STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165612	A. BUILDING _____ B. WING _____	C 01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CENTER AT LUTHER PARK	1555 HULL AVENUE DES MOINES, IA 50316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: _____ The following deficiencies were identified during investigation of Incident 64934-I, #64701-I and #64468-M conducted 12/19/16 - 1/12/17. ~~Incident #64934-I: unsubstantiated~~ Incident #64701-I: unsubstantiated See Code of Federal Regulations (42CFR0, Part 483, Subpart B - C.	F 000		
F 223 SS=G	483.12 FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews the facility failed to ensure 1 of 5 residents received kind and considerate care and failed to maintain a resident's dignity (Resident #1). Record review established Resident #1 lacked the ability to comprehend Staff F's remarks and a reasonable person would find the oral language used by Staff F on 11/26/16 to Resident #1 as disparaging, derogatory; and would likely view Staff F's language as a threat of harm. The facility reported a census of 115 residents. Findings include: The Minimum Data Set (MDS) assessment dated	F 223		

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 223	Continued From page 1 11/6/16 listed Resident #1's diagnoses as Non-Alzheimer's dementia, anxiety disorder and depression. The MDS indicated Resident #1 had long and short term memory problems and severely impaired cognition. The assessment revealed the resident required extensive assistance of two staff for dressing, toilet use and personal hygiene; and one staff for eating. The care plan dated 11/16/16 directed staff to keep Resident #1 out of the reach of a specific resident, and for nurses to do a skin check every night at bed time until further notice. The August 2016 revised abuse policy defined resident abuse to include, injuries of unknown source when both of the following conditions are met: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and b. The injury is suspicious because of the location (being located in an area not generally vulnerable to trauma). The Abuse policy identified all residents had the right to be free from verbal abuse; and residents must not be subject to abuse by anyone, including but not limited to facility staff, etc. The policy noted that abuse is defined differently under both State and Federal law and regulation. The policy identified a "caretaker" as a person who is a staff member of a facility or program who provides care, protection or services to a dependent adult by contract through employment. The policy included the following as result of the willful misconduct/reckless acts of a caretaker taking into account the totality of the circumstances. Assault of a dependent adult meant the commission of any act which is	F 223		

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F 223	Continued From page 2 generally intended to cause pain or injury to a dependent adult or which is generally intended to result in physical contact which would be considered by a reasonable person to be insulting or offensive or any act intended to place another in fear of immediate physical contact which will be painful, injurious insulting or offensive coupled with the apparent ability to execute the act. The policy defined the Federal Certification Guidelines as follows: Verbal abuse defined by the policy as the use of oral language that willfully included disparaging and derogatory terms to residents regardless of the residents' ability to comprehend. The policy listed examples as threats of harm and saying things to frighten a resident. A Resident Incident Report indicated witness as Staff B and Staff D both Certified Nurse Aides (CNAs) who heard Resident #1 screaming, and then overheard Staff F, LPN (licensed practical nurse) asking Resident #1 if he/she wanted his/her medication the easy way or the hard way. Staff According to the report, Staff B reported what she witnessed to Staff E, LPN on 11/26/16 at 8:00 a.m. No injuries were noted from this incident but on assessment some old bruising had been noted. The report indicated staff assessed the resident and identified old bruising. The old bruising identified yellowish/green bruising around the mouth and to both upper extremities, which had been previously reported, but no new injuries. Record Review for Resident #1 identified the old bruising completed by Staff E on 11/26/16: a). A Wound Assessment Report completed by Staff E, (Licensed Practical Nurse)/LPN identified bruising that measured 2 cm (centimeter) x 2.5 cm, green/yellow coloring, located on the right	F 223		

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F 223	Continued From page 3 corner of Resident #1's mouth. The bruising had first been identified on 11/26/16. b). A Wound Assessment Report noted that a 3 cm x 2 cm green/yellow bruise on the left corner of Resident #1's mouth had first been identified on 11/26/16. The bruising had first been identified on 11/26/16. c). A Wound Assessment Report noted that a 9 cm x 5 cm green/yellow bruise on Resident #1's right forearm had first been identified on 11/26/16. The bruising had first been identified on 11/26/16. d). A Wound Assessment Report noted that a 4 cm x 3 cm green/yellow bruise on Resident #1' s left wrist had first been identified on 11/26/16. The bruising had first been identified on 11/26/16. A follow up and conclusion to the unexplained bruising on Resident #1 had been signed and dated by the DON (Director of Nrsing) on 11/26/16 at 10:00 a.m. According to the document, Staff F had been sent home as a result of Staff B and Staff D alleging they overheard Resident #1 scream and Staff F saying to Resident #1, " You can either take your meds the easy way or the hard way " . A Notice of Leave Pending Investigation had been issued to Staff F on 11/26/16 for an allegation of abuse against her. A Resident Incident Report dated 11/26/16 at 10:30 a.m. indicated Resident #1's daughter reported multiple bruises around the mouth area and both upper extremities to Staff E. A Departmental Note dated 11/26/16 at 12:05	F 223		

