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9/11/2014 Survey Tag 1209 Detail for:
COLOROW CARE CENTER
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Survey Date: 9/11/2014

Regulation Number:1209

Regulation Title: Right to be free from Abuse

Regulation Description: The. right to be free from mental and physical abuse and from physical and chemical restraints, except those restraints initiated through the. judgment of professional staff for a specified and limited period of time or on the written authorization of a physician;

Surveyor Findings:

The. right to be free from mental and physical abuse and from physical and chemical restraints, except those restraints initiated through the. judgment of professional staff for a specified and limited period of time or on the written authorization of a physician;

Based on record review and staff interview, the facility failed to ensure three of 10 sample residents (#7, #8 and #9) were free from abuse. Specifically, the facility failed to adequately screen staff prior to hire, investigate, report, and protect residents from abuse.

Two staff members reported an improper transfer, mistreatment and verbal abuse by certified nurse aide (CNA) #1 involving resident #9 on 6/4/14. Two other staff members reported resident #7 had complaints about mistreatment by CNA #1 in early to mid August. On 8/15/14, resident #8 sustained a fractured hip, skin tears, hematoma/bruising and pain after an improper transfer by CNA #1.

The facility failed to adequately investigate allegations of abuse and injuries of unknown origin involving CNA #1 and residents #7, #8 and #9, failed to report abuse allegations and injuries of unknown origin to the proper authorities including the police department, and failed to protect residents from abuse during and after facility investigations.

CNA #1 continued to work on a hall where most of the residents were unable to speak for or defend themselves; the facility did not remove CNA #1 from resident care until after being notified by the district attorney that CNA #1 was under investigation regarding resident #8.

Cross-reference S504, Accident Prevention, regarding improper transfer resulting in injury.

Findings:

I. Failure to adequately investigate allegations of abuse and injuries to resident #8

A. Facility Expectations

The facility corporate "Abuse Policy," dated 8/15/14, assigned accountability to the NHA and responsibility to the social services director (SSD), director of nursing (DON) and nursing department, and provided in pertinent part:
-"Employees have a unique position of trust with vulnerable residents."
-"Residents must not be subjected to abuse by anyone."
-"Identification of abuse shall be the responsibility of every employee."
-"Staff is encouraged to talk with Guides, Nurses, Social Services, or the Administrator about residents or situations they find difficult to manage, stressful, or frustrating."
-"Residents at risk for abusive situations are identified and appropriate care plans are developed."
-"A Concern/Complaint Report form is reviewed at orientation with all staff, for use in reporting any concerns or complaints to the Administrator. The Administrator or designee maintains a file showing community action on each concern or complaint."
-"The community will take action when identifying events such as suspicious bruising or skin tears occur. Occurrences, patterns and trends that may constitute abuse will be identified and appropriate action taken."
-"The Police Department is notified in all cases or suspected cases of physical abuse, sexual abuse or misappropriation of resident property."
-"In addition to an investigation by the Police Department, the community conducts an internal investigation. That investigation includes interviewing any staff members, residents, or family members who may have knowledge of the incident."
-"When an employee of the community abuses or is suspected of abuse of a resident, the employee is placed on immediate suspension while the matter is under investigation. When the investigation shows that abuse did not occur, the employee is reinstated. A report of those findings will be available to any persons or agencies notified of the allegations as required."
-"When the investigation shows violation of a policy other than abuse, the employee will be subject to disciplinary action appropriate to the violation."
-"Screening: All employees shall be screened with background screening. In addition, employee behavior shall be assessed at the time of employment, and 90 days following employment."
-"If abuse happens: 1) Separate the assailant from the victim; 2) Isolate the assailant to protect others; 3) Assess and treat the victim; 4) Notify the Administrator on duty."

B. Resident #8

1. Closed record review revealed resident #8, 91 years old, was admitted to the facility on 11/9/12 with diagnoses including Alzheimer's disease, dementia without behavior disturbance, muscle weakness generalized, lack of coordination, generalized pain, failure to thrive, abdominal pain, hypothyroidism and insomnia.

She was a hospice patient with a primary diagnosis of dementia, according to her 7/8/14 care plan.

2. Resident Status

According to assessments dated 6/30/14, resident #8 had severe cognitive impairment. No behavioral symptoms were documented. She required extensive, two-plus person assistance with transfers. Her balance was unsteady, and she was only able to stabilize with staff assistance. She used a wheelchair

for mobility. She was 58 inches tall and weighed 91 pounds.

The care plan dated 7/8/14 identified behavioral symptoms "as evidenced by her refusing personal care assistance, yelling, cursing, combative with others, restlessness, kicking out and biting, spitting at others and increased physical aggression during moments of frustration when she is unable to clearly communicate her wants, wishes and needs with others or when others ask her complicated questions she cannot answer."

Psychosocial well-being was also identified in the care plan. Interventions included:
-"Always approach (resident) in a calm and friendly manner. When speaking with (resident), get down to her level and talk at her, making eye contact during the conversation. Ask simple yes and no questions."
-"Explain all procedures to (resident) before starting and allow the resident to adjust to changes."
-"(Resident's) triggers for her behavioral symptoms involve loud and noisy areas, moments when (resident) is unable to understand what is being asked of her. The resident's behavior is de-escalated by 1:1 conversations, redirection, toileting frequently, offer foods and fluids and participating in group activities."
-"Allow (resident) time to answer questions and to verbalize feelings, perceptions and fears."
-"Encourage participation from resident who depends on others to make own decisions."
-"Provide opportunities for the resident and family to participate in care."
-"When conflict arises, remove residents to a calm, safe environment to allow to vent/share feelings."

The resident's eight-page care plan included activities, hypnotic medication use, name preference, behavioral symptoms, discharge planning, psychotropic medication use, psychosocial well-being, and a diagnosis list.

Although she was noted as having behavioral symptoms directed toward others, she had no care plan for risk for abusive situations. (See facility expectations above.)

3. Transfer with Injuries 8/15/14

Facility record review (nurses' notes 8/15 - 8/21/14) revealed the resident sustained a hematoma on her forehead and two skin tears following a one-person transfer 8/15/14. During change of her incontinence brief after the transfer, the resident yelled out in pain and, upon subsequent assessment, she was unable to flex her left leg. X-rays were obtained and revealed a comminuted (broken, splintered, or crushed into a number of pieces) fracture of the left femoral neck and intertrochanteric fracture.

Following hospital evaluation, the resident returned to the facility. The resident continued to experience pain and additional bruising was discovered. On 8/21/14, the resident was transferred to an inpatient hospice facility for pain management.

Cross reference F323 for further details.

4. Hospice Medical Record

-On 8/21/14 at 1:45 p.m., hospice clinician narrative notes documented in pertinent part, "Phone call

with RN CM (registered nurse case manager name). She reports the 'story' is that an 'incident' occurred Friday at the (long term care) facility. An xray on Saturday showed a fractured hip. (The local hospital) on Saturday night identified a hematoma to the head. Xrays yesterday showed likely fractures to the elbow and knee. Per RN CM, the facility reports (resident) attempted to strike a staff member who ducked, and (resident) struck herself causing the hematoma. Then, she suffered the fractures when transferring her to her bed."

"(RN CM) reports the facility investigated and found no fault on the CNA's part and closed the investigation. (RN CM) reports (local agency representatives were notified and) will be investigating. A report to APS (Adult Protective Services) is required by law when injuries occur due to possible abuse or neglect in caregiving. SW (social worker) discussed that the injuries sound extreme for the 'story' that (long term care facility) has reported. This is the first this SW has learned of the 'story.'"

