STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 000	Initial Comments Complaint investigation #41696, #41739, #41859, #41869, #41874 and #41875 were completed on 9/25-28/17. No deficiencies were cited for complaint investigation #41696, #41739, #41859, and 41875. Deficiencies were cited for complaint investigation #41869 and #41874 under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		
N 401	1200-8-6-.04(1) Administration (1) The nursing home shall have a full-time (working at least 32 hours per week) administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents. This Rule is not met as evidenced by: Based on review of facility policy and procedure, medical record review, observation, and interview, the facility failed to be administered in a manner to attain or maintain the highest probable physical, mental, and physical well being by utilizing all its resources including the proper investigation process per the abuse/neglect policy and procedure, training, and education, on how to handle aggressive resident interactions during	N 401		

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N 401	Continued From page 1 care provided for 2of8 residents reviewed (#1, #2) creating a detriment to the health, safety, or welfare of the residents. The findings included: 1. Failure to provide services necessary to avoid physical harm or mental anguish for Resident #1 and Resident #2. Resident #1 suffered a fractured arm after NA (Nurse Aide) #2 intervened with physical force during perineal care being provided. Resident #2 potentially suffered from mental anguish and bruising due to LPN (licensed Practical Nurse) #4 intervening using physical force by holding her hands or arms while the resident was being aggressive and resistive to medication administration. 2. The facility failed to conduct a thorough investigation for the incident regarding Resident #2. Allegedly, LPN #4 held the resident's hands or arms while the resident was exhibiting aggressive and resistive behaviors during medication administration. The facility did not suspend the LPN during the investigation, did not interview residents and staff about their interactions with the LPN and did not provide education or training to staff after the incident on how to handle residents with aggressive and resistive resident behaviors. 3. The administrative staff of the facility failed to ensure their abuse/neglect policy was implemented related to identification of abuse/neglect, investigation of abuse/neglect and training and education offered. The Administrator failed to ensure a thorough investigation was conducted for an allegation of physical abuse by Resident #2. The Administrator, who served as the Abuse Coordinator, did not recognize the staff	N 401		

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N 401	Continued From page 2 members who had used physically forced interventions with Resident #1 and Resident #2 failed to provide the necessary services to prevent physical harm or mental anguish. Review of facility policy, Abuse, Neglect, Exploitation and Misappropriation of Property, dated 5/22/17 defined neglect as...failure to provide goods and services necessary to avoid physical harm, mental anguish or emotional distress...The Facility Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute...allegations of abuse...injuries of unknown source...exploitation...or...suspicious crime...The Facility Administrator may delegate some or all of the investigation to the Director of Nursing, Medical Director, or other subject matter experts as appropriate but the Facility Administrator retains the ultimate responsibility to oversee and complete the investigation and to draw conclusions regarding the nature of the incident...Under the heading...Investigation Guidelines...6. In cases of alleged resident abuse, the Director of Nursing or his/her designee will conduct interviews of interviewable residents on the resident's unit, or the entire Facility, as appropriate; and shall conduct an appropriate physical assessment of residents who are capable of being interviewed...10. The Facility Administrator will make reasonable efforts to determine the root cause of the alleged violation, and will implement corrective action consistent with the investigation findings, and take steps to eliminate any ongoing danger to the resident or residents." Interviewwith the Administrator on 9/27/17 at 9:30 AM in the conference room, confirmed the staff should have reviewed Resident #2's	N 401		

