F 000 INITIAL COMMENTS

Complaint investigation #31009 and 31547 was completed at Life Care Center of East Ridge on August 15, 2013. No deficiencies were cited for #31009. Deficiencies were cited for Complaint #31547, under 42 CFR PART 482, Requirements for Long Term Care Facilities.

F 226 SS=D 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of a facility investigation, review of facility policy, review of employee corrective action, and interview, the facility failed to follow facility policy to immediately intervene to protect one resident (#2) from alleged abuse and failed to immediately notify the Administrator and Director of Nursing of alleged abuse for one resident (#2) of five residents reviewed.

The findings included:

Resident #2 was admitted to the facility on November 16, 2012, with diagnoses including Dementia, Depression, Anxiety, and Hypertension.

Medical record review of a Quarterly Minimum Data Set (MDS) dated February 23, 2013,
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 revealed the resident had problems with short and long-term memory, and had severely impaired cognitive skills for daily decision making. Continued review revealed the resident was totally dependent with eating.

Medical record review of a Discharge Assessment Summary and Discharge Instructions revealed the resident transferred to another long-term care facility on April 26, 2013.

Review of a facility investigation dated April 15, 2013, (no time) completed by the Assistant Director of Nursing (ADON) revealed, on April 13, 2013, at 4:30 p.m., Certified Nursing Assistant (CNA) #1 observed resident #1's Power-of-Attorney (POA) "slapping" resident #1 across the face while feeding the resident in the dining room. CNA #1 left the dining room and reported the observation to Registered Nurse (RN) #1, who immediately went to the dining room. Continued review revealed RN #1 confronted the POA regarding the allegation and assigned constant one-to-one supervision of the POA while in the facility. The POA denied the allegation and stated, "...patted (resident) on the cheek because (resident) had a hard time staying awake to eat..." Further review revealed a head-to-toe assessment of the resident was completed and revealed no redness, bruising or other injuries related to the allegation. Continued review revealed no documentation CNA #1 intervened or attempted to intervene when the POA was allegedly slapping the resident. Continued review revealed no documentation RN #1 immediately notified the Administrator and/or DON.

Review of facility policies and procedures,

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1. CORRECTIVE ACTION
On 4/13/13, upon learning of the alleged incident, RN #1 provided immediate one-on-one supervision with Resident #2 when POA was present, informing POA that she was doing so due to alleged abuse. On 4/15/13, scheduled supervised visits were arranged for POA at all times he entered the facility. East Ridge Police were also notified of incident on 4/15/13 and a report was filed. POA remained on one-on-one supervision during the entirety of all visits until resident discharged on 4/26/13.

2. IDENTIFICATION OF OTHER RESIDENTS
Other residents on Resident #2's floor were interviewed and physically examined, with no signs or reports of abuse to be found.
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Chapter 2: Protection of Residents: Reducing the Threat of Abuse and Neglect, revised July 2011, revealed "...page 2-18...Reporting Alleged Abuse...Policy...This facility does not condone resident abuse and/or neglect by anyone. This includes, but is not limited to...the responsible party...All personnel will promptly report any incident or suspected incident of resident abuse...Policy Interpretation and Implementation...page 2-19...6...The incident will be reported immediately to the administrator or his designated representative and the director of nursing (DON)...page 2-29...Managing Incidents of Alleged Abuse and Neglect...REQUIREMENT...Immediate Action...3...Separate the alleged perpetrator from the resident(s)...5...Notify the executive director (Administrator) and the director of nursing...of the alleged incident..."

Review of a Corrective Action Form dated April 15, 2013, and signed in acknowledgement by RN #1 revealed "...Current Incident Description and Supporting Details...(Document factual details of the incident)...Description...Failure to immediately notify supervisor...Expectations...Immediate notification to supervisor to ensure appropriate action is taken...

Review of a Corrective Action Form dated April 16, 2013, and signed in acknowledgement by CNA #1 revealed "...Current Incident Description and Supporting Details...(Document factual details of the incident)...Description...Associate accurate understanding of facility's abuse and allegation of abuse policy...Expectations...Associate will immediately intervene if any observations of anyone harming or attempting to harm resident..."
LIFE CARE CENTER OF EAST RIDGE

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Interview by telephone with CNA #1 on August 6, 2013, at approximately 9:00 p.m., confirmed "I left the dining room and reported what I saw to my supervisor...there was another CNA in the dining room, but I can’t recall who..." When asked if CNA #1 attempted to stop the POA from slapping the resident or separate the POA from the resident, CNA #1 confirmed "No, I didn’t."

Interview by telephone with RN #1 on August 6, 2013, at approximately 10:00 p.m., confirmed, "It was reported to me the POA was observed slapping (resident) during supper in the dining room...I went to the dining room immediately...confronted the POA...assigned one-on-one supervision..." When asked if RN #1 immediately notified the Administrator and/or Director of Nursing of the allegation of abuse reported by CNA #1 on April 13, 2013, RN #1 confirmed "No, I didn’t notify either of them. They were not informed until April 15, 2013."

Interview with the Administrator on August 6, 2013, at approximately 10:15 p.m., confirmed the facility failed to immediately intervene to protect the resident when the POA was allegedly observed slapping the resident and failed to immediately notify the Administrator and the DON of an allegation of abuse.

C/O #31547