-Hospice physician notes dated 8/21/14 at 1:30 p.m. in pertinent part stated, "Transfers (to hospice inpatient facility) today with pain issues related to left femur fracture. I am told by staff that authorities are involved in this case due to apparent concerns of abuse ..."

"Of note, xrays are now available and show no new fractures; does have displaced femoral neck fracture on L ... Ongoing signs of pain present. Granddaughter at bedside ... Bedbound frail appearing elderly female lying in bed ... Yellow-green bruising on L forehead with hematoma evident ... Grimaces and moans with light palpation of L hip area. No observed signs of pain with palpation L shoulder, L arm, L forearm, L elbow, L knee, L foot ... Temporal muscle wasting, overall lack of muscle tone evident, cachexia ... Full skin assessment not done at time of MD rounds due to obvious patient discomfort with movement ... Please see Xray reading from (mobile Xray) for full report: 8/16/14: Left hip fracture (report states displaced fracture of the left femoral neck). 8/20/14: L elbow: negative study. L knee: moderate degenerative arthritis. L shoulder: negative for acute fracture or dislocation, moderate degenerative arthritis, previous surgery and old healed fracture..."

"Assessment/Plan: 91 year old female with Alzheimer's type dementia, failure to thrive; now with L hip fracture and bruising from traumatic injury (etiology not known to me and is reported to be under investigation, SW to verify that appropriate entities are aware). Patient transferred to (hospice inpatient care) status for pain management; granddaughter at bedside confirms goals are for comfort. Pain, severe, somatic related to L hip fracture, requiring parenteral opioids for management. Overall prognosis poor. Symptoms management: Morphine (dosage) prn pain/dyspnea/or prior to repositioning, Lorazepam (dosage) prn anxiety/nausea, Haloperidol (dosage) prn nausea/agitation..."

-On 8/22/14 at 12 noon, a hospice post mortem note documented verification of the resident's death. The coroner was notified due to "suspicious death," and it was noted an autopsy would be performed.

(As of 9/22/14, the coroner/autopsy report and police investigative findings were pending and unavailable.)

5. Facility investigation of 8/15/14 incident

The investigative report, dated 8/21/14, was provided by the nursing home administrator (NHA) on 8/25/14. It documented in pertinent part:

"At approximately 9:30AM on Saturday morning 8/16/14 I was called regarding a possible abuse situation involving one of the residents of (the facility, resident #8), and an aide (CNA #1). This incident occurred approximately 7:00 PM the night before. Since this was a potential abuse situation, an investigation was initiated immediately by myself and the Director of Nursing (DON). The following is the result of this investigation."

"According to the testimonies and interviews with every staff member working with the resident in question at the time of the incident the following is the chain of events."

"(Resident #8) was observed the day of 8/15/14 to be agitated with staff throughout the day, particularly in the evening. Due to her heightened agitation the staff were attempting to calm her down before attempting to settle her down into bed for the night. Finally she seemed to be calm and was appearing to doze off in her wheelchair so one of the aides (CNA #1) working the West hall decided to go ahead and attempt to get her into bed."

"While in the process of transferring (resident #8) from her wheelchair to her bed, she immediately became elevated and agitated with the aide. As she stood in front of her wheelchair with (CNA #1's) hands around her waist, she doubled up her fist and attempted to strike (CNA #1) with her fist. While attempting to duck out of the way, (CNA #1) inadvertently pulled (the resident) toward him. In doing so the hand which was in the process of attempting to strike (CNA #1) was also pulled forward. This caused her to strike herself in the left forehead with the doubled up fist. (CNA #1) then fearing further injury to (the resident) helped her into her bed and called to the nurse and other aides on the hallway. During the transfer into bed she was still agitated and resistant to cares but ultimately was placed into bed in a safe position."

"The nurse working that hall, (LPN #1), then came into the room along with another aide on the hall (CNA #2). (LPN #1) assessed (the resident) and immediately noticed the bruise on her forehead which she described as being the size of a quarter when she observed it. She did not notice any further injury but did hear complaints from (the resident) that her left leg was hurting her."

"(LPN #1) at this time radioed for the charge nurse on that night, (RN #1), to help her assess the leg pain. Together they assessed the leg. (RN #1) was able to move the leg and compared it to the right leg and was able to determine that similar responses were given for both legs. She seemed to have good range of motion, no signs of one leg being shorter than the other, and (RN #1) also noticed that (the resident) complained of pain in the right leg same as the left when the leg was manipulated. This was also consistent with previous encounters with (the resident) where she would voice distress anytime she was touched. At this point the nurses did not feel there was any kind of injury so as to require further action. Due to the head injury though neuro checks were initiated and found to be within normal limits."

"Later on during the night, (the resident) was still observed to be restless and agitated and was checked on by the nurses and aides. During 3:00AM rounds the nurse (LPN #2) noticed 2 skin tears to (the resident's) left arm which were not noted to be present during 1:00AM rounds. (LPN #2) also noticed at this time that (the resident's) leg seemed to not be laying just right. They placed a pillow between her legs and gave her some medication. She then fell asleep and rested comfortably the rest of the night."

The NHA noted he was notified at 9:30 a.m. "the next morning of the incident and came to investigate." He found the resident seemed "lethargic looking in her wheelchair and a significant looking bruise on her forehead." He was notified by the nurse that the resident had complained of leg pain. The DON arrived and hospice was notified and an Xray requested "to rule out any kind of break." The hospice nurse arrived and the portable Xray was ordered. The NHA noted, "At this time I performed multiple interviews with staff and residents to determine what witnesses observed."

The Xray company arrived at about 4 p.m. and results around 8:30 p.m. revealed a left femoral neck fracture. The family and physician were notified and decided to have the resident sent to the ER for further evaluation; she returned to the facility with pain medication.

"On Tuesday 8/19/14 I was called to the DON office as (the resident's) granddaughter was there and was requesting information as to how and what had happened. With all of the interviews and reports we stated the incident as we were able to piece together:"

"(The resident) was combative and aggressive throughout the day ... She attempted to strike the aide during a transfer to which he attempted to avoid thus causing her to strike herself in the head. At this point (CNA #1) transferred (the resident) to her bed and notified the nurse. During the night due to her unrest and agitation she was somehow able to cause a skin tear to her arm. The fracture we believe occurred during the transfer from the chair to her bed. Given her level of agitation and aggressiveness, it is possible that (CNA #1) unintentionally caused the fracture due to the turning and twisting motion of the transfer. This was determined by asking (CNA #1) to re-enact the scene with myself and the DON. The stress that was placed on (the resident's) leg while she was combative during her transfer to bed we believe was the cause of the fracture."

"(The resident's) granddaughter was concerned and stated that she had a hard time believing the incident as we described it." The NHA wrote that they assured the family that the resident would be well cared for, work closely with hospice, and "I also informed her that we had not removed the aide from the hall that had worked with (the resident) that night, but that he was going in with a partner as he was nervous following the incident. She did not voice displeasure with this course of action..."

"On the morning of 8/20/14 a new bruise was identified on (the resident's) left knee which was not noted on any incident report beforehand. An additional X-ray was ordered to ensure further damage was not present in (the resident's) leg. The granddaughter was also notified of this finding. Later the granddaughter came to the facility and informed us with the hospice that she was moving (the resident) to a hospice facility..."

"In conclusion we did not find in our investigation that there was the element of intent to injure (the resident) on behalf of (CNA #1) or any other aide working with her. (CNA #1) was not reckless and did not knowingly injure (the resident). She was unfortunately injured but much to her own devices. Since there was not intent to injure this is not a reportable occurrence and thus is not being reported to the state."