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N 401	Continued From page 3 previous skin sheets prior to the incident on 6/30/17 as a part of their investigation, however did not state if the staff received education or training on this issue. Continued interview confirmed they should have also interviewed other residents and staff regarding LPN #4 according to their policy. Further interview confirmed he was under the impression the investigation had been completed and since LPN #4 did not willfully harm the resident they did not suspend her. Interview with the Administrator confirmed he had talked with Resident #2's family and they were satisfied with her care and did not believe abuse occurred, however could not state how the bruises may have occurred. The Administrator confirmed the facility determined NA #2 did not willfully harm Resident #1 during the incident on 6/24/17 and she was suspended and an investigation was completed. The Administrator confirmed the NAs knew they should have handled the situation differently by stepping back, letting the resident calm down and re-approaching. Interview with the Medical Director on 9/28/17 at 11:05 AM in the conference room, confirmed she did not review the investigation regarding the abuse allegation made by Resident #2 on 6/30/17. The Medical Director confirmed the bruises on Resident #2 were not documented beforehand so they were not old bruises, they were new bruises and if a resident described an incident or person as abusive, it needed to be investigated. Continued interview with the Medical Director confirmed the facility should have followed all the steps of the investigative process including suspending the accused nurse. The Medical Director confirmed she reviewed the investigation regarding the incident with Resident #1 on 6/24/17 and if a resident had	N 401		

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N 401	Continued From page 4 aggressive/combative behaviors during care she expected the staff to call the Charge Nurse and not force the resident to do anything. She confirmed in Resident #1's case a fracture can happen very easily and if NA #2 had not touched her, her arm would not have been broken and if the resident was resisting that much she should have stopped care completely. The Medical Director confirmed NA #2 did not use common sense while providing care with Resident #1 and her actions could cause PTSD (Post Traumatice Stress Disorder) type symptoms.	N 401		
N1207	1200-8-6-.12(1)(g) Resident Rights (1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights: (g) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified immediately as required in T.C.A. §71-6-103; This Rule is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to be free from mental and physical abuse by ensuring to attain or maintain the highest probable physical, mental, and physical well-being by ensuring 2 of 8	N1207		

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N1207	Continued From page 5 residents reviewed (#1, #2) were free from neglect creating a detriment to the health, safety, or welfare of the residents. The findings included: Review of facility policy, Abuse, Neglect, Exploitation and Misappropriation of Property, dated 5/22/17 revealed " ...failure to provide goods and services necessary to avoid physical harm, mental anguish or emotional distress...The Facility Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute allegations of abuse...injuries of unknown source...exploitation...or suspicious crime...The Facility Administrator may delegate some or all of the investigation to the Director of Nursing [DON], Medical Director, or other subject matter experts as appropriate but the Facility Administrator retains the ultimate responsibility to oversee and complete the investigation and to draw conclusions regarding the nature of the incident...6. In cases of alleged resident abuse, the Director of Nursing or his/her designee will conduct interviews of interviewable residents on the resident's unit, or the entire Facility, as appropriate; and shall conduct an appropriate physical assessment of residents who are incapable of being interviewed...10. The Facility Administrator will make reasonable efforts to determine the root cause of the alleged violation, and will implement corrective action consistent with the investigation findings, and take steps to eliminate any ongoing danger to the resident or residents..." Medical record review revealed Resident #1 was admitted to the facility on 4/15/10 with diagnoses including Type II Diabetes, Dementia, Glaucoma,	N1207		

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N1207	Continued From page 6 Osteopenia and Muscle Weakness. Medical record review of a Nursing Assessment dated 5/19/17, revealed Resident #1 required extensive assistance of 1 staff for hygiene, and Activities of Daily Living (ADL). Continued review of the Nursing Assessment revealed Resident #1 was severely cognitively impaired. Further review of the Nursing Assessment revealed Resident #1 had not exhibited any behaviors. Medical record review of Resident #1's Care Plan, dated 6/6/17, revealed there was no Care Plan for agitation, aggressiveness or combative behaviors during personal perineal care. Continued review revealed there were no individualized interventions in place to address these concerns. Review of a Resident Investigative Tool for Allegation of Abuse, Neglect or Misappropriation of Property dated 6/28/17 revealed Resident #1 suffered a distal humerus (long bone of the upper arm) fracture due to physical contact with a Nurse Aide (NA) #2. Continued review revealed the "...resident was displaying agitation while staff were attempting to provide personal care...Alleged employee was attempting to redirect resident and prevent any further agitation while care could be completed." Further review of the Resident Investigative Tool revealed "...resident was displaying agitation while providing care...She became restless and began swinging her arm at the Nursing Assistant (NA #2)...(NA #2) redirected the resident by placing residents hand down by her side...Due to her diagnosis of osteopenia, resident sustained a distal humerus fracture...This allegation was not substantiated because there was no willful intent to harm the resident." The Assistant Administrator	N1207		