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F 223	Continued From page 4 p.m. and signed by Staff E indicated that a CNA told her Resident #1 had been heard screaming, and then Staff F had been overheard saying " You can either take this the easy way or the hard way, " regarding medication administration. A Departmental Note dated 11/26/16 at 1:27 p.m. and signed by Staff E, indicated Resident #1 had a 9 cm x 5 cm bruise to the right forearm, a 4 cm x 3 cm bruise to the left wrist, a 2 cm x 2.5 cm bruise to the right corner of the mouth and a 3 cm x 2 cm bruise to the left corner of the mouth. An Incident Witness Statement dated 11/26/16 and signed by Staff D, indicated she heard Resident #1 screaming and yelling "Oh My God " as she overheard Staff F say, " Do you want this the hard way or the easy way " ? Staff D wrote that she and Staff B told Staff E. An interview on 12/21/16 at 3:20 p.m. with Staff D (CNA), revealed that she worked the day shift when the incident occurred. Staff D reported she said it happened about 7:00 or 7:15 a.m. She said she had just left Resident #1's room and entered another resident's room across the hall with Staff B. According to Staff D, they heard Resident #1 yelling "Oh My God". Staff D stated she had never heard Resident #1 yell like that. Staff D said if staff were persisted at doing something Resident #1 did not want done, then Resident #1 will yell. Staff D said they heard Staff F yell "You can either do this the easy way or the hard way ". Staff D stated they immediately went to report what they heard to Staff E (LPN). As they passed Resident #1's room, they noticed Staff F in the hall at the med cart and noticed Resident #1 alone in his/her room. According to Staff D, she continued taking residents to the	F 223		

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F 223	Continued From page 5 dining room and then helped feed them. The CNA said that once residents were done with breakfast and seated in the lounge area, she went on break about 10:00 a.m. Staff D said Staff F worked at the med cart from the time they told Staff E until the time she went on break. The CNA said she saw Staff F at the med cart on Redwood Avenue when she returned from break about 15 minutes later. Staff D said Staff F worked on the floor for about an hour before they called her downstairs. According to the CNA, Staff F returned a little while later. She said Staff F had been crying and said someone reported her for abusing Resident #1. Staff D said Staff F had left the floor by the time she returned from helping another resident. Staff D said she had only worked with Staff F a couple of times before and thought Staff F was a good nurse. The CNA said she had never heard Staff F talk that way to residents before. When asked to describe Staff F's tone of voice, Staff D reported Staff F's tone of voice was serious. An interview on 12/21/16 at 9:00 a.m. and subsequent interviews with Staff B revealed that she and Staff D had gotten Resident #1 up and were on their way out of the resident's room as Staff F, entered. Staff B stated she and Staff D heard Staff F say "We can either do this the easy way or the hard way". According to the CNA, she believed Staff F meant taking medication since she entered the resident's room to administer medication. The CNA stated they heard Resident #1 screaming loudly. According to the CNA, Staff F had exited Resident #1's room right after they heard the resident scream, and she went into the resident's room to see what had happened. Staff B said Staff D stayed in the room across from Resident #1's room where they had been when they heard the scream. According to the CNA,	F 223		

