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	315209	A. BUILDING _____ B. WING _____	C 10/29/2019

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HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	43 N WHITE HORSE PIKE HAMMONTON, NJ 08037

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F 000	INITIAL COMMENTS COMPLAINT #: NJ129669 CENSUS: 207 SAMPLE SIZE: 3	F 000		
F 607 SS=G	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Complaint #: NJ 129669 Based on observation, interview, review of medical records and other facility documentation, it was determined that facility failed to ensure a safe environment by not implementing their abuse policy and procedure when an allegation of physical abuse was reported. The resident reported to the Nursing staff that a staff member pushed a bedside table that hit his/her [redacted] The facility's failure to initiate the process of investigation of alleged abuse placed Resident #2 at risk for harm as well as other residents with a similar incident. This deficient practice was revealed for 1 of 3 sampled residents (Resident	F 607	A. Immediate Correction: An investigation was immediately initiated on 10/21/19 when administration was made aware of the alleged incident. The following immediate corrective action occurred: 1. LPN#2, LPN#4 and CNA#1 were educated and received disciplinary actions. 2. UMS #3 was suspended and LPN #1 and RN#1 were terminated. 3. Resident #2 was immediately assessed for injury and a physical assessment was completed by the ADON and the Director of Social Services. There	11/26/19

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/25/2019

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F 607	Continued From page 1 #2) as evidenced by the following: On 10/22/2019, the Department of Health, Long-Term Care Complaints Program received a Facility Reporting Event of an alleged staff to resident abuse. The facility indicated in the Investigative Summary that the conclusion to their investigation indicated upon review of employee and resident statement, a reasonable person would conclude that abuse occurred. There were 5 witnesses stating that the Licensed Practical Nurse LPN #1 was either verbally and/or physically aggressive during the incident on [redacted] at 5 p.m. An on-site investigation revealed the following: On 10/28/19, the Assistant Director of Nursing (ADON) provided to the surveyor the facility "Abuse" Policy No. CA-1 Last Date Revised: 2/2019, which indicated the following: Policy: The facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriate of resident/patient property by anyone involving staff, family, friends, etc....The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property. Investigation Allegations/report of suspected abuse, neglect, mistreatment, ...shall be promptly and thoroughly investigated by facility management. The Shift Supervisor/Charge Nurse is	F 607	was an area noted to the [redacted] with [redacted] and a [redacted]. No swelling was noted. 4. Staff were interviewed and statements were obtained. 5. Social Services met with resident #2 and offered emotional support and obtained a statement. 6. MD was notified of the allegation and ordered labs to rule out any infection which included [redacted] 7. MD also ordered [redacted] and [redacted] evaluation. B. Identification of Other Patients: The following was implemented to identify any other patient affected: 1. Social Services Director interviewed all alert and oriented residents on the [redacted] to ensure no other allegations of physical or verbal abuse occurred. 2. The unit manager for [redacted] assessed all residents on the [redacted] for new [redacted] to ensure no other residents were negatively affected. All residents had the potential to be affected by the deficient practice mentioned in element #1 but no further allegations were reported. C. Systemic Changes: 1. The ADON re-educated LPN #2, LPN #3, LPN #4 and CNA #1 on the proper policy and procedure of abuse and reporting all allegations of abuse to their	