The investigative report included a written statement from the facility medical director, dated 8/21/14, that he had read the resident's chart, that she had a "history of repeated combative behaviors ... Apparently, the elder swung at the CNA (who) deflected the punch, and the elder struck her head, resulting in a hematoma on the forehead. In an effort to maintain the safety of the patient, the CNA

continued to hold on to the elder, which resulted in some twisting and torqueing of the femur ... My review does not reveal any wrongdoing on the part of the CNA ... It does appear that (the facility) conducted a thorough investigation into this event. Additionally, I did speak with several members of the nursing staff that do corroborate that the computerized records do reflect an accurate summary of this unfortunate incident."

The report also included copies of the 8/16/14 Xray report, the 8/17/14 diagnostic imaging report for the hip/pelvis CT which noted a "fall"; the 8/17/14 diagnostic imaging report for the head CT which noted "fell hit head and left hip pain"; the 8/20/14 left elbow/knee/shoulder study which were negative although the left shoulder had moderate degenerative arthritis, previous surgery with two orthopedic anchors and an "old healed fracture."

Interviews with five residents were included. They were asked if they were fearful of anyone at the facility, if anyone had handled them roughly or hurt them, if they had seen anyone handled roughly, and if there were any other concerns they would like to share. The residents were noted to have responded "No" to all the questions.

Written statements from eight staff members were included in the investigation.

-CNA #1 wrote on 8/16/14 that on 8/15/14, "I was working with (the resident). She had been very agative (stet) after dinner. (CNA #2 was) my coworker on west hall for the night. Had gotten her into PJ, and had tried to get her into bed. I do know for sure that she got her into a night shirt, but was not able to get her into bed. She (told) me what she was doing to stop her from finishing getting her to bed. I told her I will give it a try, and we had no luck, we will do it together."

"I got her up and from her wheelchair. She started to fight me, I got her turned. I saw that she was about to punch me. I ducked the punch to avoid getting hit. She then hit herself in the forehead. I thought it would be best to get her in a safe place first, then call for help. I got ahold of (LPN #1) the nurse for that hall. She came down to check her out, and I informed her what had happened. I went and started getting a set of vitals on her. I did not notice any skin tears on her, but I was not looking either. I know that she got one of the other nurses to look her over. (RN #1) the nurse looked her over. From there I do not know what happened."

-CNA #2 wrote on 8/16/14, "Last night between the time of 7:00PM and 9:00PM there was an incident with (resident #8). I was scheduled to work West hall but (was assisting on a different hall because the CNA was working by herself). (CNA #1) called over the walkie that he needed (LPN #1) to come to (resident #8's) room. (LPN #1) proceeded to (the resident's) room and I finished care with (the other resident). I then went and spoke to (the CNA on that hall and LPN #1)."

"I then proceeded to (resident #8's) room. When I went in (CNA #1) showed me the goose egg on her forehead and said that when he was transferring (the resident) that (the resident) swung at him and as he backed his head up (the resident) punched herself in her head."

"I then helped (CNA #1) change (the resident) and she was consistently screaming about her leg hurting. After changing (the resident) I went and spoke to (LPN #1) about (the resident's) leg and (LPN #1) also had (RN #1) check her out. The goose egg continued to grow as I frequently went and checked on (the resident)."

"While I was charting at the computer she was repeatedly yelling that her leg was hurting and at one point shouted that she wanted it chopped off. When (RN #1) came down the hall while I was charting I told him again that she was persistently complaining about her leg. I did privately ask (CNA #1) if she fell and he told me no."

"When the NOC (night) shift came on I was doing report to (LPN #2) and told her what happened. (CNA #1) was in the room and (LPN #2) asked if she was on neuros and he said 'no because it was witnessed she is not on neuros.' I looked at him like 'Who witnessed it?' and he said 'It was witnessed so there is not neuros.' (LPN #2) then was called to the nurses station for a phone call so that was the end to that conversation. Please let me know if you have further questions."

(Review of neuro check documentation revealed neuro checks were not documented until 8/16/14 beginning at 7:15 a.m., almost 12 hours after the resident's forehead injury, and then were done in keeping with the timing set out on the Neurocheck form.)

-LPN #1 wrote on 8/15/14 that she was "called to (the resident's) room ... Res had hand on head. This nurse removed her hand & found hematoma on L forehead, Neuros were completed & were WNL. Res complained of left leg hurting. This nurse assessed leg at this time. This nurse then got another nurse to assess same leg for second opinion. Cold cloth was applied to res head at this time. To the best of my knowledge this is what I saw."

-RN #1 wrote on the night of 8/15/14, "Floor nurse asked if I could take a look at (the resident). Nurse said that she had a goose egg to left forehead above eye. When entering room, I found pt lying in bed talking to self. In looking at pt found bruised goose egg over left eye. Pupils equal but equally sluggish. Pt was able to move both arms. As she tried to slap this nurse. In examining the lower body, pt did scream as I touched her left leg. I then touched her right leg and got the same response. Pt was moving both legs. Did ROM to both legs after looking at them both visually and finding no shortening of limbs, no internal or external rotation. Pedal pulses were present. I then did ROM and found limbs and joints could freely move. No grinding or other non-anatomically weird skeletal movements. Pt was yelling at this nurse to get out of room and swinging at this nurse once in awhile."

"Upon the results of this exam I found no injuries other than the goose egg over the left eye. When asked, the aide (CNA #1) said pt had swung at him when transferring her and he had ducked and she missed. This resulted in her hitting herself in the head. Floor nurse was already writing this incident up."

-RN #2 wrote on 8/16/14, "I was first in (resident #8's) room around 12 MN to give resident (non-interviewable roommate) her nebulizer. At that time I observed (resident #8) being changed by (CNA #3). (The resident) was very agitated as she can be and I spoke with her as she was being changed. Myself and the other staff looked at the injury on (the resident's) head, looked at her hips and repositioned her with a pillow. At that time I did not recall seeing any skin tears on her left arm."

"Later in the shift around 2:30ish, (LPN #2) asked if I could give (resident #8's roommate) a PRN neb since she seemed congested and could we do something for pain for (resident #8). I took (the resident) Tylenol, and Kerforpen cream down to her room, turned the light on and at that time I

noticed the very obvious skin tear on her left elbow. (LPN #2) came in the room right behind me. I asked her if she had noticed if (resident #8) had the skin tears earlier and she had not seen them either. After I gave (the resident) her Tylenol, cream, and PRN Ativan, she went to sleep and appeared to be comfortable the remaining part of the shift."

-LPN #2 wrote on 8/16/14, "I came on shift @ 10pm on 8/15/14. I was a CNA & took report from the West hall aide (CNA #1). He stated that (resident #8) had been combative with cares & swung her fist at him. He stated he ducked & she hit herself in the forehead causing a 'goose egg.' When I saw it she was lying in bed & it was dark. I saw an abrasion around 3 AM, the nurse & I went in to give her pain medication. We then noticed 2 skin tears to her left elbow. I also noticed her L knee/leg looked displaced/not right. We placed a pillow between her knees. She seemed in pain at this time. After she was medicated, she fell asleep & looked comfortable. She had been agitated most of the night."

-CNA #3 wrote in an undated statement: "The night of the incident I received report from (CNA #1) for West, at that time I didn't notice whether or not the resident's arm had a skin tear or not, as the only injury I saw was the knot on the resident's head that (CNA #1) was pointing out to me."

"I went in on rounds and explained to the resident I was going to change her brief, she began to yell out as I was taking the blankets off of her, about that time (RN #2) and (LPN #2) came into the room, I told the nurse the resident had been yelling and I thought she may need some pain medication for her hips, there was no draw sheet or pad underneath the resident so I rolled the resident towards me using her shoulder and behind her knees, at about (1:30 a.m., RN #2) called me back in the room and asked me had I seen the skin tear on the resident's arm while I was changing her, I said no, I had not seen it at that time. The nurses told me they had not seen it either, and that we would each need to write up a written statement for the incident."

