STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29015 Based on facility record review, staff and resident interviews, it was determined the facility failed to ensure two residents (R) (R#121 and R#55) from a sampled 57 residents were free from physical and psychological abuse. R#121 was subjected to a painful failed urinary catheter insertion along with verbal threats from a staff member. Five days later on 12/23/18, R#55 was subjected to painful dis-impaction removal of stool by the same employee. On 1/8/19, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing, and the Regional Nurse Consultant and Regional Nurse Consultant were informed of the immediate jeopardy on 1/8/19 at 5:14 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on 12/18/18. The immediate jeopardy continued through 1/9/19 and was removed on 1/10/19. The immediate jeopardy was related to the facility's noncompliance with the program requirements at 42 C.F. R. 483.12 (a)(a)(1), Freedom from Abuse, Neglect, and Exploitation (F600, Scope/Severity: J); 42 CFR 483. 12(b)(1)?(4), Develop/Implement Abuse/Neglect, etc. Policies (F607, Scope/Severity: J); 42 CFR 483. 12(c)(2)?(4) Alleged Violations-Investigate/Prevent/Correct (F610, Scope/Severity: J); 42 C.F.R. 483. 21(b)(3)(i), Professional Standards (F658, Scope/Severity: J); 42 C.F.R. 483.70, Administration (F835, Scope/Severity: J). Additionally, Substandard Quality of Care was identified at: F600, Freedom from Abuse, Neglect and Exploitation F607, Develop/Implement Abuse/Neglect, etc. Policies F610, Alleged Violations-Investigate/Prevent/Correct (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER OR SUPPLIER Northridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Medical Center Drive Commerce, GA 30529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Credible Allegation of Compliance was received on 1/10/19. Based on observations, record reviews, interviews and review of the facility's policies and staff training as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 1/10/19. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of staff treatment of residents. In-service materials and records were reviewed. Observation and interviews were conducted with staff and residents to ensure they demonstrated knowledge of facility Policies and Procedures governing identifying and reporting Abuse, Neglect and Exploitation of residents. The Immediate Jeopardy is outlined as follows: 1. The facility's failure to protect R#121 from abuse were related to lack of a complete investigative procedures of the multiple attempts to insert an indwelling urinary catheter for R#121. During the initial tour of the facility on 1/7/19 the surveyor conducted a family interview and was informed that on 12/18/18 a urinary catheter insertion was attempted at least nine times on R#121. Interviews with staff revealed that during the failed attempts R#121 was screaming spank them . The nurse replied to the resident, I will spank you. The facility did not conduct a full investigation when this incident of alleged abuse was reported to the Director of Nursing (DON) and Administrator by Resident (R) #121's family member and three Certified Nurse Aides (CNA) who were present in the room with R#121 when the incident occurred. The alleged perpetrator, Licensed Practical Nurse (LPN) II, continued to work at the facility until dismissed on 1/9/19. 2. On 1/9/19 the surveyor was made aware during staff interviews of R#55 receiving a forceful dis-impaction by the same nurse on 12/23/18. The nurse continued to digitally dis-impact the resident when he yelled out in pain Can we take a break, the nurse replied to R#55, We don't take breaks here. The alleged perpetrator refused to stop attempts to dis-impact stool from R#55's rectum when the resident yelled and told the nurse he needed a break because she was hurting him. The resident has a diagnosis of constipation. It was bought to the attention of the Administrator on 1/9/19 that resident #55 received digital stimulation by LPN II without a physician's order, on 12/23/18. The facility began an immediate investigation and an allegation of abuse was sent to the state. Findings Include: 1. Interview conducted on 1/7/19 at 10:00 a.m. with the family of R#121 revealed approximately the week before last she was walking down the hall to R#121's room when the family heard R#121 screaming bloody murder. The family member walked into the room of R#121 and there were two Certified Nursing Assistant (CNAs) at the head of the resident's bed and Licensed Practical Nurse (LPN) II was attempting to insert a catheter. The family member also stated LPN II tried at least six times while the resident was still screaming. LPN II told family to get out of her way. The family member left the room to get LPN EE to put the catheter in. The family further stated they felt LPN II had abused R#121 because LPN II wouldn't stop even when R#121 was screaming in pain. The family was asked if they had told anyone and they stated yes, they had spoken to the Director of Nursing (DON), and LPN II is still working here. The family was questioned if LPN II had been assigned to the resident since the incident had occurred? They stated, No, we requested that nurse not be allowed to take of R#121. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER OR SUPPLIER Northridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Medical Center Drive Commerce, GA 30529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with the Administrator and DON in the Administrative office outer room on 1/7/19 at 3:30 p.m. The Administrator and DON were informed of R#121's family's allegation of abuse concerning the insertion of R#121's urinary catheter by LPN II. The DON and Administrator stated they both were aware of the catheter incident with LPN II and they had investigated the incident and did not consider it to be abuse, but rather a personality conflict. The DON and Administrator stated the family never told them it was abuse. The Administrator further stated they would begin another investigation related to abuse and report to the State as such. Review of the resident's face sheet revealed R#121 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, vascular dementia with behavioral disturbance, artificial openings of urinary tract (there was no evidence in the clinical record to confirm the resident had any artificial openings of the urinary tract), obstructive and reflux uropathy, restlessness and agitation, and neuromuscular dysfunction of bladder. Review of the resident's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the Brief Interview for Mental Status (BIMS) indicated R#121 was severely cognitively impaired. A review of Section E, Behaviors, indicated the resident did not exhibit physical behavioral symptoms directed towards others (such as hitting, kicking, pushing, scratching and grabbing), verbal behavioral symptoms directed towards others(such as threatening, screaming or cursing at others) and Other behavioral symptoms not directed at others (physical symptoms such as hitting or scratching self, .verbal/vocal sounds such as screaming and making disruptive sounds). A review of R#121's functional status indicated the resident was totally dependent for all activities of daily living (ADLs), with assistance from two or more people. This includes but is not limited to bed mobility, transfers, dressing, eating, toilet use and personal hygiene. A review of Section H, Bowel and Bladder indicated the resident had an indwelling catheter. Review of R#121's care plan, dated 10/17/18, problem: urinary catheter related to obstructive and reflux uropathy as evidenced by indwelling catheter. Goal: patient will be free of complications of indwelling catheter through the review period. Interventions: assess for bladder distention, small frequent voids, dribbling, resident complaint of bladder feeling full, care/changing of urinary catheter as ordered, confer with physician regarding the continued need of urinary catheter, consider the risks and benefits of continuing the long-term use of an indwelling urinary catheter and remove it as soon as possible if indicated, keep catheter tubing placed below of bladder, maintain closed, sterile system, tubing free of kinks, medications as ordered, observe and report any signs and symptoms of urinary tract infection(UTI), observe output, observe urine appearance, amount, odor, clarity, secure catheter tubing, and Urology consult as ordered. The care plan did not indicate R#121 was difficult to insert a urinary catheter. Review of Physician's orders, dated 10/1/18 at 2:11 p.m., revealed an order to change urinary catheter as needed (PRN) malfunction or dislodgement. Review of the grievance log for 8/1/18 through 1/7/19 and facility's reported incidents since last annual survey on 1/7/18 did not reveal any reports were made to the DON concerning R#121 and R#55. Review of the staff statements provided by the facility revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of CNA FF's signed statement dated 12/18/18 indicated that R#121 was agitated and screaming spank them, spank them, spank them! LPN II leaned down and told R#121 I'll spank you back. LPN II looked at R#121, and CNA FF and CNA HH we need to drug R#121 up because I can't deal with the screaming. R#121 is way too agitated, you won't be to hold R#121's legs open. CNA HH left the room, LPN II told me, you need to go and get someone to help hold R#121's hands while you hold R#121's legs. I don't have time for this, I have other things that I have to do. LPN II proceeded to try and insert the catheter into the clitoris and the vagina around eight times. family walked into room and asked what was going on. I explained the situation and the family came over to help. LPN II put a gloved hand up to the R#121's family members chest and told them to step away, you're in my light. The family immediately was agitated with LPN II and came to my side to help calm R#121. LPN II attempted to insert the catheter at least seven more times. The family and I told CNA GG to go and get LPN EE. LPN EE came in and asked what was going on? LPN II replied it won't go into R#121's meatus. LPN EE immediately took over and easily inserted the catheter on the first try. Review of CNA GG's signed statement dated 12/18/18 indicated that CNA GG was asked by CNA FF to help both CNA FF and LPN II insert a new catheter for R#121 because the resident's old catheter was clogged. LPN II attempted to insert the catheter into the clitoris around eight times. The resident's family entered the room and was wondering what was going on, CNA FF began to explain the catheter was clogged and it was being replaced. The family member stepped over near the bed by LPN II, when LPN II put her hand up and told the family Stay away, you are in my light. LPN II continued to put the catheter into R#121's vagina at least six more times and I was told