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N1207	Continued From page 7 went on to write the facility "...educated all clinical staff to step away from residents when they become agitated during care." Medical record review of General Emergency Department Discharge Instructions dated 6/24/17 revealed Resident #1 had a fracture of the humerus and was given a splint to use. Resident #1 was also written a prescription for Norco (pain medication) 5 milligrams (mg). Review of a Witness Statement taken by the Administrator on 6/24/17 at 1:15 PM, from NA #1 revealed 2 NAs were assisting Resident #1 with perineal care. Continued review revealed, " ...NA [#1] said NA [#2] got a towel trying to clean her and [Resident #1] started swinging [and] flailing arms not making contact...NA [#2] stepped back and stated don't be hitting me...Then grabbed patient's arms [and] held [them] down on [the] bed with the towel in the other hand trying to clean her...Grabbed [her] arm too hard [and the] arm snapped...Looked like bone was going to come through [resident's] arm. Force held arm down and bone popped...Patient screamed said you broke my arm. I commented [NA #2] you broke her arm..." Review of a Witness Statement dated 6/24/17 written by NA #2 revealed, "...I attempted to provide morning perineal care for [Resident #1] but she wouldn't let me clean her because she was swinging her arms...I went to get the assistance of [NA #1] but the resident was still swinging her arms so hard, she almost hit my face because I was standing at the head of the bed so she can't hit me but she was swinging so hard that I proceed [ed] to hold her hand when I heard a crack..."	N1207		

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N1207	Continued From page 8 Review of a Witness Statement dated 6/24/17 written by NA #1 revealed, "...[NA #2] came to get her for assistance with the Resident [#1] morning perineal care...[Resident] started swinging her arm and trying to hit staff...don't hit me, then grabbed [the] resident's arm and held it down, I heard her bone crack..." Review of a Witness Statement dated 6/24/17 written by Licensed Practical Nurse (LPN #3) revealed, "...[NA #2] came and asked her to come to Resident [#1's] room quickly...She said NA [#2] said she had broken Resident [#1's] arm...[LPN #3] asked [NA #2] how she know [knew] she had broken her arm and [NA #2] stated the resident was swinging her arms and she put her arm up to block it and she heard it crack...[LPN #3] looked at Resident [#1's] arm and could tell it was broken..." Interview with NA #1 on 9/26/17 at 9:30 AM in the conference room revealed Resident #1 could be "very feisty" and did not like to be changed during perineal care. NA #1 stated Resident #1 would become aggressive at times, trying to hit or kick staff. NA #1 stated when the resident became agitated she would re-approach, go get help from another NA or let the nurse know she could not complete personal care for the resident. NA #1 continued to state on 6/24/17 NA #2 came to get her to help provide perineal care for Resident [#1] because she was agitated and had bowel movement (BM) all over her. NA #1 continued indicating the resident had BM on her hands and was swinging her arms around in agitation, but she was not involved in the actual perineal care but was trying to talk to the resident and calm her down. She said she suggested to NA #2 they take a break and re-approach the resident but [NA #2] continued doing care. NA #1 said [NA #2] blocked	N1207		

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N1207	Continued From page 9	N1207		

the resident from touching her face and held her arm down on the bed when she heard a loud popping sound. NA #1 said she told the other [NA] that she broke the resident's arm and to go get the nurse. NA #1 said she worked with [NA #2] for a long time and did not think she intentionally hurt the resident. NA #1 said [NA #2] had a "we're going to do it now, want to get your work done" type of attitude.