-CNA #4 wrote on 8/16/14, "I was not working on that side last night at all. I worked only on South."

Three incident reports were included in the investigative report:

(1) On 8/15/14 at 8 p.m., LPN #2 noted a "bruise," and that "CNA stated resident doubled up fist & tried to hit while doing cares. CNA stated he ducked & res hit self on left side of forehead. Quarter size hematoma appeared."

There was no drawing on the body map. The pain assessment was blank. The physician notification was blank and family member notification was 1630 (4:30 p.m.) The DON noted reviewing the incident on 8/18/14. Treatment was noted as "cold cloth" and action taken was noted as "staff re-education" and "2 person transfer, de-escalation education."

(2) On 8/16/14 at 2:30 a.m., a skin injury of unknown origin was noted, with no drawing on the body map, no description of the location, and no measurements of the injuries. The description read, "On rounds resident noted to have two separate areas possible bruises that were open with (illegible)." The pain assessment was blank, but pain management intervention was checked "yes."

Physician notification was documented as 3:30 a.m., no family notification was noted, the document was completed by RN #2, with no review sign-off or dates from nursing management. Treatment was

"first aid," action taken was "staff re-education" and "geri sleeves offered & encouraged."

(3) On 8/20/14 at 10:45 a.m., an unidentified staff person who did not print their name or title documented, "Green/yellow bruising noted on anterior and medial aspect of L knee. Measures 6x7cm and there is a small scab/abrasion on patella - measures 0.7x1.5cm."

A large circle was drawn around the left knee on the body map picture. The treatment was "assessment" and the action taken was "Xray of knee done." The pain assessment noted, "No s/sx of pain to L knee w/ gentle palpation." The hospice nurse was notified at 11:25 a.m. and the family at 11:30 a.m. There were no signatures from the DON, medical director or NHA.

6. Facility Failures in Response to Incident 8/15/14

a. Failure to report violations of potential abuse

See facility policy above, indicating that the Police Department is notified in all cases or suspected cases of physical abuse, sexual abuse or misappropriation of resident property.

Although the incident was investigated as potential staff to resident abuse (see facility investigation above), the resident's family member as well as the resident's hospice providers and staff (see below) expressed concern and doubts about the circumstances of the resident's injuries, the facility did not report resident #8's injuries to the police, the state health department, or other government/advocacy agencies/entities as required by facility policy (see above).

b. Failure to thoroughly investigate circumstances surrounding the 8/15/14 transfer.

There was insufficient evidence of investigation of the circumstances involved in the transfer; specifically, whether or not a gait belt was used and how the resident's multiple injuries were sustained.

Resident #8, per MDS, required extensive two-plus person assistance for transfers, but CNA #1 transferred her alone, unassisted.

-Although the CNA said when interviewed on 8/26/14 at 4:06 p.m. (see below) that he used a gait belt, the investigative report said he had his hands on the resident's waist. And, see below; CNA #2 when interviewed 8/27/14 at 3:45 p.m., said she did not see a gait belt in the room.

There was no evidence in the facility investigation about the CNA's use of a gait belt or why, even with a gait belt, he was transferring the resident in a manner inconsistent with her assessed needs.

-Moreover, record review showed the resident was a frail 91-year-old with muscle weakness and a history of pain and injury to her shoulders. She was under five feet tall and weighed approximately 90 pounds. CNA #1, per observation and employee record review, was over six feet tall and weighed more than 250 pounds.

There was insufficient evidence in the facility's investigation to show how the resident could sustain such significant and varied injuries (see above) given her physical state and the abilities of the CNA,

given his physical state, to protect her from self-harm.

Several staff members (CNAs #5, #6, #7, #9, #11, #12, and RN #3, interviewed on 8/27/14, LPN #2 interviewed on 8/28/14 and and LPN #1 interviewed on 9/2/14), who knew resident #8, said that although resident #8 was combative, they did not believe she had ever injured anyone, or that she was capable of self-inflicting the forehead injury that she sustained.

c. Failure to conduct comprehensive interviews of residents, staff, family, and hospice staff

Resident interviews:

It was noted that resident interviews should be conducted by social services, according to the instructions on the resident interview forms. However, the dates and times the interviews were conducted, and the persons conducting the interviews, were not documented.

Both social services staff members (see below) stated during interviews that they were not involved in the investigation.
-The social services director was interviewed on 8/25/14 at 4 p.m. She said she was not involved in the investigation of resident #8's injuries. She said she was not asked to conduct interviews, or review or discuss the investigative findings.
-The social services assistant was interviewed on 8/27/14 at 10:45 a.m. She said she was not asked to participate, or conduct interviews, in the investigation of resident #8's injuries.

Staff interviews:

Questions to ask staff were documented to include: 1) how the resident received the injury, 2) what type of care was provided for the resident on your shift, 3) what type of equipment was used, and 4) have you noticed anything that the resident does normally that may have likely caused this type of injury?

There was no evidence that staff were actually interviewed and asked these questions, and no evidence all staff who worked with CNA #1 and resident #8 were interviewed. Specifically, see staff interviews below; CNAs #5, #6, #7, #9, #11, #12, and RN #3, interviewed on 8/27/14, LPN #2 interviewed on 8/28/14 and and LPN #1 interviewed on 9/2/14, all expressed uncertainty about the circumstances around resident #8's injuries.

Moreover, although written statements were gathered, there was insufficient evidence that these statements were considered together with hospital reports that documented the hospital staff had been notified by facility staff the resident had fallen (see hospital documentation above).

Finally, there was no evidence staff were questioned why more injuries continued to appear, such as the skin tears to the elbow and the bruising to the knee. There was no evidence the facility explored with staff whether the assessments were inaccurate.

Family and Hospice Interviews:

There was no evidence that family members were interviewed regarding resident care, or that

hospice staff were interviewed for their observations of resident care.

d. Failure to Protect Resident #8 and Other Residents on the West hall

Protection 8/15/14:

CNA #1 was not suspended during the above investigation (see facility investigation above); he continued to work the evening shift on the West hall where most of the residents had dementia and were unable to defend or speak for themselves.

Although the NHA noted telling the resident's family member that CNA #1 would have a coworker with him when providing cares, nursing staff said he was not required to, nor did he, go into resident rooms with a partner.

The evening shift charge nurse, RN #1, was interviewed on 8/26/14 at approximately 3:35 p.m.; and LPN #4 who typically worked on the East/West halls, was interviewed at approximately 3:45 p.m. Both nurses said CNA #1 typically worked on the West hall during the evening shift. Both nurses were asked if they had been asked to monitor or supervise CNA #1 in any way, or to ensure he entered resident rooms two by two. They both said, "No."

Protection prior to 8/15/14

Although CNA #1 was up for quarterly review as a new employee (see policy above), there was no evidence in the employee record that this was done, although he had worked in the facility for three months as of 8/5/14.

Moreover, review of CNA #1's employee record provided by the NHA and reviewed on 8/25/14, revealed CNA #1 was hired on 5/5/14. There was no evidence of reference checks in the record, although CNA #1's application documented previous work experience included three other long term care facilities and an assisted living residence.

The NHA was interviewed on 8/26/14 at 3:30 p.m., and provided two references dated 5/5/14, and when asked, said they were not in the record but were found "in a HR (human resources) pile." The references were from current facility staff who the NHA said "used to work at other facilities" with CNA #1. When asked if he thought this was sufficient for reference checks, the NHA said he "thought that was sufficient," and that he "had no reason to question or doubt at the time."