by both the family and CNA FF to go get LPN EE. LPN EE inserted the catheter. Review of CNA HH's hand written statement, dated and signed on 12/18/18 indicated that CNA FF and CNA HH were changing R#121, when they noticed the resident's catheter was clogged and all the urine was going into the brief. CNA FF went and told LPN II about the catheter and LPN II agreed it needed to be changed. R#121 had become very agitated and was yelling slap them, slap them. LPN responded I'll slap you back. LPN II also got a little tense and told CNA FF and me that we need to drug R#121 up before I do this. CNA HH told LPN II No and CNA FF told LPN II that she could hold resident's legs open for LPN II to insert the catheter. At this time, I was so mad at the situation I walked out of the room to calm down. The facility provided no other witnesses statements/interviews from LPN EE, LPN II, Social Worker (SW) or, resident's family member or any other documentation related to this incident. The facility presented LPN II's written statement (undated) to the survey team on 1/8/19 after LPN II came to the facility and spoke to the Administrator. An interview was conducted with LPN EE on 1/7/19 at 4:20 p.m. in the Unit 1A nursing station. LPN EE was asked if she recalled the incident with R#121 and LPN II? LPN EE stated, Yes, CNA HH and R#121's family came out of room to get LPN EE. They stated LPN II was hurting R#121. When I went into the room, R#121 was sweating and appeared to be in pain. I was able to insert the urinary catheter, everything was visible. LPN II should have asked for help. LPN EE was asked how many times did it take her to insert the urinary catheter and did you have any difficulty inserting the urinary catheter? LPN EE stated, I was able to insert the catheter on the first attempt, I didn't have any difficulties and could visualize R#121's anatomy without any problems. Who did you report this to? The LPN stated, the Social Worker and DON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER OR SUPPLIER Northridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Medical Center Drive Commerce, GA 30529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with LPN JJ, the Unit Manager for Units 1A and 1B, on 1/7/19 at 4:39 p.m. at the Unit 1B nursing station. LPN JJ stated, The family came out of R#121's room upset about LPN II trying to insert the urinary catheter while the resident was yelling. The family told me not to let LPN II go back into resident's room. LPN JJ was asked what she did next? LPN JJ stated, I immediately informed the DON. Interview with the SW was conducted on 1/7/19 at 5:00 p.m. in the basement hallway. SW stated LPN EE called and told her what happened and told LPN EE to bring family down to talk to SW. The family told her that they had walked in when LPN II was attempting to insert the catheter. The family said they told LPN II to stop, do not touch her anymore. I took her to the DON's office to speak to the DON and Administrator. The SW was asked if there was any documentation of R#121's family and the SW's conversation? The SW stated, 'No. The SW was questioned who handles the complaints and grievances and who is the Abuse Coordinator? The SW replied, Complaints and grievances are handled by the SW, DON and Administrator. The Administrator is the Abuse Coordinator. An interview was conducted with Director of Nursing (DON) on 1/8/19 at 1:30 p.m. in the basement classroom. The DON was questioned when did the incident related to R#121 occur and what prompted her to obtain statements from CNA FF and CNA GG? The DON stated, the incident occurred on 12/18/18, R#121's family came to the DON's office and told the DON that LPN II had tried to insert the urinary catheter five or six times. The family member told the DON that they had offered to help but LPN II told her I have been a nurse for [AGE] years, I know what I am doing. The DON was asked what actions did she take? The DON stated, I took statements, spoke with and counseled LPN II and removed LPN II from R#121's care. The DON was asked why after reading the CNA's written statement and spoke with the family did the facility not report the incident or initiate an investigation? The DON stated, After speaking with LPN II, I did not feel the incident was abuse but a customer service issue. The DON was questioned if there was anything else included in the facility's investigation of the incident? The DON stated, No, I only have the CNA's statements. There were no statements from other nursing staff, family, other resident or LPN II's counseling included in the documentation provided to the survey team on 1/8/19. A review of the staffing reports from the date of incident on 12/18/18 until 1/8/19 revealed that LPN II continued to work at the facility either on the same or adjacent unit where R#121's room was located. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted on 1/8/19 at 5:29 p.m. with LPN II. LPN II was asked to describe the incident on 12/18/18 concerning R#121's catheter insertion. LPN II stated that she was passing medications when a CNA told her that R#121's catheter was occluded (blocked). LPN II went to resident's room and assessed the catheter, there was a white milky substance in catheter tubing. LPN II decided that it needed to be changed and went out to gather supplies. R#121 was agitated and yelling, LPN II asked the CNA FF to go get a second CNA to help while she stood at beside patting resident's hand and telling her what she was going to do. LPN II asked the CNAs to position R#121 so she could insert the catheter. The resident had a different anatomy, the meatus (urethral opening) is inside her vagina. LPN EE came into room to ask if she could help. LPN EE inserted catheter without difficulty. LPN II was asked how was R#121's demeanor at the time of the catheter insertion? LPN II stated that the resident was laughing, saying spank you, spank you and she replied to resident I'll spank you back. LPN II was asked how was the family during this procedure? The LPN stated the family did not appear to be upset. LPN II was asked how many times did you attempt to insert the catheter? The LPN stated two to three times, I stopped after the third attempt. LPN II was asked if she would do anything different the next time? The LPN stated In hindsight, it would have been better to get help. An interview was conducted on 1/9/19 at 8:40 a.m. with CNA HH in Unit 1B nursing station. CNA HH was questioned if she recalled the incident with R#121 and LPN II? CNA HH stated, Yes, CNA FF and I laid R#121 down after lunch to change her. The resident was agitated. While changing the resident's brief they noticed the urinary catheter appeared nasty and needed to be changed. CNA FF told R#121's nurse, LPN II. R#121 was very agitated and was yelling, smack you, smack you. LPN II told R#121 I'll smack you back. CNA HH was so upset she left the room and reported it to LPN EE. CNA HH was asked if LPN II was joking with R#121 when she said, I'll smack you back? CNA HH stated, No, LPN II was agitated and serious when LPN II said it. CNA HH was asked if she had ever witnessed any inappropriate treatment or responses by LPN II? The CNA stated, LPN II is always rude with other residents and has a bad attitude. CNA HH did she think LPN II was being abusive towards the resident? CNA HH stated Yes, LPN II had no patience and was verbally abusive to the resident. CNA HH was questioned what happened after she reported it to LPN EE? CNA HH stated, LPN II went to the DON's office, when she came back LPN II went right back to work. CNA HH was questioned if LPN II went back to taking care of R#121? CNA HH stated, No, LPN EE took over the care of the resident, but LPN II still work on the unit. Interview was conducted on 1/9/19 at 9:07 a.m. with CNA FF in Unit 1B nursing station. CNA FF stated remembering the incident with R#121 and LPN II. The resident was very agitated, yelling and clapping her hands. CNA HH and I were changing R#121's brief because the resident had a bowel movement and noticed the urinary catheter was clogged and there was no urine output. I went to tell her nurse, LPN II. LPN II came to room and assessed the catheter and agreed it needed to be changed. R#121 was yelling spank you, spank you when LPN II told R#121 I am going to spank you. CNA FF was asked if LPN II said this in a joking manner? CNA FF stated No, LPN II was very irritated with the resident, it did not come off as a joke but as a threat. This is when CNA HH left the resident's room. LPN II told me I needed to get some help and I asked CNA GG to come in to help. LPN II was struggling to get the urinary catheter inserted when R#121's family walked into the room. When the family stated, let me help, LPN II put her dirty hand up and told the family they needed to back up. At one-time LPN II stated, We need to drug R#121 up because she is too agitated. I felt I needed to stay in R#121's room or LPN II would hurt her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with CNA GG on 1/9/19 at 9:25 a.m. in Unit 1B nursing station. The CNA was questioned if the CNA recalled the incident with R#121 concerning the urinary catheter insertion on R#121? The CNA stated, Yes, I do. The CNA stated, CNA FF asked if I could help with R#121. LPN II had tried to insert the urinary catheter about 10 times. CNA FF told LPN II that the nurse needed to go up higher. LPN II told CNA FF I know what I am doing. The family came in and LPN II put her hand up in front of family and told them, they were in the way. R#121 was getting more agitated and sweatier, CNA FF told me to go get LPN EE. LPN EE came in inserted the urinary catheter in one attempt. A telephone interview was conducted on 1/10/18 at 11:25 a.m. with the facility's Medical Director (MD). The MD was asked what level of competency for nursing with placing a Foley (urinary) catheter do you expect? The MD stated, Only difficulty I am aware of have been anatomical, i.e., men with benign prostatic hypertrophy (BPH). If the catheter is difficult to place then we would send resident next door to the hospital, but I can't remember any instances. What are your expectations if the nurse is having difficulty inserting catheter? The MD stated, Even if proficient, if you realize you can't place the catheter, don't continue, ask for help, use good decision making. Related to R#121's incident what are your thoughts? R#121 anatomy is a little difficult (legs are contracted), the resident has had a catheter for four to five years. She not only gets agitated she can get really wound up. Need to limit people giving care, the nurse should have stopped, she lost control. 