Interview with NA #2 on 9/26/17 at 10:00 AM, in the conference room revealed she had worked with Resident #1 for many years and Resident #1 had dementia but would be more agreeable to care if you gave her coffee. NA #2 stated on 6/24/17 she attempted to provide perineal care for Resident [#1] but she became agitated and she went to get help from [NA #1] who came into the resident's room to assist her. NA #2 said the resident was swinging her arms and had BM on her hands when she swung her arm towards NA [#2's] face. She continued to state she reacted and it all happened so quickly but she blocked her arm and put the resident's arm down by her side when they heard a crack.

Interview with Licensed Practical Nurse (LPN #1) on 9/26/17 at 11:20 AM in the 300 Hall manager's office revealed LPN #1 served as the Unit Manager for the 300 Hall and stated Resident [#1] was a confused, pleasant lady who, at times, was resistive to perineal care and showers. He said Resident #1 did not have any specific triggers and that it varied from day to day whether the resident would become agitated or aggressive during personal care. Regarding the incident on 6/24/17 LPN #1 indicated he would expect staff to always back away and re-approach a resident who was resisting care and having combative behaviors. He indicated he would expect staff to

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N1207	Continued From page 10 back away from residents before it came to the point where they had to put their hands on them. He stated, "we have a lot of psych and dementia training." Interview with the Behavior Health Manager (BHM) on 9/26/17 at 2:30 PM in the conference room revealed she would expect staff to respect resident's rights without neglecting them. Continued interview revealed if a resident exhibited aggressive behaviors during care she would expect them to step away and not expect staff to physically touch the resident to intervene unless a resident was falling or about to hurt themselves. The BHM stated she did not have a Behavior Health Plan for Resident #1 and did not recall a time where staff approached her for suggestions or education for Resident #1. Interview with LPN #3 by telephone on 9/26/17 at 4:10 PM revealed on 6/24/17 she was notified by NA #2 she had broken Resident #1's arm during personal care. LPN #3 said she assessed the resident and called the Unit Manager. Continued interview revealed Resident #1 could be resistive to care, very fragile and if the resident was swinging her arms around she would expect the NA to step back, let her calm down, re-approach and get a nurse if needed. Interview with the Administrator on 9/26/17 at 3:10 PM in the conference room, revealed the facility determined NA #2 did not willfully harm Resident #1 during the incident on 6/24/17. Continued interview confirmed she was suspended and an investigation was completed. Further interview revealed the Administrator confirmed there should be a Care Plan in place to address Resident #1's combative behaviors during care and the individualized interventions	N1207		

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N1207	Continued From page 11 the staff uses for her. He confirmed the NAs knew they should have handled the situation differently by stepping back, letting the resident calm down and reapproaching. Interview with the Medical Director on 9/28/17 at 11:05 AM in the conference room, confirmed she reviewed the investigation regarding the incident with Resident #1 on 6/24/17 and stated if a resident had combative behaviors during care she expected the staff to call the charge nurse and not force the resident to do anything. She further confirmed in Resident #1's case a fracture can happen very easily and if NA #2 had not touched her, her arm would not have [been] broken. Continued interview confirmed if the resident was resisting that much she could have stopped care completely. The Medical Director confirmed NA #2 did not use common sense while providing care with Resident #1 and her actions could cause PTSD (Post Traumatic Stress Disorder) type symptoms. Medical record review revealed Resident #2 was admitted to the facility on 8/4/15 with diagnoses including Dementia, Depression, Muscle Weakness and Heart Disease. Medical record review of the Nursing Assessment dated 5/3/17, revealed Resident #2 the resident was severely cognitively impaired. Continued review of the Nursing Assessemnt revealed the resident had not exhibited any behaviors. Medical record review of Resident #2's Care Plan, dated 5/24/17 indicated Resident #2 had a "mood" Care Plan due to "increased confusion and agitation" as evidenced by "resisting care/combative with staff when attempting to perform care." Resident #2 also had a "behavior"	N1207		

