 2019 at 1:24 p.m. During the interview, the investigative reports for the incidents on (MONTH) 22 and (MONTH) 30 were reviewed. Staff #98 stated she could not find any documentation that both incidents were reported to APS and that she did not know why. She also stated that based on the documentation, the incident on (MONTH) 30 was reported to the State Agency on (MONTH) 31 at 1:30 a.m., which was approximately 3 hours after the incident. She stated their policy was to report any incident with serious injury to the State Agency within 2 hours. Review of the Abuse Prevention policy revealed it is the responsibility of all employees to immediately report any suspected or alleged violation of abuse, neglect, injuries of unknown source and/or misappropriation of resident property. It also included the facility will take appropriate steps to ensure that all suspected or alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown source, exploitation and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegations is made to the Administrator and to other officials including the State Survey Agency and APS where State law provides for jurisdiction.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy and procedures, the facility failed to identify weight loss in 1 of 5 sampled residents (#34) and implement additional interventions to address the weight loss. The deficient practice could result in additional residents experiencing weight loss, without adequate interventions. Findings include: Resident #34 was admitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED]. An annual Minimum Data Set (MDS) assessment dated (MONTH) 27, 2019 revealed the resident had severe cognitive impairment, required extensive two-person assistance with Activities of Daily Living (ADLs) and required supervision and set-up for meals. The MDS also included the resident was 5 feet tall and weighed 126 lbs. A nutritional status care plan included the resident had potential nutritional problems such as biting, chewing and swallowing related to inability to consume regular texture, as evidenced by a mechanically altered diet. The goal was for the resident to tolerate a mechanically altered diet without signs or symptoms of choking through the next review. Interventions included to notify the nurse if the resident refuses to eat or consumes less than 25% of meals and fluids, to monitor intake and monitor weight per order. A physician's order report dated (MONTH) 11, 2019 - (MONTH) 11, 2019 included for a puree diet with cornmeal mush, large protein portions at meals and for ProMod liquid protein supplement once daily. The Restorative Nursing Assistant (RNA) documentation for (MONTH) 2019 revealed that resident #34 weighed 126.3 lbs on (MONTH) 5, 125 lbs on (MONTH) 12, and 124.8 lbs on (MONTH) 19. There were no weights documented for the rest of August. According to the Certified Nursing Assistant (CNA) meal intake documentation for (MONTH) 2019, the resident consumed less than 25% of meals on more than 30 occasions. Further review of the clinical record revealed no documentation to indicate that nursing had been aware or that the physician had been notified. The RNA documentation for (MONTH) 2019 revealed that resident #34 weighed 119.9 lbs on (MONTH) 2, and was reweighed and the weight was the same. On (MONTH) 9, the resident's weight was recorded as 125.2 lbs and the resident was reweighed and the weight was 118.9 lbs, which indicated a weight loss of 7.4 lbs (5.86%) in approximately one month. In addition, the CNA meal intake documentation from (MONTH) 1-10, 2019 included the resident consumed less than 25% of his meals on more than 10 occasions. Continued review of the clinical record revealed no documentation that nursing was aware of the resident's low meal intakes

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	035254	A. BUILDING _____ B. WING _____	09/12/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) or weight loss, or that dietary had identified the resident's weight loss and implemented any additional dietary interventions to address the 7.4 lb weight loss. There was also no documentation that the physician was notified of the resident's low meal intakes or the weight loss. On (MONTH) 11, 2019 at 10:27 a.m., an interview was conducted with a RNA (staff #4), who stated that one of her responsibilities is to observe the residents during meals and to record their intake afterwards. She stated her process is to notify the nurse if a residents' intake is less than 25%. She said that she told the nurse that resident #34 was not eating his meals. She stated that it is also her responsibility to take the resident's weight every week. She stated that because the weight loss seemed to be a gradual one, she hadn't noticed that the resident was losing weight. On (MONTH) 11, 2019 at 10:35 a.m., an interview was conducted with a Registered Nurse (RN/staff #71). She stated that she is alerted if a resident has significant weight loss by the CNA, RNA or by notification in the resident's electronic record. She stated that resident #34 did not have a physician's order for weekly weights and that meant the physician was not aware of the weight loss. She said if someone had notified her, she would have reviewed the resident's intake sheets, assessed the resident for swallowing/choking issues, alerted the physician and asked the dietician if something could be added to the resident's diet. She stated that she had not done any of those things, because she had not been aware that the resident wasn't eating and had been losing weight. An interview was conducted on (MONTH) 11, 2019 at 10:50 a.m., with the Registered Dietician (staff #149). She stated that either she or the diet technician is in the facility one day per week. She said the process begins with looking through the report section of the resident weights to see if one of the residents is having a weight change. She said the report is run for all residents, one report at a time. She stated that through that protocol, she would become aware of any weight loss/gain. She said that she would then review the clinical record to assess factors that may have led to it. She stated they usually meet on a Thursday to address the needs of identified at-risk residents in a Weights Intervention and Nutritional Support (WINS) meeting. At this time, she reviewed the list of residents identified in the past month for weight loss and stated that resident #34 was not on the list. She stated it had been a slow, insidious loss and that's why it hadn't been identified before. On (MONTH) 11, 2019 at 1:44 p.m., an interview was conducted with the Director of Nursing (DON/staff #98). She stated that her expectation was for the Registered Dietician to be aware of residents with significant weight loss, make recommendations and notify the nursing department. She stated the process was for the WINS committee and the doctor to discuss residents who are identified to be at risk, and then make appropriate recommendations. On (MONTH) 12, 2019 at 11:14 a.m., an interview was conducted with a Nurse Practitioner (NP/staff #150). Staff #150 said that generally, she gets the report sheet which indicates if a resident is not eating and/or losing weight. She said dietary provides that information to her. She stated that she was not aware that resident #34 had lost a significant amount of weight in the past month. She stated her process would be to see the weight report, assess the reasons why, then go from there. Review of the facility policy titled, Significant Weight Loss revealed the goal for Medical Nutrition Therapy for significant unintended weight loss is to identify the underlying causes or factors contributing to the significant or unintended weight loss, and intervene as appropriate to resolve the problem and stabilize the weight. The policy included that appropriate members of the interdisciplinary team would identify individuals with significant/severe weight losses, interview direct care givers for information on recent changes, assess for risk of under nutrition or protein-energy malnutrition, identify potential causes, request/implement nutrition interventions based upon the individual's food and beverage preferences and monitor and evaluate to assess effectiveness of the intervention.