2. During an interview conducted with CNA GG on 1/9/19 at 9:25 a.m. in Unit 1B nursing station. CNA GG was asked if LPN II was involved in any other incident regarding resident care? CNA GG stated, Yes, about a month ago, CNA GG was in R#55's room holding him on his side so LPN II could remove stool from R#55's rectum. During the procedure, R#55 told LPN II I need a break. LPN II told R#55, We don't take breaks, I have other residents to take care of. CNA GG stated after LPN II had finished removing stool from the resident's rectum, I went to LPN EE and let her know what had happened. LPN EE and I both wrote statements of what happened. An interview was conducted with LPN EE in Unit 1B hallway on 1/9/19 at 9:45 a.m. LPN EE stated CNA GG came to me and told me that LPN II had refused to stop the dis-impaction when the resident had yelled and told LPN II he needed a break. I immediately went into the resident's room and did an assessment. There were no injuries. CNA GG and I both wrote statements and I placed them on the DON's desk. LPN EE was asked if she had done any dis-impactions at the facility? LPN EE stated, No, I will try other interventions such as medications, suppositories and rectal massage but not dis-impaction. If none of that worked, then I would contact the physician. The facility could not produce any written statements for 12/23/18 incident written by the staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with R#55 at the resident's bedside on 1/9/19 at 10:15 a.m. R#55 was asked if he recalled LPN II and initially he stated, No. R#55 was then questioned if he has a problem with constipation and ever needed any help to have a bowel movement? The resident was hesitating to reply but stated Yes, I do have constipation and sometimes I ask for help. The resident was asked what does staff usually do to help with the constipation? R#55 stated the nurse usually gives me some pills to help. R#55 was questioned if he recalled an incident before Christmas where he yelled at a nurse helping him to stop, he needed a break? The resident stated, Yes, he did recall that incident, the nurse was very rough with me. R#55 was asked why he had yelled and asked the nurse for a break? R#55 stated, Because she was hurting me. When questioned if he could recall who the nurse was, R#55 stated No I don't recall her name. R#55 was asked if he reported the incident to anyone? The resident stated, No, but the other nurse came in and checked me. An interview was conducted with the DON on 1/9/18 at 4:15 p.m. in the basement classroom. The DON was asked what the expectation of the nursing staff and treating a resident with constipation? What should have LPN II done when R#55 asked the nurse to stop because it hurt? The nursing staff is expected to administer medications first, if no results than notify the Physician. LPN II should have not have been dis-impacting the resident because we don't do dis-impaction of stool. The nurse should have notified the Physician for further orders. The DON made the survey team aware that LPN II was let go. When the DON was questioned what was the reason for letting the LPN go? The DON stated it was based on not following professional standards related to the dis-impaction of R#55. There were no concerns expressed prior to December concerning LPN II. On 1/10/19 at 10:00 a.m. and at 11:30 a.m. two failed attempts were made to contact LPN II for an interview related to R#55. There was no answer and the voice mailbox was full. Record review revealed R#55 was admitted to the facility on [DATE] with diagnoses that included: diverticulosis, colon polyps, colostomy repair, hemicolectomy with colostomy, hypertension and left abdominal hernia repair and constipation. Review of the resident's admission MDS dated [DATE], indicated R#55's BIMS of 14 indicating the resident was cognitively intact. Review of the resident's functional status indicated R#55 required extensive assistance with bed mobility, toilet use and personal hygiene with an assistance of two or more persons. Review of section HH, Bowel and Bladder, indicated the resident was frequently incontinent of bowel and bladder but did not indicate the resident currently has a colostomy. A review of the physician's history and Physical dated 11/9/18 indicated R#55 had a colostomy repair, hemicolectomy with colostomy and diverticulosis. Review of Physician's orders dated 11/8/18 revealed orders for Senna 8.6 milligram(mg) one tablet by mouth two times per day as needed for constipation. Bisacodyl EC 5 mg tablet, delayed release, one tablet by mouth one time per day as needed for constipation. Order dated 11/12/18 for docusate sodium 100mg capsule, 1 capsule one time per day for constipation A review of the nursing notes dated 12/23/18 indicates R#55 was administered Bisacodyl EC 5mg tablet at 9:02 a.m. and reassessed the resident at 12:11 p.m. as having no results. Further review of the nursing note did not indicate that LPN II notified the Physician of the resident's condition or to receive Physician orders prior to manually removing R#55's stool impaction at 1:25 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 1/10/19 at 11:25 a.m. with the facility's Medical Director (MD), the MD was asked if there is a standing order for nursing to dis-impact a resident? Is nursing supposed to dis-impact a resident? The MD stated, not unless they communicate with the Physician. Dis-impaction should not be a first choice, there should be orders for stool softener/laxative. Questioned what are the risks of dis-impaction? Stated rectal exam is a low risk, in general with dis-impaction could develop a tear. The MD was questioned concerning R#55's incident related to dis-impaction. Did you recall if LPN II called you about R#55 and dis-impacting the resident? The MD stated, I don't recall anyone asking me about dis-impaction. I recently added a new medication for R#55, he has had a problem in the past. Dis-impaction is not something I would encourage and is not commonly done. The facility implemented the following actions to remove the Immediate Jeopardy: 1. Associate LPN was immediately suspended from services until investigation is completed. 