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F 223	Continued From page 6 when she entered the room, the resident seemed angry and irritated as he/she sat in the wheelchair. Staff B said the resident seemed unharmed. The CNA said she asked the resident if he/she was OK, but he/she did not respond. The CNA said she wheeled the resident from his/her room to the sitting area, and immediately reported what she knew to Staff E. According to the CNA, Staff E told her she had heard a scream, but thought another resident had screamed. Staff B said she became suspicious when she overheard Staff F say something so inappropriate. Staff B said she became good friends with Staff F when they 1st started working together. Staff B stated Staff F had been a very helpful nurse when she first started at the facility, but as time passed, she became less helpful. According to Staff B, she thought Staff F had been a little too harsh to residents at times. The CNA said she saw Staff F administering medication with a spoon a day or two before the incident. Staff B said it almost appeared that Staff F shoved the spoon in the resident's mouth. According to the CNA, it happened in the dining room. She could not remember which resident when asked, but knew it had not been Resident #1. The CNA stated she had not reported what she saw because other staff talked about it too, and she thought it was common knowledge. Initially, the CNA refused to name other staff that knew Staff F had been too rough when she shoved the spoon in a resident's mouth. The CNA said it could cause conflict with her coworkers if they knew she named them. Finally, the CNA divulged a coworker's name in confidence, but that person denied knowing anything about it. The CNA said if Staff F returned to work at their facility, she would probably keep her distance and continue to be suspicious of her.	F 223		

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F 223	Continued From page 7 Staff B stated she was a mandatory reporter, and would not hesitate to speak up if something did not set right with her. Staff B said there had never been any conflict between her and Staff F. Staff B said about a week before the incident she noticed a bruise about the size of a thumbprint on the right side of Resident 1 ' s chin. The CNA said she reported it to Staff G. She said the resident still had the bruise on the day of the incident, but it had changed in color and appearance by then. Staff B stated she had not noticed any other bruising. An Incident Witness Statement dated 11/26/16 and signed by Staff B, indicated she heard Staff F, say to Resident #1, " you can take this the easy way or the hard way " , and then heard the resident scream on the 6:00 a.m. to 2:00 p.m. shift on 11/26/16. An interview on 12/21/16 at 1:00 p.m. and subsequent interviews with Staff E (LPN) revealed that Staff B approached her at about 8:00 a.m. as she stood by the med cart on Redwood Boulevard near the common area. Staff E said Staff B asked her if she heard Resident #1 screaming. The LPN said she told Staff B she thought it was another resident that frequently screamed. Staff E stated she had never heard Resident #1 scream and he/she usually sat very quietly in the common area. The LPN said Staff B reported that Resident #1 screamed and she overheard Staff F tell Resident #1 "you can either take the meds the easy way or the hard way". After she heard of the allegation, Staff E said she checked and Resident #1 had been seated in the lounge area. The LPN said she wanted to ensure that the resident was not with Staff F. Staff E said she went and talked with Resident #1 who denied	F 223		

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F 223	Continued From page 8	F 223		

having pain or any recollection of anything happening to him/her. The resident seemed confused, but able to interact. When asked, Resident #1 could not recall whether or not he/she had taken their medication. According to Staff E, nothing seemed peculiar or out of the ordinary. Staff E said she visualized Staff F down Redwood Avenue hallway by the med cart. Staff E said she did not think Staff F suspected that anyone had made an allegation against her at that point. Staff E said she called the ADON (assistant director of nursing) downstairs shortly after 9:00 a.m. and reported what she knew. According to Staff E, the ADON told her to tell Staff F to go downstairs to the break room right away and wait for the DON. Staff E said she immediately approached Staff F at the med cart on Redwood Avenue near the common area and told her to go downstairs and wait for the DON. According to the LPN, Staff F asked what happened, and Staff E told her the DON would speak to her. Staff E said she kept Staff F within sight, until she entered the nurses' station where she put her paperwork away and collected her belongings. Staff E reported the DON called her shortly after to ensure that Resident #1 had been assessed and all the necessary paperwork had been completed. Staff E said she first noticed the bruising when she assessed the resident after the alleged incident. Without looking at the documentation, the LPN described the bruising she saw as yellowish/greenish bruising on both sides of Resident #1's mouth. Staff E also saw purplish reddish bruising to both forearms. When asked what she knew about Staff F' s character, Staff E stated that about a month or two before, she borrowed Staff F ' s blood pressure cuff with permission, and put it on the desk after using it. Staff E said about a half an hour later, Staff F saw

