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	145880	A. BUILDING _____ B. WING _____	C 07/07/2006

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F 490	Continued From page 28 and reporting on 07-06-06 and again on 07-07-06 and will be completed be completed by an entire staff mandatory in-service from corporate nurse as of 07-10-06. 4. All staff will be in-serviced upon hire and monthly according to abuse protocol. 5. The facility will follow current abuse protocol as written, we have reviewed our current policy and feel it is appropriate at this time. We will continue to review and revise as necessary. 6. The facility will vigorously check all references of facility personnel and will maintain documentation of such in individual personnel files. 7. The Licensed Nurse who received the initial report has been counseled and in-serviced on a 1 to 1 basis on abuse reporting and protocol. 8. The Administrator and Director of Nursing have been in-serviced by the Director of Operations on abuse reporting protocol including screening, training, prevention, identification, investigation, protection, reporting and following each aspect of the protocol without exception.	F 490		
F9999	FINAL OBSERVATIONS Licensure Violations 300.510e) 300.610a) 300.3240a) 300.3240b) 300.3240e)	F9999		

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Section 300.510 Administrator
e) The licensee and the administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities.

Section 300.610 Resident Care Policies
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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.
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

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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.

Based on interviews and record review the facility failed to investigate allegations of verbal abuse in a prompt and timely fashion and failed to do a thorough employee reference check prior to hire. This failure resulted in an accused abuser completing 2 full shifts of work related activity, including care for the resident she had been accused of abusiving. The abuse incident resulted in the resident requiring a nebulizer treatment for shortness of breath and appearing very fearful of the abusive staff member. The resident was R-1. The identified failures resulted in 54 in house residents being put at risk of actual or potential verbal abuse.

Findings Include:

Per interview with E-6 (Certified Nursing Assistant/CNA) on 06-29-06 at approximately 8: 00AM., R-1 was sitting in the dining room of the facility on 06-25-06 at approximately 7:00PM. R-1 was in a wheelchair and had a personal alarm on. Per E-6, R-1 was attempting to stand up without staff assistance. Per E-6, every time R-1 attempted to stand, the alarm would go off. E-6 said that R-1 was very confused and would attempt to rise as soon as staff would walk away from her. E-6 said she was assisting another resident in the dining room and 2 other CNA'S were working down the halls. E-7 (Licensed Nurse) got up from the desk when R-1 started to rise from the chair. E-7 went to R-1 and took the alarm off of the chair. E-7 pushed the still

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sounding alarm to R-1's ear and said "do you like to hear that noise?" in a very loud and abrasive tone of voice. "Nobody else likes to hear it either, it only happens when you stand up, so stay sit down!" Per E-6, R-1 did not say anything but was trying to pull away from the noise. As she leaned her head away from the loud sound E-7 followed the movement with the alarm, not allowing R-1 to get away from the noise. E-6 said that R-1 had a stunned look on her face, her eyes were wide and her mouth was open. Per E-6 this went on for about 35 to 45 seconds then E-7 attached the alarm back on the wheelchair and went back to the desk. Per E-6, E-7 made several statements in R-1's presence, before the incident and after the incident, that R-1 was trying to fool the staff, she knew what she was doing and was only trying to get attention from the staff by attempting to stand without assistance.

Per E-6, after E-7 had gone back to the desk R-1 was distressed and short of breath. R-1 asked staff for a breathing treatment and the CNA set one up for her due to E-7 telling E-3 that R-1 "did not need a breathing treatment." The nurse that was assigned to care for R-1 on that night was out of the building on a lunch break when the incident occurred. Per E-6, E-7 did not have any intention of starting a breathing treatment. E-6 said that she assisted R-1 with the treatment because R-1's hands were shaking and she was confused. E-6 said that E-7 said "she is playing you like a fiddle, she knows what she is doing." After a few minutes of using the breathing treatment R-1 wanted to rest, so the machine was left on and the mouth piece was removed from R-1's mouth. At that point E-7 came over and turned the machine off, this caused R-1 to