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N1207	Continued From page 12 Care Plan due to "being combative with staff while performing care at times, urinating in room, moving belongings from room into hallway and refuses medications at times." Two of the approaches listed on the Care Plan that staff were to use included "...provide non-confrontational environment for care..." and "...reapproach resident later, when she becomes agitated..." Continued medical record review of Resident #2's Care Plan dated 6/30/17, revealed Resident #2 had bruises on her bilateral forearms and top of hands. Medical record review of a Weekly Skin Assessment dated 6/29/17, revealed Resident #2 had "reddened intact skin" on her sacrum. Continued review revealed no other skin issues were noted on the assessment. Medical record review of a Daily Skilled Nurses Note dated 6/29/17 at 11:50 PM revealed Resident #1 refused all her nighttime medications. Continued review revealed the note did not indicate Resident #2 had any aggressive behaviors or that LPN #4 had any contact with the resident during her shift. Review of a Resident Investigative Tool for Allegation of Abuse, Neglect or Misappropriation of Resident Property with an incomplete date of "7/", revealed Resident #2 made an allegation of abuse against LPN #4 on 6/30/17 stating "...LPN [#4] came into her room to get her to take 7 pills and she refused because she had her own Dr. [doctor] and reported the nurse cut her arms to pieces with her claws..." Continued review of the tool revealed Resident #2 had a history of bruising and "resident arms, skin fragile and	N1207		

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N1207	Continued From page 13	N1207		

could be easily bruised by minimal contact." Further review revealed Resident #2 "had episode slapping meds [medications] out of [the] nurse hands...Nurse did hold hand to avoid being hit while getting meds off bed." The facility found there was no incident of harm and the resident bruises easily.

Review of a Witness Statement dated 6/30/17, written by NA #3 indicated Resident #2 called the NA between 9 AM and 10 AM and stated, "look what she did to me" while showing her both of her arms.

Review of a Witness Statement dated 6/30/17, written by LPN #2 who served as the Unit Manager for the 200 Hall revealed a NA came to her and reported, "someone was rough." LPN #3 took Resident #2 to her room to complete a skin assessment and interview. Resident #2 stated to LPN #3 on 6/29/17, "a nurse came into her room and try [tried] to get her to take 7 pills and that she refused because she had her own Dr. and then stated the nurse cut her arms to pieces with her claws trying to get her to take meds."

Review of a Witness Statement dated 6/30/17, written by LPN #4 revealed "she went in to give her the meds and she slapped the meds off my hand stating she didn't want it. I then held her hands and scooped up the crushed meds off her bed."

Review of the C.N.A. (Certified Nursing Assistant) Skin Care Alert form dated 6/30/17, completed by LPN #2 revealed Resident #2 had 4 areas on her left arm and hand and 3 areas on her right arm and hand with the words "multiple discolorations" written in.

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N1207	Continued From page 14 Review of the facility investigation revealed there were 2 resident interviews as a part of the investigation and 5 staff interviews regarding Resident #2 and whether she was confused, had behaviors, if she was assigned to them and if they noticed any bruising on her. Review of one of the staff interviews dated 6/30/17, written by LPN #4 with the questions "Did you notice any bruising on her legs?" revealed the response, "her arms was what I noticed (bruises/dark spots)." Review of the facility handwritten notes provided by the Assistant Administrator revealed on 6/30/17 at 2 PM an allegation of abuse was reported regarding Resident #2. Continued review revealed Resident #2 stated "...that nurse came in last night to give medication, but she refused it...The nurse allegedly cut her arms with her claws...She didn't take her medication but then stated that she did take her medicine because it was the only way that she could stop what the nurse was doing. States she tried to call for help...does have bruising to bilateral forearms/discolorations/dark spots?" The Assistant Administrator took a statement from Resident #2 that stated "...she grabbed her arms when she refused her meds...Felt like she was cutting her arms with a knife...she was in bed and trying to fight her off and she finally left the room...she tried to call for help...Described the nurse as having black frizzy hair with some red...she [nurse] tried to give her 9 pills but she wasn't going to take them...she didn't tell anyone during the night because they cut her communication off." Continued review revealed the notes also describe information taken from the Psych Services provider revealed APN [Advanced Practice Nurse] #1 reported the	N1207		