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F 223	Continued From page 9 her from a distance and called for her very loudly. The LPN said Staff F approached her and asked where her blood pressure cuff was. As Staff E went to get it, Staff F followed her and said, "don't ever leave it there again because it could get stolen. According to Staff E, Staff F said the prior in front of a CNA and multiple residents. Staff E said she did not appreciate the way Staff F spoke to her. Staff E said Staff F had worked at their facility as an agency nurse for many months, and they worked together quite a bit. The LPN stated that Staff F can be rude and short tempered and does not seem to work with well with others. Staff E stated she had not known of any "bad blood" between Staff F and Staff B, and had never heard either one of them say something bad about the other. Staff F did not believe that Staff B or Staff D were malicious. An Incident Witness Statement dated 11/26/16 and signed by Staff E, indicated Staff B, and Staff D reported Resident #1 had been yelling and then Staff F had been overheard telling the resident " You can either take them the easy way or the hard way " . An interview on 12/26/16 at 10:30 a.m. with Resident #1's daughter revealed she and her brother paid a random visit to their parent on 11/26/16. According to her, the resident sat in his/her wheelchair when they first arrived. The family member said she noticed bruising around her parent's mouth, which was more pronounced on the right side. The daughter said at first glance, she thought someone pinched the side of Resident #1's mouth. She described the bruise as purple/yellow and about 2 inches big. She described a smaller purple/yellow bruise on the left corner too, which was not as pronounced.	F 223		

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F 223	Continued From page 10 Once she got a closer look, she thought that someone's thumb made the larger bruise on the right side and fingers caused the bruise on the left side, as if someone squeezed her parent's mouth. She said her brother thought the same thing. The family member said she could not actually see an impression left by fingers. She described another bruise that she estimated as about a 3 inch elongated deep purple bruise on the right forearm. Resident #1's daughter said she and her brother thought that it was plausible that the bruise on the arm could have easily been caused during a transfer, but expressed much more concern about the bruising around the mouth. The daughter said those were the only bruises apparent to them because their father/mother had clothes on. She and her brother sat at a table in the dining room when a nurse asked to speak to them. The nurse told them another nurse had been overheard saying "we can either do this the easy way or the hard way". The family member said they did not tell the nurse about the bruises, and the nurse did not mention the bruises to them either. Resident #1's daughter said they initially did not do anything about it, but called back at 8:00 a.m. the following Monday to set up a meeting. After not hearing from the facility yet, she called back again about 10:00 a.m. and left a message that emphasized the urgency of the matter. The daughter said the DON finally called back about 11:00 a.m. She said the DON did not seem surprised about the bruising because she thought the DON had a little time to check into it before she called her back. Resident #1's daughter said they met with the facility on 11/30/16. She said they discussed the bruising and how it happened, but stated nobody really knew what happened. She said they told her an agency nurse got sent home. The family	F 223		

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F 223	Continued From page 11 told them they did not want that nurse taking care of their parent, which the facility assured them of. She said the facility said a spoon is used for medication administration and Resident #1 could have bitten down on it too hard. The daughter said she told them they could believe what they want, but she believed someone pinched her parent's mouth. The daughter said she could not see any way possible that it happened from biting down too hard on a spoon. The family member said they asked their parent what happened, but he/she is demented, and unreliable. A document titled ' Summary of Bruise of Unknown Origin on Resident #1 on 11/26/16 ' and authored by the DON concluded that after talking to staff, it seemed that Resident #1 very commonly becomes resistive and combative with cares, and when he/she is given medication or food/drink, clamped his/her mouth down. The DON continued by writing that the problem happened so frequently that staff does not think to document it because it is not abnormal for the resident to do it. The documentation continued to note that it appeared with the bruising that the resident could have a utensil/cup/end of a medicine cup placed in his/her mouth and clamped down on it hard causing the bruising to his/her mouth. An interview on 12/27/16 at 9:40 a.m. and subsequent interviews with the DON revealed that when she spoke to Staff F about the allegations against her, she denied the allegations and thought staff had ganged up on her. The DON stated a week or 2 before the incident, other CNAs told her they heard Staff F talking on the phone to a Doctor at shift change. According to the CNAs, Staff F asked them to be	F 223		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 12 quiet while she spoke to the Doctor. The CNAs told the DON they apparently had not gotten as quiet as she wanted them to, because Staff F slammed the phone down and broke it after she finished her conversation with the Doctor. When asked, the DON said Staff F denied that she slammed the phone down, and gave a completely different reason for how the phone got broken. The DON said she spoke with Staff F about conducting herself in an appropriate way. According to the DON, other employees had told her Staff F had a short fuse. Based on what she had heard, she thought Staff F was capable of what she had been accused of saying to Resident #1. The DON stated Resident #1's daughter reported the bruises on her parent's arms and face to Staff E on 11/26/16 at 10:30 a.m. when she came to visit. The DON said that although the bruises had not previously been documented, their investigation concluded that Staff B had reported them to Staff G on 11/21/16, and therefore they were not related to the alleged incident. The DON stated she first knew about Resident #1's bruises when Staff E told her about them when she arrived to investigate the incident on 11/26/16. Per the abuse task interview with the DON on 12/27/16 at 10:00 a.m., the facility investigates everything and reports anything suspicious in nature, like multiple bruises or injuries in abnormal places. An Incident Witness Statement from Staff B, related to unexplained bruising on the right side of Resident #1 ' s mouth had been dated 11/28/16. Staff B stated she noticed the bruise on the right side of Resident #1's lips while she assisted the resident to bed on 11/21/16. According to the CNA, she reported the bruise to Staff G, RN (Registered Nurse).	F 223		