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F9999	Continued From page 32 become even more upset and short of breath. Per interview with E-3 (Certified Nursing assistant /CNA) on 06-29-06 at 1:20PM., she had been working down the hallway and entered the dining room at approximately 7:00PM. and saw E-7 walk over to R-1 and put the sounding alarm up to R-1's ear and E-7 started to"go off" on R-1 (yelling at her). R-1 had a frightened look on her face and was trying to pull away from E-7. Per E -3, E-7 kept going back to R-1 saying to her in a very loud and abrupt tone of voice "you can't fool me, I know what you are doing and you know what you are doing." This resulted in R-1 becoming more upset. R-1 asked for her nebulizer treatment and E-7 said that "she did not need it." E-6 had already got the machine and brought it to the dining room. E-7 then said "the medicine is in her room," but did not go to get it. E-3 went to the room and got the medication to start the treatment for R-1. Per interview with E-5 (CNA) on 06-29-06 at 1:40 PM., E-5 could hear the alarm on R-1's chair going off as she came up the hallway, as she entered the dining room at approximately 7:00PM ., she saw E-7 put the sounding alarm up to R-1 's ear saying "are you tired of hearing this because I am." Per E-5, R-1 was trying to pull away from E-7 and R-1 was asking her to stop but E-7 kept the alarm close to R-1's ear. Per E-5, R-1 was very confused and had no idea why she was being yelled at. E-5 said that E-7 is short tempered all the time and does not have any patience. Per review of a consultation note from a hospital admission on 06-14-06, R-1 was admitted	F9999		

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because "she was suicidal" at the nursing home. Per the report, R-1 said that she had not been listened to and that her pain had not been adequately controlled at the nursing home. The diagnosis given on the report was Bone Cancer and Major Depression.

E-6 also said during the 06-29-06 interview at 8: 00AM., that as soon as E-8 (Licensed Nurse/LPN) returned from her lunch break, at approximately 7:30PM., she told E-8 about the incident. Per E-6, E-8 did not do anything about what she had told her. E-6 said that she was off duty at 8:00 PM., and was still very concerned about R-1, so she stopped at the home of E-4 (R,N./Care Plan coordinator) on her way home to relate the incident to her, because E-8 had not done anything about it when she was told of the incident.

Per interview with E-8 (Licensed Nurse) on 06-29 -06, at 3:00PM., verification was given that E-6 had reported an allegation of verbal abuse involving R-1 and E-7. Per E-8, she did not observe a problem with E-7 or E-7's interactions with any resident and did not do anything about the allegation of abuse reported by E-6. E-8 said that E-7 had told her that she believed R-1 was trying to fool staff by acting confused. Per E-8, E -7 believed that R-1 was aware of her actions and the behavior was to gain attention.

Per interview with E-4 on 06-29-06 at 10:15AM., E-6 had stopped by her home a little after 8:00 PM. on 06-25-06 and told her about an alleged abuse she had witnessed at the facility involving R-1 and E-7. E-4 said that after E-6 left, she called E-2 (RN/Director of Nursing) and related

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the incident to her. E-2 said that she would notify E-1 (Administrator) of the allegation of abuse. Per E-4 nothing else was done until 06-27-06 when E-1 asked her to write a statement regarding the incident reported to her by E-6. E-4 said that E-7 completed her shift on the 25th and worked a full shift on the 26th, before being suspended because of an abuse allegation investigation.

Per interview with E-2 on 06-29-06, at 11:00AM., E-4 did call her at home on the night of 06-25-06 to repeat the allegation of abuse that E-6 had told her about. E-2 said that she in turn called E-1 and relayed all of the information that she received to her. E-2 said that an investigation into the allegation did not start until the 27th of June. E-2 confirmed that E-7 had completed her shift on the 25th. and worked a full shift on the 26 th. When E-2 was asked if the facility had checked with previous employer's prior to hiring E-7, E-2 replied that she had called the previous facility and thought she had spoke to the administrator of the facility. Per E-2 the administrator said that E-7 would be a candidate for rehire at her facility and did not give any indication of any problems encountered while E-7 was in her employee. Per E-2, E-7 had told her there had been some type of problem while E-7 had been employed at the last facility, but E-7 assured her that the problem had been resolved did not go into details or give specifics related to the type of problem it had been.

Per interview with Z-1 per phone on 06-30-06 at approximately 12:30PM., E-7 had been accused of resident abuse at her facility. Per Z-1, as administrator of the facility, she was the only

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F9999	Continued From page 35 person that could respond to requests for employee references and she had not received any requests from this facility for any type of reference. Per Z-1, E-7 would not be recommended for rehire at her facility. Per interview with E-1 on 06-29-06 at approximately 2:45PM., she had been notified of the allegation on 06-25-06 and started interviewing staff on 06-27-07. E-1 confirmed that E-7 had not been suspended from duty until the 27th, and had completed her full shift on the 25th as well as the 26th. (A)	F9999		