Finally, see below; CNA #1 had been involved in other incidents involving potential abuse or mistreatment. Review of his employee record revealed no documentation of disciplinary actions, additional training working with cognitively impaired/combative residents, or monitoring of the CNA's interactions with residents on the West hall.

7. Staff Interviews

a. Staff working with resident #8 on 8/15/14 and 8/16/14

-RN #1, who was on duty 8/15/14 and assessed resident #8 that evening after her transfer, was

interviewed on 8/25/14 at 2:19 p.m. When asked about his assessment, he said, "She had no presentation of a fractured hip - no bruises to her hips or legs or anywhere else like if she'd fallen. All I saw was the goose egg forming above her left eyebrow and it was starting to bruise. If I saw something like she would've fallen or something I would've reported it and started the paperwork and everything."

-LPN #3, the wound care/restorative nurse, was interviewed on 8/25/14 at 4:15 p.m. She said she was on call the night of resident #8's injury, and was called at home. She said she asked about a fall, and staff answered the resident did not fall and her only injury was the resident's forehead bruise. She opined that the resident could have bruised and scratched herself, causing the hematoma and the skin tears.

-CNA #1, who transferred resident #8 on 8/15/14, was interviewed on 8/26/14 at 4:06 p.m. He said the night resident #8 was injured, "She was wound up, having behavioral issues. (CNA #2) who was working with me attempted to put her into bed first, and was not successful ... Some time went by, I attempted to get her into bed, I thought she was calmed down, got her stood up, got her transferred halfway. Once I got to the halfway point, she just started winding up again."

"I saw her getting ready to throw a punch towards me. I leaned left, my right elbow up, and she hit herself in the head. Immediately after, I thought I needed to get her to a safe spot where she wasn't going to hurt herself. I got her into bed and called my nurse for backup. It was somewhere between 7 and 9 p.m. It was a very busy night. That hall usually has behavioral issues due to sun-downing."

When asked, he said the resident is "really a one person assist," stating, "She can stand very short (time periods) but she is very unstable on balance and you definitely have to guide her. I had a gait belt. She was halfway between the bed and the chair. She'd started to stand and pivot, and that's when she started to wind up, ball up her fist, and that's just where I leaned and pulled up my elbow. I just moved her the rest of the way into the bed." He further stated, "How it happened it was just so much of a fluke. It's something you really can't prepare for."

He adamantly stated that the resident did not fall. He said, "The way I set up the wheelchair with her, I had the wheelchair close to the bed. I'm pretty sure she did not hit her head on the wall, but I'm not sure about her elbow or her leg. Nobody else was inside the room or within earshot. I think (the resident's non-interviewable roommate) was in bed already, I'm not really sure. I didn't hear anything from that side."

CNA #1 said he had been "hit or bitten more than ten times" by resident #8, and added, "It was a fight to get her into bed depending how wound up she'd get." Asked what types of residents he preferred to provide care for, he said he preferred "residents with orthopedic issues because I'm more experienced in that area."

-LPN #2, who came on duty at 10:00 p.m. on 8/15/14, was interviewed by phone at 2:25 p.m. on 8/28/14. She said, "I was working as a CNA that night. I came in at ten and took report for west hall where (resident #8) lived. (CNA #1) was telling me that she had hit herself in the head and had a goose egg ... Between 2 and 3 a.m. she was kind of agitated and was saying that her leg hurt so I asked the nurse should we go ahead and give her her ketaprophen gel that they usually rub on her hips and it helps with the pain. The nurse and I went down there, gave her some tylenol, we both

noticed she had two skin tears on her left arm."

"When we went to put the gel on and pulled the covers back, her pillow wasn't there. I was like 'wow her leg looks really distorted.' Every time I've seen her she's been on her side with the pillow between her legs, and I didn't know if that was normal for her or not. We put on the gel, put her pillow back between her legs, and it seemed to kind of hurt when we put the pillow back..."

The LPN said, "She's a pretty tiny little thing and I was kind of shocked she'd hit herself and done that. I'm not saying it was not possible but I don't know ... Because of her combativeness I'd always have the aide go with me just in case and they would help talk to her and hold her hands so she wouldn't punch or hit. I recall one time she swung and it made contact with the aide, but it wasn't violent and it wasn't enough to hurt. That's just how she was. So you'd just have to see what kind of mood she was in so you could take someone else in there. She never beat anybody up or anything to my knowledge."

-LPN #1, who was on duty the evening of 8/15/14, was interviewed by phone at approximately 9 a.m. on 9/2/14. She said she "got a page to come to (resident #8's) room from (CNA #1). The resident was lying in bed and was holding her little head." She said, "I asked (CNA #1) what happened. He told me that (the resident) had doubled up her fist to hit him, he ducked, and when he ducked, her arm came around and she hit herself in the head. This is what I was told."

"(CNA #1) was the only one in the room. In my mind I questioned (the CNA's explanation), but I had nobody there to tell me any different. You try to believe your CNAs you know. I've never seen (CNA #1) abuse or be unkind to another resident that I observed." However, she said she is not always in the rooms when the CNAs put the residents to bed.

LPN #1 said CNA #1 worked with resident #8 that night until he went off duty. She said, "I wasn't asked to monitor/supervise (CNA #1) in any way or ensure he went in rooms two by two. I worked with him at least two or three more times after that."

-CNA #2, who worked with CNA #1 on 8/15/14 the night resident #8 was injured, was interviewed on 8/27/14 at 3:45 p.m. She said resident #8 was already in bed when she entered her room that night. She said she saw a goose egg on the resident's head and asked what was going on. "(CNA #1's) reply was, 'When I went to transfer (resident #8) she swung at me and I ducked and she hit herself in the head." CNA #2 said CNA #1 denied that he had dropped the resident. The CNA said, "(Resident #8) is a two person (transfer) with a gait belt. I didn't see one in there, but I was looking at the goose egg on her head." She said, "I've never tried to transfer (resident #8) by myself, ever, because she does better with two people."

When asked if resident #8 could have injured her own forehead, the CNA said in part, "I don't know. (Resident #8) is known for swinging. She's such a tiny little thing but I don't know what she's capable of. She'd move her elbows back and forth if she didn't want to get out of the chair. With her leg being painful she could've banged it on the wall. But everything was on her left side."

b. Staff familiar with resident #8 and her care

Several staff members who provided care for resident #8 stated during interviews that she needed

two-person transfer assistance, could not have injured herself, and that they had concerns about what happened to resident #8 on 8/15/14. Specifically:

-CNA #5 who was familiar with resident #8 was interviewed the morning of 8/27/14. When asked if the resident could have injured her forehead herself, said, "No. Unless she were to fall. I don't think I could even do that to myself..."

-CNA #6 who was familiar with resident #8 was interviewed the morning of 8/27/14. She said, "(Resident #8) would get combative sometimes, but ... she was about four-feet-seven-inches tall and weighed 87 pounds ... Every time I'd transfer (resident #8) I'd know she was going to pinch the back of my arm or bite me on my chest, but it wasn't rough because she didn't have a lot of power behind it ... I thought (resident #8) was a two-person transfer. So you should not have been transferring her by yourself..."

CNA #6 said resident #8 had never injured herself or anyone else, to his/her knowledge. When asked if resident #8 could have bruised her own forehead, CNA #6 said, "No. I think her ADL (activity of daily living) notes conclude that she probably didn't have that much range of motion. And the contact would not have had that much force behind it to leave the bruise that it left. I have no idea how those injuries got there unless she fell, but I don't know."