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	165612	A. BUILDING _____ B. WING _____	C 01/12/2017

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F 223	Continued From page 13 An interview on 12/28/16 at 10:12 a.m. with Staff G, RN revealed that she worked at the facility through a staffing agency for about 5-6 weeks. She stated Staff B told her about the bruising around Resident #1's mouth about a month ago. The RN said she had only worked on Resident #1's hall for the 2nd or 3rd time. The RN said she had administered medication to Resident #1 in the common area, and recalled that she saw an approximately 2 cm circular shaped reddish bruise on the right corner of the resident's mouth. To her recollection, she believed she only saw a bruise on one side of the mouth. The RN said she believed she had noticed it the day before too. According to the RN, Staff F told her about it at shift change. The RN said the resident sat in the common area by the TV, when the RN asked Staff F about the redness and bruising around the resident's mouth. The RN stated Staff F told her "They already know about it ". Staff G said she assumed an incident report had been initiated. When asked what she would have done differently, the RN said she wished she would have checked to see if an incident report had been initiated. The RN said she did not want to make excuses, but it had only been about her 3rd day on that floor. She said she had worked at Trinity for about a week and a half before that and did not really know the names of the residents. Staff G said when she had charted, she noticed that nobody else had been charting about Resident #1's bruises. She stated she knew the facility expected her to report any injuries that she either saw or had been aware of. According to the RN, the bruise had been there for a while. She said it kept getting bigger and turned from red to purple. Staff G said the DON asked her to give a statement at a later date.	F 223		

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F 223	Continued From page 14 An Incident Witness Statement related to unexplained bruising on the right side of Resident #1 ' s mouth had been dated 11/28/16 and signed by Staff G. The document indicated Staff B reported to her on 11/21/16 that Resident #1 had a bruise on the mouth. According to the RN, she checked the bruise, and acknowledged she had already seen it and been informed about it by the previous nurse. Staff G stated she had the impression it had already been documented and the facility had also been informed. At the top of the document, someone wrote "CNA claims to have reported this bruise to nurse on 11/21/16 " . An interview on 12/21/16 at 12:30 p.m. with Staff H, LPN revealed her impression of Staff F. Although she thought highly of Staff F as a nurse, Staff H said Staff F had an unpredictable attitude. The LPN mentioned Staff F got upset once during report because the laptop had not been on top of the computer when she came in. Staff H said Staff F yelled at the other nurse and stormed out. According to Staff H, Staff F has slammed doors and broke a phone by slamming it down. Staff H said she reported Staff F for not being able to work well with others. An Incident Witness Statement dated 11/26/16 and signed by Staff F, indicated she went to Resident #1's room before 8:00 a.m. to administer medication. According to the LPN, Resident #1 struck out, like the combative behaviors he/she demonstrated every day. The LPN stated she told the resident to take her medication so they would make him/her feel better. Staff F indicated Resident #1 said, "What are you trying to do, kill me? " According to Staff F, Resident #1 took the medication, and then she	F 223		