2. Interview was conducted with resident #121 daughter in law by Administrator on 1/7/2018. No concerns around patient care was expressed at this time. Patient #55 was interviewed and did not recall any concerns with the nurse: patient states he trusted the nurse however patient did state that during the middle of the procedure he did ask her to stop and because she was in the middle, she did not immediately stop but did shortly after. 3.1/8/2019 resident #121 and #55 received a complete body assessment by unit manager. No signs of adverse. were noted. Resident #121 unable to be interviewed. No signs of emotional distress were noted during assessment or have been reported by staff. On 12/23/2018 resident #55 received an assessment post procedure to look for signs of injury and none were noted by change nurse statement. Reason for post assessment by different change nurse was due to a CNA voice concerns around the treatment resident #55 had just received. 4. On 1/8/2019 All 78 current residents with a BIM score of one or higher were interviewed by Social Services Coordinator and Admissions Coordinator regarding abuse. Two of 78 residents were interviewed, indicated concerns that are currently under investigation. The two concerns that were voiced where: 1) CNA handled a resident rough during a shower and 2) resident claimed that she was handled rough CNA delivering care. Both incidents have been self-reported as allegations of abuse. All 73 current residents with a BIM score of nine or lower were given full body assessments by ADON, MDS, Unit Managers and wound care nurse, and education coordinator. No evidence of abuse was identified (0/73). 5. As of 1/8/2019 review of Resident #121's care plan was conducted by DON and Regional Nurse. Changes were made to resident #121's care plan to reflect current behavior of crying, yelling, and pinching. Interventions were added to reflect anxiety/agitation is demised by watching TV, and if resident displays anxiety/agitation to stop care and re-approach. The sections of the care plan on obstructive and reflux uropathy had interventions added to ensure visualization of urethra before attempting to place Foley catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Beginning 1/8/2019 staff education was provided by the education coordinator to associates currently on duty regarding recognition and reporting abuse/neglect. This education included Activities (4/4), Administration (9/10), Dietary (23/23), Social Services (2/2), RN's (11/11), LPN's (24/25), CNA's (54/60), Environmental Services (5/6) and Maintenance (2/2) associates. In total 95% (134/141) of associates have been educated on abuse and neglect. Associates that have not received the education will be in-serviced before returning to work. 7. As of 1/8/2019 physician and Medical Director was notified of incidents related to patients #55 and #121 with no new orders indicated. 8. Ad-hoc QAPI meeting was held 1/9/2019 at 8:00 am to discuss finding from patient interviews, finding from body assessments, professional standards of care. The QAPI policy was discussed for process improvement. No changes were made to the current policy on abuse, professional standards of care, or QAPI. Systemic Changes 1. Beginning 1/8/19 staff education was provided by the education coordinator to associates currently on duty regarding recognition and reporting of abuse/neglect. This education included Activities (4/4), Administration (9/10), Dietary (23/23), Social Services (2/2), RN's (11/11), LPN's (24/25), CNA's (54/60), Environmental Services (5/6) and Maintenance (2/2) associates. In total 95% (143/141) of associated have been educated on abuse and neglect. Associates that have not received the education will be in-serviced before returning to work. 2. On 1/8/2019 The Social Service Director and admissions director conducted patient interviews for all 78/78 interviews for all 78/78 interview able residents to determine if there are concerns involving abuse. On 1/8/2019 all 73/73 non-interviewable residents received a full body assessment from ADON, MDS, Wound Nurse, education coordinator, and unit managers. These results were submitted to the QAPI committee. 3. 78/78 interviewable residents received verbal education on how to report abuse, neglect, and /or exploitations by Unit Mangers on 1/9/2019, 151/151 residents received a printout on how to contact the abuse preventive officer for suspected abuse. On, 1/9/2019 a letter was mailed to 73/73 on interview able residents responsible parties o [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER OR SUPPLIER Northridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Medical Center Drive Commerce, GA 30529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 29015 Based on interviews, review of the facility's abuse investigation, and review of facility policy titled Abuse Prohibition, it was determined the facility failed to implement abuse interventions for two alleged abuse incidents involving residents (R) R#121 and R#55 by the same employee. The facility failed to implement a thorough investigative process for R#121. The facility failed to implement a monitoring system of the alleged perpetrator thereby leading a second abuse incident involving R#55. The survey sample was 57 residents. On 1/8/19, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing, and the Regional Nurse Consultant and Regional Nurse Consultant were informed of the immediate jeopardy on 1/8/19 at 5:14 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on 12/18/18. The immediate jeopardy continued through 1/9/19 and was removed on 1/10/19. The immediate jeopardy was related to the facility's noncompliance with the program requirements at 42 C.F. R. 483.12 (a)(a)(1), Freedom from Abuse, Neglect, and Exploitation (F600, Scope/Severity: J); 42 CFR 483. 