-CNA #7 who was familiar with resident #8 was interviewed the afternoon of 8/27/14, said, "If (resident #8) goes to hit you, she'd barely tap you. That's the hardest she ever hit me. She doesn't seem like the type of person who'd give it her all." Asked if she could have bruised her own forehead, the CNA said, "No. The way she tried to hit me, it doesn't seem she could have swung herself that hard to have a really big bruise ... She had big skin tears and I wouldn't know how she got those."

-CNA #9 who was familiar with resident #8 was interviewed on the afternoon of 8/27/14, said, "...(Resident #8) sometimes got combative, but she weighed 89 pounds. She could not hurt you." Asked if the resident could have injured her own forehead, the CNA said, "No. There's no possible way this little lady could do that to herself. She's not that strong. She's hit me and she can't hit hard ... Nobody can hit themselves that hard." She said she thought it was suspicious that that all the resident's injuries (hematoma, skin tears, hip fracture) were on her left side.

-CNA #11, who was familiar with resident #8, was interviewed on 8/27/14 at 4:15 p.m. CNA #11 stated, "It would've taken a lot of force for her to hit herself and put a knot that size on her forehead. I never saw her take a swing like that at anyone."

-CNA #12, who was familiar with resident #8, was interviewed on 8/27/14 at 4:30 p.m. She said, "I saw the knot on her forehead. I didn't know how it happened." When asked if she could have injured herself, the CNA said, "Not that big a one. That big and that much? No. And I know some of the elders are stronger than they appear. I doubt she would've done that much damage to herself."

-RN #3, who was familiar with resident #8, was interviewed at 10:20 a.m. on 8/27/14. When asked if resident #8 could have bruised her own forehead, the RN said, "No. She's thin, she doesn't seem strong enough, and considering the size of the bruise... I've never known her to hurt anybody, but I have known her to be agitated with staff, like at bath time."

(The director of nursing (DON) was interviewed at 11:50 a.m. on 8/25/14. She said she had started in her position on 8/14/14, "right before the occurrence" with resident #8.)

II. Failure to thoroughly investigate earlier allegations of potential abuse or mistreatment involving CNA #1

A. Resident #9

1. Closed record review revealed resident #9, age 90, was admitted to the facility on 2/26/14 with diagnoses including unspecified extrapyramidal disease and abnormal movement disorder, cerebral aneurysm, other choreas, chronic airway obstruction, hypertension, osteoarthrosis, muscle weakness, lack of coordination, and anxiety state. The resident resided on the facility's West hall. The resident died on 7/29/14.

2. Resident status

According to a 6/2/14 assessment, she had physical and verbal behavior symptoms directed toward others, had moderate cognitive impairment, exhibited inattention and disorganized thinking, was depressed and tired with little energy; required extensive, two-plus-person assistance with transfers and toilet use. She was 60 inches tall and weighed 118 pounds.

Psychosocial progress notes dated 6/11/14 documented she was "alert and oriented to person and place ... Has difficulty recalling time sensitive information and has poor recall when it comes to recalling pertinent personal history information and is unable to accurately recall what year certain events occurred in her life ... does often reject personal cares and assistance with personal cares and has behavioral outbursts that are directed at others ... Has been known to attempt to strike others during personal cares. It is recommended that staff talk with (resident) and explain tasks and procedures to her prior to cares."

3. Staff interviews

a. CNA #10 was interviewed by phone at 9:15 p.m. on 8/27/14 about resident #8 (see above).

When asked about the care provided by CNA #1, CNA #10 said, "I've had to report (CNA #1) before for an incident with another resident. It was between 10 and 10:15 p.m. He picked up (resident #9) off the commode so high in the air that her legs were dangling and she was screaming and he turned and dropped her on her bed. I reported it to the night nurse, (the SDC and NHA)."

"That was about two months ago, I want to say ... It happened on the evening shift when I was getting report from him. I was standing in the hall outside the room watching. There was another CNA with him, she was new and I don't think she's (here) anymore. When he came out of the room he was (angry); he said, 'I'm fed up with that one. I think he called her a (derogatory name). He was so angry. I didn't know how he'd react he was so angry. It made me afraid how he'd react with other residents. I was a little bit afraid of him myself."

CNA #10 said, "After we got done getting report from him I went straight to the nurse and told her

what was going on. I asked a couple of people what I should do. They told me I should report it. I wrote a statement and left it on (the SDC's) door (that night) and talked to (the SDC and NHA) the next day. I gave a copy to my nurse, a copy to (the SDC), and kept a copy for myself."

CNA #10 said, "I think (CNA #1) got suspended for three days and he wasn't allowed to go back in (resident #9's) room. Someone else had to take care of her. I hear that he's working also at (another LTC facility on the night shift). ...He needs to find some other way to deal with the stress rather than take it out on the residents. He was working (at the facility) as recently as Saturday. I only see him on shift change now. I'm sad they didn't go about it differently. I didn't know you were allowed to keep working..."

CNA #10 stated, "(CNA #13) also saw it and made a report about it. He saw it with me, and I wanted another person to say it so they wouldn't think it was me making stuff up ... I don't think (CNA #1) needs to be a CNA. He has too much built up anger, he gets mad at the drop of a hat and he takes it out on the residents. I want him gone. It's like he can't control himself."

b. CNA #13 was interviewed by phone on 8/28/14 at 5:15 p.m. and asked about the incident with resident #9.

He said, "It was the evening aide and (CNA #1). He was mistreating (resident #9). When he was transferring her, he was a little upset. We're a no lift facility. She was freaking out - she yelled. She sounded like she got hurt a little bit. She was on the commode and he lifted her under the armpits. Her feet were like tippy toe off the ground. He sat her down and the other aide pulled her clothes up and put her to bed."

CNA #12 said his view was blocked a little as he was standing in the hall. When asked, he said he thought this to be abusive treatment. He said, "I don't think a resident should be treated like that. I wouldn't want to be treated like that. I reported it that night. I had a written report and had a meeting about it with our (NHA and former DON)."

When asked how the NHA and DON responded to the report, he said, "I don't know what they did. I didn't really hear anything. I'm not sure what they did because (CNA #1) was back to work. There were no injuries, but she was fearful of him. If he gets heated up that quick, yeah, I'm concerned about him providing care for residents."

3. Abuse Investigation regarding Resident #9

The NHA was interviewed on 8/28/14 at 11:30 a.m. He was asked for any investigative reports regarding staff mistreatment or abuse involving resident #9. He said, "The night with (resident #9), she was very rude to (CNA #1), touched him inappropriately, and he didn't handle it well, moved a laundry cart in an abrupt manner. He received education on that."

The SDC was interviewed on 8/28/14 at 12:15 p.m. Regarding the abuse investigation about resident #9, she said, "Every person's interpretation is different. I wasn't there in the room to say what was said or done. I was told he was lifting her up so somebody could clean her. They (two CNAs) thought he'd lifted her a little too high. I can't say because I didn't hear what was said. I wasn't involved in this investigation. We did some verbal education and we're always doing education all the time.

Some of it's in passing, some of it's documented, some of it's in groups. When it was brought to us we did talk to (CNA #1)."

The investigative report regarding resident #9, provided by the NHA, dated 6/9/14, documented he was notified on 6/5/14 of a "possible situation involving" resident #9 and CNA #1. The report read:

"The alleged incident occurred the night of 6/4/14. (CNA #1) was working on the hall on which (resident #9) resides. (Resident #9) was being very rude and mean to (CNA #1) that night. She was demanding of him and was touching him inappropriately. (CNA #1) continued to provide cares throughout the evening. One such instance involved (the resident) touching (CNA #1) in his private parts. (CNA #1) asked her to stop that and tried to back away. At this point another aide was in the room and they together provided care for the resident. (CNA #1) lifted her up so the other aide could remove her pants and allow her to use the commode."