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F 223	Continued From page 15 took the resident up to the TV room to wait for breakfast. The LPN said the resident had no complaints, and she had not been abusive to Resident #1 in any way. The LPN stated she would never physically or verbally abuse a resident or coworker. An interview on 12/27/16 at 9:56 a.m. and subsequent interviews with Staff F, LPN revealed that she had verbally reprimanded Staff B multiple times for excessive breaks, being unavailable to do her job and talking on her phone in a resident's room in front of the resident. Staff F said the incidents of disciplinary action occurred the same week that Staff B made allegations of abuse against her. Staff F reported Staff B tends had been rude and disrespectful to staff in front of residents and other staff. According to the LPN, if Staff B's behavior continued, she would have given her a written reprimand. Staff F said she knew of a recent incident where Staff B told Staff H off in front of residents. The LPN said she had never talked to the Administrator or the DON about the verbal reprimands that she gave Staff B. She stated she wanted to handle the situation by herself. According to Staff F, Staff B and Staff D were across the hall from Resident #1's room helping another resident. Staff F stated she had just gone in to Resident #1's room alone to administer medication and the door had been left open. The resident had sat in the wheelchair in his/her room. According to the LPN, Resident #1 can be difficult and combative at times, but taking the time to talk with him/her sometimes helps. The LPN said she crushed the medication and mixed them with applesauce to administer them. According to Staff F, Resident #1 kind of pushed her hand away the first time she attempted to spoon feed	F 223		

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F 223	Continued From page 16 the medication, but the resident willingly took them on the second attempt. Shortly after she was told by an LPN said she had to speak to the DON downstairs in a conference room. The DON said that Staff B told her she overheard the LPN say "You can either take these meds the easy way or the hard way ". Staff F said the news devastated her and she started crying. Staff F denied the allegations and said she had never been disciplined at Trinity before. She said they love her there, and she got along with Staff B and Staff D fine. The LPN stated that she did not like drama or issues, and hated to confront Staff B because she can be very dramatic at times. The LPN repeated she thought she got along with staff fine. When asked about conflict with other employees, Staff F mentioned a time when Staff E borrowed her blood pressure cuff. The LPN said Staff E said she would return it. About 20 minutes later, the LPN asked Staff E about the blood pressure cuff, and Staff F showed her where she left it. Staff F told Staff E to never to leave it unattended again because it could get stolen. The LPN said she had to meet with Staff E and the 2nd floor manager at Staff E' s request. Staff F said she had previously been investigated at a different facility. She thought it might have been in 2006, but could not be sure. She stated she put medication in a resident's hand, but then the resident said he/she did not want to take it. The LPN said when she tried to get the medication back; the resident said the LPN squeezed her hand. When asked about the bruising on Resident #1, the LPN said she saw slight discoloration around the resident's chin area on 11/26/16 when she administered the medication. The LPN stated that she had never seen the bruising around the resident's mouth before that day, and denied that she ever told	F 223		

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F 223	Continued From page 17 another nurse about the bruising during a previous shift report. When she had been informed that other people previously identified the bruising, Staff F stated her responsibilities include identifying and reporting injuries of unknown origin. The LPN stated she had already said she did not remember, which means she did not remember. Record review established Resident #1 lacked the ability to comprehend Staff F's remarks and a reasonable person would find the oral language used by Staff F on 11/16/16 as disparaging and derogatory. A reasonable person would likely view Staff F's language to Resident #1's on 11/26/16 as a threat of harm.	F 223		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 225		

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F 225	Continued From page 18 (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey	F 225		

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F 225	Continued From page 19 Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to investigate and report bruising of unknown origin for 1 out of 5 residents reviewed (Resident #1). The facility reported a census of 115 residents. Findings include: The MDS (Minimum Data Set) assessment dated 11/6/16 listed Resident #1's diagnoses as Non-Alzheimer's dementia, anxiety disorder and depression. The MDS indicated Resident #1 had long and short term memory problems, severely impaired cognition and required the extensive assistance of one staff for most activities of daily living. The care plan dated 11/16/16 directed staff to keep Resident #1 out of the reach of a specific resident, and for nurses to do a skin check every night at bed time until further notice. An Incident Witness Statement related to unexplained bruising on the right side of Resident #1's mouth had been dated 11/28/16 and signed by Staff G. The document indicated Staff B reported to her on 11/21/16 that Resident #1 had a bruise on the mouth. According to the RN, she checked the bruise, and acknowledged she had already seen it and been informed about it by the previous nurse. Staff G stated she had the impression it had already been documented and the facility had also been informed. At the top of the document, someone wrote " CNA claims to have reported this bruise to nurse on 11/21/16 " . Clinical record review revealed no investigation or	F 225		