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F 607	Continued From page 2 identified as responsible for immediate initiation of the reporting process upon receipt of the allegation. Collect factual data on the Incident Entry Report Initiate the investigative process. The investigation should be thorough with witness statements from staff, residents, visitors and family members who may be interview and have information regarding the allegation. Conclusion must include whether the allegation was substantiated or not and what information supported the decision. Employee Suspension from Duty Any time an allegation is made involving abuse, neglect or mistreatment of a resident/patient, which names a specific employee, the employee is suspended until the completion of the investigation. The employee is not to remain on duty and is not to be assigned to any other area of the facility. Reporting Report the incident to the Administrator and Director of Nursing. The Administrator and Director of Nursing or designees will report to the Regional Clinical manager and RDO. Notify the local law enforcement and appropriate State Agency(s) immediately (no later than 2 hours after allegation/identification of allegation/identification of allegation) by Agency's	F 607	immediate supervisor to ensure a proper investigation is initiated. 2. All staff have been re-educated on the proper policy and procedure of abuse, neglect and involuntary seclusion, dementia and dealing with difficult behaviors by the RDCS, ADON and facility educator. The lesson plan and sign in sheet will be kept on file for validation. 3. Laminated signs were placed in all employee areas to continue to educate on how to report abuse. 4. Every employee was issued a laminated card to place behind their name badge on abuse prevention protocols. 5. Social Services will conduct interviews with a sample of residents focusing on resident abuse, weekly x 1 month and monthly x 6 months to ensure that reportable events are identified and investigated by the abuse prevention protocol officer. 6. An e-mail will be utilized by the nursing supervisors and weekend Manager on Duty indicating any allegations of physical or verbal abuse that may have occurred during their shift. The email will be sent to administrative staff for review. D. Quality Assurance Monitoring: 1. The Administrator/ DON will conduct random weekly audits x 1 month and monthly x 6 months to ensure compliance on abuse allegations and reporting. The audit will consist of interviews of 10% of staff members to determine if they have witnessed any alleged abuse and if they	

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F 607	Continued From page 3 designated process after identification of alleged/suspected incident. Initiate process according to the elder Justice Act and State-specific regulations. Once an allegation of abuse has been made, the supervisor who initially received the report must inform the Administrator/Director of Nursing immediately and initiate gathering requested information. An investigation MUST be directed by the Administrator or designee immediately. Upon receiving reports of physical or sexual the DON/designee shall immediately examine the resident. Findings of the examination must be recorded in the resident's record. For any allegations of physical assault with evidence of injury or witnessed physical assault the police should be contacted immediately. On 10/28/19, the surveyor received from the ADON the "Resident Abuse Response Checklist" worn by facility staff on their badges, indicated the following: Separate residents and/or send staff home. Provide for the residents' safety. Report to the incident to the supervisor. Prepare a physical assessment. Call doctor and family. Call police in the event of physical or sexual abuse by staff. Begin investigation. Obtain statements from residents and staff on unit. Notify the administrator and DON. Begin 72 hours of Nurse Notes for any resident involved in an altercation either verbal, physical or	F 607	understand the required reporting procedures. The results of the audits will be presented at monthly QA. 2. The Social Work Director will conduct an audit using the Elder Abuse Suspicion Screen on 5% of all patients weekly x 4 weeks and then monthly x 6 months. The results of the audit will be reported at QA.	

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sexual.
Notify social worker (5 days of notes).
Update care plan.

On 10/28/19, the surveyor reviewed the medical record of Resident #2 who was admitted to the facility on [redacted]. The Minimum Data Set (MDS), an assessment tool, dated [redacted] indicated that Resident #2 had a brief Interview for Mental Status (BIMS) score of [redacted] indicating Resident #2's [redacted] however, Resident #2 was able to understand what is being said to him/her.

During a tour of the unit on 10/28/19 at approximately 1:00 p.m., the surveyor observed Resident #2 in his/her room sitting in a wheelchair on [redacted]. The surveyor interviewed Resident #2 about the incident that occurred on [redacted]. The resident stated that at approximately 5 p.m., LPN #1(Licensed Practical Nurse) pushed the wheelchair into his/her room on [redacted] from the [redacted]. As LPN #1 was leaving the room, "I shoved the overbed table at the nurse and the nurse shoved it back hitting my [redacted] At this time, in the presence with another surveyor, Resident #2 picked up his/her [redacted] and the [redacted] had a [redacted]. Resident #2 recalled that none of the staff looked at the [redacted].