"A witness (CNA #13) said that (CNA #1) lifted her off of the toilet further than he should have when transferring her off of the commode. (CNA #1) then left the room and according to witness 'kicked' the laundry cart sitting outside the door. (CNA #1) then used some unkind verbiage in describing (resident #9) and the way he was being treated by her. (CNA #1) admitted that he did lose his cool during this encounter. At this point his shift had ended and he left the facility."

"Interviews were conducted with residents on the hall. None of the other residents complained of ever being handled roughly and were not fearful of anyone working within the facility. I myself approached (resident #9) and spoke with her regarding the situation. (Resident #9) did not complain of any rough handling or fear. In fact (resident) spoke highly of the staff caring for her and was very happy to be here. In speaking with co-workers they referred to (CNA #1) as a wonderful teammate and spoke very highly of him."

"At the conclusion of this investigation, (CNA #1) was called in to the NHA office and we went over the incident as I understood it with (SDC) present as well. (CNA #1) admitted to me that his emotions had gotten the best of him and he apologized for the way he had handled himself."

"I informed him at that time that I did not have evidence of abuse, but that his actions were not appropriate. He was given a verbal warning regarding his conduct and given education regarding the appropriate way to handle himself when caring for a resident who is purposely trying to 'push your buttons.' (W)e informed him in this sort of an instance to remove himself from the situation and rely on another aide to help her with cares."

"We also informed him that he was to no longer work with (resident #9) as their personalities did not blend well apparently and to leave her care to someone else. (CNA #1) agreed and apologized for the incident and assured us he would not let his emotions get to him again."

"In conclusion since there was no injury from the alleged incident and the element of intent to injure was also not present, this is not a reportable occurrence and thus will not be reported to the state for further action."

Attached to the investigative summary were:

-Interviews with three residents including resident #9, dated 6/5 and 6/6/14. Residents were asked: "Do you have any fear of anyone here at the facility? Has anyone ever handled you roughly or hurt you? Do you have any pain that is not being addressed? Are there any concerns you would like to share with me?" The three residents were documented to have stated no related concerns.

-Written statement from CNA #10 dated 6/4/14: "I (CNA #10) was getting report from evening shift on west hall from (CNA #1). He was angry and frustrated over (resident #9). She is a two person transfer. I witness(ed) him lift her up off the commode so high that her feet were dangling in the air, she was scared. Before he entered her room he was in the hallway saying she was being a f------ b---- and he was tired of her. He then continued to walk around very angry. His face was red as he was talking, his eyes would get open wide, he proceeded to slam the lid down on the trash can and kicked the laundry bag. He said he was going to come back in the morning to talk to (first name of another staff person) because (the resident) needed to be on some kind of medication." The statement was signed by CNA #10, and noted as received 6/5/14 at 7:45 taped to door front by a person identified with initials (not the NHA or SDC).

-Written statement from CNA #13, dated 6/4/14 which read, "I (CNA #13) observed (CNA #1) was upset with (resident #9), upon getting report he was mentioning how the resident's behavior was throughout the shift while doing this he was showing frustration. He had said 'he had enough of her' and that she was 'a pain in the butt.'"

"After a brief report (CNA #1) went to the resident's room to give his partner a hand. While trying to transfer the resident from the commode to bed, (CNA #1) lifted up the resident higher than he should have. The resident was scared during the brief moment of the transfer."

"After the transfer he came out of the room still frustrated with the resident and mentioned some foul language before leaving and finishing his report. During this behavior his eyes were wide open with anger and speaking with anger. He kicked the laundry bag, slammed the trash and laundry lid, stomped his feet in the resident's room. This statement is the best way I could describe the incident to the best of my memory." It was signed by CNA #13 and noted as also received by the same person, same date and time, taped to door front.

-Witness interview summary from CNA #10, dated 6/5/14, documented by the SDC, which read: "They got report from (CNA #1). He said he was frustrated over a certain resident. Went in to help a resident (room number). She is a two person transfer but lifted her up, her feet were dangling in the air, his face was red and his eyes were wide open. Slammed the lid down and kicked the trash can."

4. Failures in Facility Response

There was no evidence the CNA who worked as CNA #1's partner was interviewed, that any other staff were interviewed, that any family members were interviewed, or that any more than three residents who received care from CNA #1 were interviewed.

Although the incident described by the CNA witnesses involved an improper transfer, mistreatment and verbal abuse:

-There was no documentation in CNA #1's employee record of the incident, or the education and

verbal counseling CNA #1 was to have received.

-There was no evidence of a monitoring and supervision plan for CNA #1 to ensure he did not provide care for resident #9 and that his care for other residents was appropriate. He continued to work the evening shift on the same hall, where most of the residents were cognitively impaired and unable to speak for or defend themselves.

-There was no documentation in the resident's progress notes of the incident, and no documentation in her progress notes at all on 6/5 or 6/6/14. However, the nursing weekly assessment dated 6/10/14 noted the resident was "on the light often, anxious, wanting someone in the room with her, on scheduled Ativan, comforted with stuffed animal by her side." Her skin was intact and no skin issues were noted. She required "assist of 2 with transfers, legs weak, does self propel, assist of 1 with ADLs" and "wheelchair for mobility."

-There was no documentation the resident's family was notified of the incident on 6/5/14.

-There was no evidence of an accompanying skin assessment for resident #9 to check for injuries.

B. Resident #7

1. Resident #7, age 78, was admitted to the facility on 5/12/14 with diagnoses including rehabilitation, aftercare following circulatory system surgery, personal history of fall, muscle weakness, difficulty walking, cognitive communication deficit, lack of coordination, senile dementia, unspecified psychosis, depressive disorder, unspecified joint disorder, and unspecified backache.

2. Resident status

According to a 6/26/14 assessment, he had modified cognitive independence, inattention, disorganized thinking, delusions, and no behavioral symptoms. He needed extensive two-plus person assistance with transfers and dressing, had balance problems, and needed a walker for ambulation.

The care plan, dated 5/29/14 and revised 8/25/14, noted in pertinent part:
-"His ability to perform ADLs (activities of daily living) does vary, he needs cueing PRN to initiate and sequence ADLs, he is alert to person, and reorients to place and time. He does have confusion at times, but he can usually make simple needs known.

Interventions included: Explain all procedures before starting and allow resident to adjust to changes, resident's triggers for behaviors include feeling like he is being ignored or 'brushed' off, lots of activity and when he has an increase in confusion, responds well to 1:1 conversation, quiet and calm environments and when others take time to explain procedures and the 'steps' to resident #7. Provide the resident with necessary cues - stop and return if agitated."

On 7/16/14, the resident "has a new diagnosis of dementia with psychosis and his behavioral symptoms are evidenced by delusions that others are attempting to harm him and statements of hallucinations that pertain to hearing and seeing people that are not present. Provide 2 person assistance during personal cares. (Resident #7) also strikes out at others during personal care and is not easily re-directed."

3. Staff interviews

Two CNAs reported that resident #7 expressed concerns about mistreatment by CNA #1. Specifically:

CNA #2 stated during an interview on 8/27/14 at 3:45 p.m., "I've never seen (CNA #1) do anything to hurt anybody when I was working with him ... But I guess you never know. I told them (after the incident with resident #8 that) this is the second statement I've had to write when working with him. I heard (resident #7) scream, 'Don't hit me' and he kept screaming it. (CNA #1) was standing there holding his pajama pants and (resident #7) was standing there with his walker between them and his recliner behind him. That's not the first time (resident #7) has done that either. One time he accused (two other CNAs) of beating him up on a transport too. And I know (RN #1) assessed (resident #7) that night." The CNA said the incident with CNA #1 and resident #7 occurred in early to mid August.