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F 225	Continued From page 20 reporting of the bruise on 11/21/16, until 11/26/16, 5 days later.	F 225		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide complete and thorough incontinence care for 3 out of 5 residents reviewed in the sample (Residents #1, #2, #3). The facility reported a census of 115 residents. Findings included: 1. The MDS (Minimum Data Set) assessment dated 11/6/16 listed Resident #1's diagnoses as Non-Alzheimer's dementia and a history of falling. The MDS indicated Resident #1 had been frequently incontinent of bowel and bladder and required the extensive assistance of one staff for most activities of daily living. The care plan dated 11/16/16 directed staff to provide peri care related to bowel and bladder incontinence. On 12/21/2016 at 7:45 a.m. Staff A, CNA (Certified Nursing Assistant) provided incontinence care for Resident #1. Observation revealed the CNA removed an incontinence brief soiled with urine and feces as the resident lay in bed. Staff A cleansed the resident's peri area but	F 312		

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F 312	Continued From page 21 failed to cleanse the resident's groin and lower abdomen that had been covered by the soiled brief. The CNA rolled the resident on his/her side to cleanse the resident from behind. Staff A cleansed Resident #1's peri/rectal area, but failed to cleanse the resident's buttocks or hips. The CNA used the same gloved hands that wiped feces from the resident to apply a clean brief. 2. The MDS assessment dated 12/11/16 listed Resident #2's diagnoses as Alzheimer's disease and osteoarthritis. The MDS indicated Resident #2 had been incontinent of bowel and bladder and totally dependent on staff for all activities of daily living. The care plan dated 12/21/16 directed staff to provide peri care related to bowel and bladder incontinence. On 12/21/2016 at 7:22 a.m. Staff A, CNA and Staff B, CNA provided incontinence care for Resident #2. Observation revealed a urine soiled incontinence brief removed as the resident lay in bed. Though Staff B cleansed the resident's peri area, she failed to cleanse the groin and lower abdomen that had contact with the urine soiled brief. Staff then rolled the resident on his/her side to cleanse the resident from behind. Staff B wiped Resident #2's peri/rectal area and buttocks with a circular scrubbing motion without folding the wipe to expose a clean surface. 3. According to the MDS assessment dated 11/23/16 Resident #3's had a diagnosis of dementia. The MDS indicated Resident #3 had been frequently incontinent of bowel and bladder and totally dependent on staff for most activities of daily living.	F 312		

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F 312	Continued From page 22 The care plan dated 12/7/16 directed staff to provide peri care related to bowel and bladder incontinence. On 12/21/2016 at 9:35 a.m. observation revealed Staff B, CNA and Staff C, CNA as they provided incontinence care for Resident #3. Observation revealed Staff B and C removed a wet incontinence brief from the resident as the resident stood to transfer from the wheelchair to the toilet. While being toileted, the resident had a large bowel movement (BM). The resident stood again and remained standing while holding onto the grab bar as Staff B wiped feces from the resident's rectal area. Staff B then used another wipe to cleanse the peri/rectal area and buttocks with a circular scrubbing motion without folding the wipe to expose a clean surface. Neither Staff B nor Staff C provided incontinence care to the resident's genitalia, groin and lower abdomen that had been covered with the soiled brief. Pericare Skill Competency form dated 12/11/15, directed nursing staff to: Female. Spread genitalia and cleanse in a smooth downward motion using separate section of cloth with each motion. Male. With a clean area of the wash cloth wash genitalia in gentle downward motion with a clean area of the wash cloth. Turn the resident from side to side as needed to wash the abdomen, hips, thighs, legs and buttocks. When interview on 12/27/16 at 9:40 a.m. the Administrator stated she expected staff to provide incontinence care after every episode of incontinence. Staff are to use one wipe per swipe	F 312		

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F 312	Continued From page 23 or fold to a clean surface before the next swipe and cleanse the peri area from front to back and every area that had contact with the soiled brief.	F 312		

F000 This plan of correction constitutes our credible allegation of compliance. Date Completed: 02/10/17.

F223

Resident #1 was assessed and investigation was completed. Staff F an agency nurse was permanently removed from the facility on 11-26-16. Facility informed staffing agency of the incident. Completed: 02/10/17.

F225

Incident reports are part of the facility internal investigation process. Incident reports pertaining to "injury of unknown source" will be investigated to rule out abuse. Random audits will be completed weekly for one month. Continued monitoring will be a part of the facility QA process. Completed: 02/10/17.

F312

Education and Training was provided to CNA and CMA staff on incontinence care. Ongoing training will be provided semiannually. Continued monitoring will be a part of the facility QA process. Completed: 02/10/17.