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel record reviews, facility assessment, staff interviews and policy review, the facility failed to ensure 3 out of 3 sampled nursing staff (#28, #62 and #71) possessed the specific competencies and skills needed to provide nursing and related services required to meet residents' needs safely. The deficient practice could result in staff not being knowledgeable of how to provide emergency care to residents. The facility census was 114. Findings include: Review of the Facility assessment dated (MONTH) 16, 2019 revealed the staffing plan included ,[DATE] licensed nurses/approximately 84+ hours per day, to provide direct care for up to 119 residents every day including emergencies. The assessment also revealed the facility resources needed to provide competent support and care for their resident population every day and during emergencies included Registered Nurses (RN), Licensed Practical Nurses (LPN), and the Minimum Data Set (MDS) nurse. -Review of the personnel record for LPN (staff #28), revealed a hire date of (MONTH) 25, 2009. Further review of the personnel record revealed staff #28's Cardio [MEDICAL CONDITION] Resuscitation (CPR) certification expired (MONTH) 2014. -Review of the personnel record for RN (staff #62), revealed a hire date of (MONTH) 9, 2014. Further review of the personnel record revealed staff #62's CPR certification expired (MONTH) 2019. -Review of the personnel record for RN (staff #71), revealed a hire date of (MONTH) 27, 2011. Further review of the personnel record revealed staff #71's CPR certification expired (MONTH) of 2019. On (MONTH) 11, 2019 at 8:35 a.m., an interview was conducted with the payroll manager (staff #51). She stated that she had been in this position for 2 months and that it was her responsibility to remind licensed staff when their CPR certification was due for renewal. She stated that according to the personnel records, the last time staff #62 and #71 had signed up for CPR certification was in (MONTH) (YEAR). She said their CPR certifications expired (MONTH) 2019. She said that she had been aware that staff #28's CPR certification had expired several years ago. However, she said she did not think it was a problem because staff #28 had been working as the MDS nurse since (MONTH) (YEAR) and was no longer working as a floor nurse. Staff #51 acknowledged staff #28 generally worked from home, but came into the facility at least one day per week. She stated that staff #62 and #71 had been providing direct care to residents since (MONTH) 2019 in spite of the lapse in re-certification. She stated that she uses a spreadsheet to ensure CPR certification for nurses is current. Review of the spreadsheet revealed the nurses' CPR certifications had expired. Staff #51 also stated that staff #62 and staff #71 were reminded about re-certification on (MONTH) 28, 2019 and again on (MONTH) 2, 2019. On (MONTH) 12, 2019 at 8:44 a.m., an interview was conducted with the business office manager (staff #56). She stated that during her previous role as payroll manager, she alerted staff #62 and staff #71 that their CPR certifications were going to expire. She said that after the CPR certifications expired, she reminded them once or twice more. Staff #56 said that she told the Director of Nursing (DON) about the expired CPR certifications in (MONTH) or March. She stated that she thought the problem with re-certification for the nurses had to do with the issue of getting a class set up for such a small number of staff. During an interview conducted with the Director of Nursing (DON/staff #09) on (MONTH) 12, 2019 at 8:26 a.m., she stated that the process for ensuring CPR certification does not expire, is for payroll to send notifications to the staff as a reminder. She stated she was not aware that some of the nurses had expired CPR certification. The facility's policy titled Cardiopulmonary Resuscitation Certification First Aid Training revealed that in accordance with a resident's advance directives, or in the absence of advanced directives or a Do Not Resuscitate (DNR) order, prior to the arrival of emergency medical services, the facility shall provide basic life support, including initiation of CPR, to a resident who experiences [MEDICAL CONDITION]. CPR-certified staff shall be available at all times. The policy also revealed licensed nurses shall be required to provide documentation of current cardiopulmonary resuscitation training certification/re-certification obtained from a trainer authorized to train and certify individuals in CPR, in accordance with the curriculum of the American Heart Association Basic Life Support (BLS) for Healthcare Providers Program. CPR re-certification shall be in accordance with the recommendations of the certifying provider. Licensed nurses shall be responsible for providing a copy of a current certification card, documenting CPR training certification, which will be maintained in the staff members personnel file. The policy also included a nurse who becomes delinquent with his/her renewals may be removed from the schedule until in compliance with this requirement.

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