CNA #9 stated during an interview on 8/27/14 at 2:45 p.m. that on another occasion, "We (nursing staff members) were giving report and (resident #7) would not go around (CNA #1). (Resident #7) glared at (CNA #1) and said, 'Is he going to keep his hands to himself?' (CNA #1) crossed his arms over his chest, leaned against the wall and glared at (the resident) ...(CNA #1) is not the type of person who should be taking care of elderly people, because he's rough. And if you try and talk to him about it, he gets very defensive."

4. Resident Interview

Resident #7 was interviewed on 8/27/14 at 1 p.m. He said he sometimes did not know "what's real and what's delusion," and "unless you lead and hit on something I don't know what to tell you."

When asked how he was treated by staff, the resident reiterated the allegation (mentioned by CNA #2 in interview above) about two staff beating on him in the facility transport van, which he said occurred a month or two ago. He did not mention CNA #1. He said, "Most of the time everything is okay except there's some strange possibilities of things that go on, like they'll say wait just a minute we'll be right back and you don't see them till two hours later. Just a second I'll be right with you and they never come back. And that happens not only to me but to several people. It would be worth checking out, why is that going on? Like if I told you just a second I'll be right with you and leave you sitting on that bed ... when you're neglected or shunned or treated like that, those are not good things. Those should be secondary ways to have to cope with something I would think."

5. Administrative interview

The NHA was interviewed on 8/28/14 at 11:30 a.m. He was asked for any investigative reports regarding staff mistreatment or abuse involving resident #7. The NHA said he "wasn't here when (resident #7) made the allegation about abuse," and the SDC would have done that investigation. He said he was not sure of the outcome.
- When asked why there was nothing in CNA #1's employee record about these incidents, the NHA said the facility "just started adding these things to personnel records as part of their corrections from last survey." (But see CNA #2's interview that she had written a statement.)

The SDC was interviewed on 8/28/14 at 12:15 p.m.
-Regarding the investigation about resident #7's abuse allegation she said,
"It was brought to me by another aide saying (resident #7) had made a comment in the hallway, I didn't hear the comment. She said (resident #7) was walking out of his room and she and (CNA #1) were doing report so he could take over the hallway. (Resident #7) was coming out of his room, he stopped and (a CNA) had said you can go on through we're just talking, and (resident #7) said, 'Well, only if he'll keep his hands to himself.' Then (CNA #1) crossed his arms and moved away so (resident #7) could come down the hallway."

"A couple days later, (the CNA who reported the incident) came to me and I asked (resident #7) if he could tell me what happened, and (resident #7) said, 'I just don't like him.' So I asked (CNA #1) what happened and he said he had no idea."

"At that time I felt there was no abuse or anything. We made him a two-person if (CNA #1) was going to provide care in that room. I didn't document anything at the time. We made him a two-person at times, being when (CNA #1) was working. Not for specific people, no. It was just a PRN basis depending on his mood or behavior. (CNA #1) said he felt comfortable having two people with (resident #7) just because of the comment."

During the exit interview, conducted at 4:30 p.m. on 9/11/14, the findings above were reviewed with the NHA and corporate consultant. When asked, the NHA said he was unable to find any documentation regarding allegations or an investigation regarding resident #7's concerns about CNA #1. He said he felt the investigations the facility conducted were thorough and the findings led to the determinations as set forth in the investigative reports. He said staff did not state that they felt CNA #1's actions toward resident #9 were abuse. He said CNA #1 was now suspended, due to a police/district attorney investigation which was initiated 8/23 or 8/24/14. He stated that residents were pleased with the care provided by CNA #1.

Facility Plan of Correction:

F225

Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Colorow Care Center of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and /or executed solely because the provisions of Federal and State law require it. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facilityâ€™s allegation of compliance in accordance with section 7305 of the state operations manual.

1. Resident # 9, no longer resides in the facility.

Resident #8, no longer resides in the facility.

Resident #7, has been re-interviewed by the NHA, and has no complaints in regards to mistreatment, fear or abuse at this time.

CNA #1 no longer works for Colorow

CNA #1 was not referred to the board of nursing

2. Residents who are currently in the facility are being interviewed via Room round questionnaire which contains the QIS questions regarding abuse to identify if they have any complaints in regards to mistreatment, fear or abuse. Those who are not interview able are being observed for physical signs of mistreatment through the use of skin checks and a weekly phone call to question the MDPOA using the same audit tool. This was completed on 10/3/14.

Non-communicative residents are being monitored for changes in behavior from baseline. These observed changes are being noted in the nurses notes and the physician is also notified. For example if a resident who normally enjoys eating in the dining room with others is now confining herself to her room this would be noted in her chart, Social services would follow-up and the physician would also be notified.

3. Facility Leadership Team including the NHA, DON, SDC, SSD and assistant, Activities Director and assistant, Medical Records, BOM, wound nurse, Dietary manager, Maintenance Director, and MDS Coordinator have been in serviced on Abuse Reporting and Investigating by Elizabeth Schulte MSW, NHA on 9/29/14. Included in this in service was types of abuse, reporting guidelines for CDPHE and the Elder Justice Act, how to initiate an investigation and what to investigate.

The facility will complete a thorough investigation per state and federal regulatory guidelines regarding any reported instances of potential abuse to ensure our residents are safe and protected.

Facility staff has been in serviced on the Abuse Policy, with an emphasis on reporting via notification to the DON/nurse manager on call and/or NHA. This was completed on 9/29/14.

Facility Human Resource and Staff Development Coordinator has been educated on proper screening of potential employees by the NHA on 9/29/14.

Department Heads are completing rounds weekly throughout the entire facility and during both day and evening shifts interviewing residents with regards to concerns with mistreatment, fear or abuse. At least once a month rounds will be completed on the night shift to ensure proper care is being provided including answering of call lights, room cleanliness, facility appearance, and resident satisfaction if available. Any issue noted will be reported immediately to the NHA and the appropriate steps for investigation will be taken.

Any resident having been involved in an altercation or abuse situation will have revisions made to their plan of care to monitor for the safety and psycho-social well being of the resident.

Resident Community meetings are held three to five times weekly, any concerns of the above nature, brought up during this time will be brought to the NHA, immediately for follow up.

A new employee screening process was instituted on 9/11/14 regarding the need for 2 reference checks to be completed as well as a background check, computer integrity examination, I-9â€™s completed, E-Verify, license verification check. New employees are also being provided training concerning abuse, resident rights, the Elder Justice Act, and other.

Dementia care and behavioral symptoms training was completed on 9/29/14.

Continued Dementia care and behavioral education is provided during general orientation and is ongoing quarterly throughout the year. Hand in hand training is provided during general orientation for all new hires which addresses how to appropriately respond to residents' needs, rights and choices. Abuse training is completed with new hires and again quarterly with staff. Quarterly behavioral symptoms training will be provided on-going which will encompass a variety of trainings including CPI training, Dementia care training, and reviews of hand in hand training on a rotating schedule.

Employee files have been reviewed, going forth, the NHA/designee will review that all adequate screening have taken place prior to job offer and all proper trainings are completed before anyone begins. The NHA will sign off on employee files when reviewed.

Going forward all education provided to staff members will be documented and a copy placed in the employee file.

4. NHA/DON will report status of abuse investigations going forward and submit it to the IDT team for a comprehensive, interdisciplinary review which is to be reviewed monthly with the QA Committee to ensure proper screening, reporting, and protection of residents was conducted. This data obtained will be reviewed and analyzed for trends. The QA Committee evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance.

Cross reference F323.

Back to Survey Tag Summary for:COLOROW CARE CENTER

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Return to Health Facilities Main Page