12(b)(1)?(4), Develop/Implement Abuse/Neglect, etc. Policies (F607, Scope/Severity: J); 42 CFR 483. 12(c)(2)?(4) Alleged Violations-Investigate/Prevent/Correct (F610, Scope/Severity: J); 42 C.F.R. 483. 21(b)(3)(i), Professional Standards (F658, Scope/Severity: J); 42 C.F.R. 483.70, Administration (F835, Scope/Severity: J). Additionally, Substandard Quality of Care was identified at: F600, Freedom from Abuse, Neglect and Exploitation F607, Develop/Implement Abuse/Neglect, etc. Policies F610, Alleged Violations-Investigate/Prevent/Correct A Credible Allegation of Compliance was received on 1/10/19. Based on observations, record reviews, interviews and review of the facility's policies and staff training as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 1/10/19. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of staff treatment of residents. In-service materials and records were reviewed. Observation and interviews were conducted with staff and residents to ensure they demonstrated knowledge of facility Policies and Procedures governing identifying and reporting Abuse, Neglect and Exploitation of residents. The Immediate Jeopardy is outlined as follows: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The facility's failure to protect R#121 from abuse were related to lack of a complete investigative procedures of the multiple attempts to insert an indwelling urinary catheter for R#121. During the initial tour of the facility on 1/7/19 the surveyor conducted a family interview and was informed that on 12/18/18 a urinary catheter insertion was attempted at least nine times on R#121. Interviews with staff revealed that during the failed attempts R#121 was screaming spank them . The nurse replied to the resident, I will spank you. The facility did not conduct a full investigation when this incident of alleged abuse was reported to the Director of Nursing (DON) and Administrator by Resident (R) #121's family member and three Certified Nurse Aides (CNA) who were present in the room with R#121 when the incident occurred. The alleged perpetrator, Licensed Practical Nurse (LPN) II, continued to work at the facility until dismissed on 1/9/19. 2. On 1/9/19 the surveyor was made aware during staff interviews of R#55 receiving a forceful dis-impaction by the same nurse on 12/23/18. The nurse continued to digitally dis-impact the resident when he yelled out in pain Can we take a break, the nurse replied to R#55, We don't take breaks here. The alleged perpetrator refused to stop attempts to dis-impact stool from R#55's rectum when the resident yelled and told the nurse he needed a break because she was hurting him. The resident has a diagnosis of constipation. It was bought to the attention of the Administrator on 1/9/19 that resident #55 received digital stimulation by LPN II without a physician's order, on 12/23/18. The facility began an immediate investigation and an allegation of abuse was sent to the state. The findings include: The facility's Abuse Prohibition policy dated August 2017 indicated it is the intent of this center to actively preserve each patient's right to be free from mistreatment, neglect, abuse and misappropriation of patient property. Whenever a patient, family member, or anyone else makes a complaint on behalf of the patient that alleges abuse, corporal punishment, involuntary seclusion, neglect, mistreatment, misappropriation of patient property, or exploitation has occurred, the procedures listed in this policy will be adhered to. Under the section titled Identification of possible abuse, neglect, or exploitation indicates 'Once an injury or event is identified as suspicious and may constitute abuse, the center will follow the investigation procedures. 5. It will be the responsibility of any department head receiving the complaint of alleged abuse, corporate (sic) punishment, involuntary seclusion, neglect, mistreatment, misappropriation of patient property or exploitation to inform the Administrator or designee immediately The section titled Prevention B. indicated the Center will identify, correct and intervene in situations in which abuse, neglect and /or misappropriation of patient property is more likely to occur. This will include an analysis of: 3. The supervision of staff to identify in appropriate behaviors, such as using derogatory language, rough handling, ignoring patients while giving care, directing patients who need tilting assistance to urinate or defecate in their beds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER OR SUPPLIER Northridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Medical Center Drive Commerce, GA 30529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. During