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N1207	Continued From page 15 resident told her "nurse came in and gave her 7 pills and told her that the Dr. had ordered them...the resident slapped them away and grabbed her with her claws and she tried to call for help...she grabbed and twisted her arms." Review of a Social Service Note dated 6/30/17 at 5:41 PM revealed the Social Service Worker (SSW #1) "spoke with resident as she was eating in the unit dayroom and noticed bruises on the resident's arm and asked the resident what happened. Resident #1 began the story of how she refused medications but the nurse made her take them anyway. SSW asked the resident why she did not want to take her medications and the resident responded she only takes medications from her doctor whom she trusts." Medical record review of a Behavioral Medicine/Progress Note dated 6/30/17, written by APN #1 revealed during an interview Resident #2 "appeared to acknowledge her confusion as she struggled to find words and organize her thoughts." APN #1 wrote Resident #2 said "last PM she had gone to her room for the evening...The black lady that checks on me came in to give me 7 pills and I refused to take them swatting her hand away...She grabbed my arm and twisted it...She pointed to open areas and said those were her claws...she struggled staying awake to watch the black lady that kept checking on her...As above, pt struggled very hard to express her words, was confused..At times, appeared to want to become tearful...The last thing she told this provider was if it can happen to me then it can happen to someone else..." Review of a facility Coaching & (and) Counseling Session form dated 6/30/17, revealed LPN #4 was counseled regarding failure to complete	N1207		

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N1207	Continued From page 16 proper paperwork regarding medication administration. Review of the Working Schedule for LPN #4 revealed she worked on 6/30/17 clocking in at 6:35 PM and out at 7:22 a.m. LPN #4 worked on B2 which was the 200 Hall with Resident #2. Interview with SSW #1 on 9/26/17 at 9:05 AM in the conference room revealed on 6/30/17, Resident #2 was unable to recall any details about how she got the bruises on her arms. She stated Resident #2 refused medications frequently and was unaware if Resident #2 had ever made an allegation against a Nurse in the past. Interview with LPN #2 on 9/27/17 at 8:40 AM in the Manager's office who served as the Unit Manager for the 200 Hall revealed on 6/30/17, Resident #2 had discolorations on her arms but not bruises. She stated they were purple in color but they were not bruises and she did not discuss the incident with LPN #4 who was accused of abuse by the resident. She further stated NA #4 came to her and told her Resident #2 said someone grabbed her arms. LPN #2 said she did the skin assessment and interviewed the resident and passed the information on to the Administrative staff. Interview with the Assistant Administrator on 9/27/17 at 8:50 AM in the conference room, revealed she interviewed LPN #4 and she stated Resident #2 smacked the medications out of her hand. Continued interview revealed the Assistant Administrator questioned LPN #4 about her statement and she stated LPN #4 told her she put the resident's hand down in her lap and reassured her. Further interview confirmed the	N1207		