On 10/28/19, the surveyor requested Resident #2's Interdisciplinary Care Plan (IDCP). The facility provided an undated IDCP. The surveyor reviewed that the IDCP did not include the [redacted] to the [redacted] or injury secondary to staff to resident abuse. On 10/29/19, the surveyor was provided with an IDCP initiated [redacted], which included but was not limited to: In the "Focus"

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F 607	Continued From page 5 section:" Resident is at risk for [redacted]'s health [redacted]. In the "Goal" section: Resident skin will remain intact throughout the review period, initiated [redacted]. In the "Interventions/Tasks" section: Avoid [redacted], initiated 1[redacted]. Report to MD (Medical Doctor) any signs of deterioration or significant change to area of improvement, initiated [redacted]. The facility failed to update the IDCP when the incident occurred on [redacted] and upon discovery of the incident on [redacted] On 10/30/19, the surveyor conducted a post-survey interview via telephone with LPN #1 who had allegedly hit the resident on [redacted] LPN #1 was suspended by the facility on [redacted] pending the investigation and terminated on [redacted] LPN #1 stated that on 10/19/19 at 5 p.m., he observed Resident #2 in a wheelchair on the [redacted] nursing unit talking very loudly and being uncooperative with staff during dinner time. LPN #1 stated he went over to Resident #2 and bent down to the resident at eye level and was struck on the cheek. After being struck by the resident, LPN #1 stated he went to the sink to wash his face. When he returned to the floor, Resident #2 was still yelling loudly at the staff. He took Resident #2 back to his/her room. During the return to [redacted], the resident was still yelling and making attempts with [redacted] arms to reach behind the wheelchair to hit LPN #1. LPN #1 stated he had to use his thigh 2 times to hit the back of the wheelchair to prevent the wheel chair from tipping backwards. When he wheeled Resident #2 into his/her room, the resident was still yelling extremely loud to him. He assumed the resident	F 607		

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was getting ready to throw something at him, so LPN #1 walked backwards out of the room still facing the resident. At this time, Resident #2 grabbed the overbed table and pushed it at him. The overbed table hit the foot of the bed and fell on Resident #2's [redacted] LPN #1 then exited the room and told LPN #2 that the resident had tried to attack him. Also, LPN #1 went on to state that he failed to inform LPN #2, that the resident's overbed table fell on his/her [redacted]. LPN #1 stated that he proceeded to the nurses' station to contact a supervisor (Registered Nurse) RN#1.

The surveyor attempted to interview by phone RN #1 on 10/30/19 at 3:09 p.m., but she did not return the phone call. This employee was terminated by the facility on [redacted]

During an interview with the surveyor on 10/28/19 with LPN #2, she stated that she was assigned to Resident #2 on this 3PM- 11PM shift. She observed LPN #1 exit Resident #2's room and she confirmed that he didn't inform her of the overbed table hitting the resident's [redacted]. When LPN #2 entered Resident #2's room, he/she informed her that LPN #1 kicked him/her. Resident #2 then lifted his/her [redacted]. LPN #2 stated she left the resident's room to call supervisor RN #1.

LPN #2 stated she observed RN #1 enter Resident #2's room for approximately 2 minutes, then left the room and the unit. She stated RN #1 did not request an incident report or a statement from her on [redacted]. LPN #2 further stated she didn't document in the Interdisciplinary Progress Note (IPN) about the resident's injury to the [redacted]. She further stated she did not initiate an

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incident report, notify the physician of the injury, follow-up about the incident with RN#1 and update the care plan. LPN #2 stated that she should have followed the Abuse policy and procedure.

During an interview with the surveyor on 10/28/19, CNA #1 stated that on [redacted] around dinner time, she observed LPN #1 pushing Resident #2's wheel chair "really fast" towards the resident's room on [redacted] CNA #1 stated she observed that LPN #1's eyes were "bulging". She heard Resident #2 say to LPN #2 that he/she was kicked by LPN #1 on the[redacted] Later that evening, she observed RN #1 come to the unit and speak to LPN #1. RN #1 did not speak to her about what she observed during the incident or request a written statement. CNA #1 stated she spoke to LPN #3 on 10/20/19, on the 3 p.m.-11 p.m. shift regarding the incident on [redacted]. She was concerned that LPN #1 was back at work on [redacted]. CNA #1 also stated that she observed LPN #1 had no contact with the resident on the 3 p.m.-11 p.m. shift.