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N1207	Continued From page 17 Assistant Administrator did not interview NA #4 who Resident #2 told first about the incident. Further interview with the Assistant Administrator revealed the resident always had discolorations and age spots on her skin. Interview with the Assistant Director of Nursing #1 (ADON) on 9/27/17 at 9:05 AM in the Manager's office, revealed she sat in on the interview between the Assistant Administrator and LPN #4. Interview revealed ADON #1 confirmed LPN #4 stated in the inerview she held Resident #2's hands in her hand while she picked up the medication. Continued interview revealed ADON #1 stated when she reviewed the skin assessment and it said multiple discolorations on her arms she would think "bruising, a purplish color, maybe age spots, may be old" but I would need more detail. She further stated since the skin assessment from 6/29/17 and 6/30/17 do not match, it would make her want to investigate further. Further interview with ADON #1 confirmed LPN #4 could have done something differently so she would not have had physical contact with the resident. She confirmed LPN #4 could have stayed in the room but backed away from the resident so she would calm down or pulled the call light so someone would come and help her. Continued interview confirmed LPN #4 did not have to physically intervene with the resident and if Resident #2 had discoloration on her arms all the time, she would expect to see it reflected in the skin assessments. Interview with the Administrator on 9/27/17 at 9:30 AM confirmed the staff should have reviewed Resident #2's previous skin sheets prior to the incident on 6/30/17 as a part of their investigation. He confirmed they should have also interviewed other staff regarding LPN #4.	N1207		

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N1207	Continued From page 18 Continued interview with the Administrator confirmed he believed the investigation was complete and LPN #4 did not willfully harm the resident so they did not suspend her and he had talked with Resident #2's family and they were satisfied with her care however he could not state where they thought the bruises came from. Further interview revealed the Administrator was unsure if the family was in the facility on 6/29/17 or if they had seen the resident on the evening of 6/29/17. Interview with the Administrator revealed it was more likely the skin assessment prior to the incident was inaccurate because the night shift nurse who completed it may not have seen the resident. Interview via phone with LPN #4 on 9/27/17 at 1:30 PM, revealed on 6/30/17 she went into Resident #2's room to give her medication. Continued interview revealed the resident slapped the medications out of her hand and was swinging her arms trying to hit her. Further interview revealed LPN #4 stated she held the resident's hands with one hand and picked up the medication with her other hand. Interview with LPN #4 revealed the resident always had discolorations on her hands and arms and she did not use any physical force on Resident #2. Interview with the Medical Director on 9/28/17 at 11:05 AM in the conference room, confirmed she did not review the investigation regarding the abuse allegation made by Resident #2 on 6/30/17. Continued interview revealed the Medical Director confirmed the bruises on Resident #2's arms wasn't documented beforehand so they were not old bruises, they were new ones and stated if a resident describes an incident or person as abusive, it needed to be investigated thoroughly. Further interview	N1207		

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N1207	Continued From page 19 confirmed the facility should have followed all the steps of the investigative process including suspending the accused nurse per facility policy. Interview with APN #1 on 9/28/17 at 1:10 PM in the conference room, confirmed after reading her documentation from 6/30/17 on Resident #2 she was clearly distraught about something that had happened. APN #1 stated she communicated this information to the Assistant Administrator and the DON that day. Interview with the Assistant Administrator on 9/28/17 at 1:30 PM in the conference room, confirmed the investigation was completed on 6/30/17 and she cleared LPN #4 to come back to work that night to the same assignment. Continued interview confirmed she did not know if the investigative tool needed to be filled out and dated with the date the investigation was completed. Further interview confirmed the Assistant Administrator did not document an interview with LPN #4 during the investigation and did not document where she cleared her to work that night on the same assignment. Interview with the DON on 9/28/17 at 2:10 PM revealed the DON was not employed with the facility in June 2017 and stated if residents have combative behaviors she expects staff to always stop what they're doing, ensure the residents are safe, call for help, re-approach and let the nurse know. Continued interview confirmed if the staff are unable to complete care or give medication then they should document it. Further interview confirmed staff should not have unnecessary physical contact with residents and if a staff person was described in the allegation they should be suspended for the course of the investigation. The DON confirmed if staff were	N1207		

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N1207	Continued From page 20 accused of abuse and the allegation was unsubstantiated, staff should still receive education and training regarding the issue.	N1207		