During an interview with the surveyor on 10/29/19, LPN/Unit Manager/Supervisor of the Nursing Unit (UMS #3) on [redacted] stated that on [redacted] between 4:15 p.m. and 4:30 p.m., CNA #1 informed her she was not comfortable with LPN #1 being assigned back on the floor because of the incident that happened yesterday with him and Resident #2. UMS #3 did not check if the incident report was done. However, she obtained written statements from CNA #1, LPN #2 and LPN #4. LPN #4 informed her that she overheard Resident #2 say "Hey, Hey Stop That" and that LPN #1 "hit the resident like he would be hitting a child." UMS #3 stated, "I was supposed to call

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Assistant Director of Nursing (ADON), but I didn't. Normally staff to resident abuse is investigated and LPN #1 should have been suspended pending the investigation." UMS #3 stated she should have followed the Abuse policy and notified the Assistant Director of Nursing immediately but failed to do so.

During an interview with the surveyor on 10/29/19 at 3:06 PM., LPN #4 stated she observed LPN #1 turn Resident #2's wheelchair around quickly and proceeded to run with the wheel chair to the resident's hallway and took the resident into his/her room. LPN #1 went into the room and slammed the door. LPN #4 stated "I heard noises, like bumping into things, like muffled bumping." She said she heard Resident #2 say "stop that". However, she didn't observe the incident.

During an interview with the surveyor on 10/30/19 at 11:34 AM. via telephone, RN #2 who worked the 7PM-7AM shifts on [redacted] and [redacted] stated she was aware that Resident #2 hit LPN #1 but was not aware of the alleged allegation that LPN #1 hitting Resident #2. RN #2 further stated she did not investigate to see what precipitated the incident between Resident #2 and LPN #1.

The surveyor requested the Time Cards provided by the facility to confirm that LPN #1 was not suspended even though RN #1 was aware of the incident on [redacted]. LPN #1 continued to work in the facility until [redacted] as indicated by the following:

10/19/19 4:11 PM 10/20/19 7:30 AM 14.25
10/20/19 2:53 PM 10/21/19 7:46 AM 15.75

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F 607	Continued From page 9 The facility was not able to provide the actual Assignment Sheet for [redacted], 3 PM-11PM. and 11PM.-7 PM. shifts. During an interview with the surveyor on 10/30/19 at 3:36 PM, via telephone, the Medical Director (MD) stated that on [redacted] at approximately 5 p.m., he received a call from the answering service to call the facility. The MD stated he spoke to a nurse who informed him of a change in Resident #2's behavior. The MD stated he was not informed of the allegation of physical abuse involving LPN #1 injuring Resident #2 until [redacted]9 by the ADON. It was at this time he gave orders to assess the injury and mental status of the resident. During the interview with the surveyor on 10/29/19 at 12:20 PM., the ADON stated after she finished reading the staff statements provided to her by UMS #3 on [redacted] at 8:30 a.m., regarding the staff to resident abuse on [redacted]9, she immediately notified the Administrator and the Regional Director Clinical Services (RDCS). The ADON stated the incident report completed by the RN #1 was found hidden in the back of the narcotic book. The report indicated that RN #1 was aware that Resident #2 reported LPN #1 hit him. RN #1 did not report the allegation of abuse. The ADON stated RN #1 should have notified Administration immediately and LPN #1 should have been suspended pending the investigation. During an interview with the surveyor on 10/29/19 at 1:35 PM., the Regional Director Clinical Services (RDCS) stated she was notified by the ADON on [redacted] at approximately 9 a.m. of the allegation of abuse by LPN #1 hitting Resident	F 607		

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F 607	Continued From page 10 #2. The RDCS stated that on [redacted], the staff should have acted upon the information they received according to the facility policy, to report the allegation of abuse, but failed to do so. On [redacted] the RDCS instructed the ADON to notify the Department of Health and the Police. According to RDCS, LPN #2, LPN #4 and CNA #1 were educated and received disciplinary actions. UMS #3 was suspended. LPN #1 and RN #1 were terminated. On 10/28/19, the ADON provided the surveyor the "Investigational Summary" dated [redacted]. The facility conclusion to their investigation of the alleged staff to resident abuse indicated: "Upon review of employee and resident statement, a reasonable person would conclude that abuse occurred. There were 5 witnesses stating that the LPN [#1] was either verbally and/or physically aggressive during the incident on [redacted] at 5 p.m. " NJAC 8:39-4.1 (a) 5	F 607		