an interview on 1/7/19 at 10:00 a.m. the family of R#121 revealed the family reported they had walked into the resident's room where they witnessed LPN II attempted at least six times to unsuccessfully insert a urinary catheter into R#121. The family added that LPN II did not stop even though the resident was screaming. The family reported the incident to the Director of Nursing (DON). Review of the facility's investigation dated 12/18/18 revealed documents that consisted of three CNA witness statements. Review of the witness documentation dated 12/18/18 from CNA FF indicated R#121 was agitated and screaming spank them, spank them, spank them! LPN II leaned down and told R#121 I'll spank you back. LPN II looked at R#121, and CNA FF and CNA HH we need to drug R#121 up because I can't deal with the screaming. R#121 is way too agitated, you won't be to hold R#121's legs open. CNA HH left the room, LPN II told me, you need to go and get someone to help hold R#121's hands while you hold R#121's legs. I don't have time for this, I have other things that I have to do. LPN II proceeded to try and insert the catheter into the clitoris (area above the urethral opening) and the vagina around eight times. Family walked into room and asked what was going on. I explained the situation and the family came over to help. LPN II put a hand up to R#121's family member and told them to step away, you're in my light. The family immediately was agitated with LPN II and came to my side to help calm R#121. LPN II attempted to insert the catheter at least seven more times. The family and I told CNA GG to go and get LPN EE. LPN EE came in and asked what was going on? LPN II replied it won't go into R#121's meatus. LPN EE immediately took over and easily inserted the catheter on the first try. Review of the witness documentation dated 12/18/18 from CNA GG indicated that CNA GG was asked by CNA FF to help both CNA FF and LPN II insert a new catheter for R#121 because the resident's old catheter was clogged. LPN II attempted to insert the catheter into the clitoris around eight times. The family entered the room and was wondering what was going on, CNA FF began to explain the catheter was clogged and it was being replaced. The family stepped over near the bed by LPN II, when LPN II put her hand up and told the family Stay away, you are in my light. LPN II continued to put the catheter into R#121's vagina at least six more times and I was told by both the family and CNA FF to go get LPN EE. LPN EE inserted the catheter. Review of the witness documentation dated 12/18/18 from CNA HH indicated that CNA FF and CNA HH were changing R#121, when they noticed the resident's catheter was clogged and all the urine was going into the brief. CNA FF went and told LPN II about the catheter and LPN II agreed it needed to be changed. R#121 had become very agitated and was yelling slap them, slap them. LPN responded I'll slap you back. LPN II also got a little tense and told CNA FF and me that we need to drug R#121 up before I do this. CNA HH told LPN II No and at this time, I was so mad at the situation I walked out of the room to calm down. The facility's investigation report failed to include statements from LPN EE, the family member, and additional residents taken care of by LPN II. In addition, the investigation did not include the determination or outcome of the investigation and what corrective actions were put in place to prevent a reoccurrence of this type of incident. Review of Nursing Notes dated from 12/1/18 to 1/7/19 failed to reveal any documentation of the incident involving R#121. Review of the Physician's Notes dated from 12/1/18 to 1/7/19 failed to reveal any medical documentation of assessing the resident after incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with the Administrator and DON in the Administrative office outer room on 1/7/19 at 3:30 p.m. informed the Administrator and DON of R#121's family allegation of abuse concerning #121's urinary catheter and LPN II. The DON and Administrator stated they both were aware of the catheter incident with LPN II They investigated it but did not find it to be abuse, it was a personality conflict. Both the DON and Administrator stated the family never told them it was abuse. The Administrator stated they will begin another investigation related to abuse and report to state as such. Interview was conducted with LPN JJ, Unit Manager for Units 1A and 1B, on 1/7/19 at 4:39 p.m. at the Unit 1B nursing station. LPN JJ was questioned what she recalled about the incident with R#121 and LPN II? LPN JJ stated, The family came out of R#121's room upset about LPN II trying to insert the urinary catheter while the resident was yelling. The family told me not to let LPN II go back into resident's room. LPN JJ was asked what she did next? LPN JJ stated, I told the DON. LPN JJ was questioned what else did LPN JJ do after informing the DON? LPN JJ stated the DON instructed me to remove LPN II from R#121's care and assign LPN II to another resident. LPN JJ was asked if LPN II was working on the same unit after their assignment was changed? LPN JJ stated, Yes, the only change was R#121's nurse assignment. 2. During an interview conducted with CNA GG on 1/9/19 at 9:25 a.m. in Unit 1B nursing station, CNA GG stated, About a month ago, she was in R#55's room holding him on his side so LPN II could dis-impact the resident. During the procedure, R#55 told LPN II I need a break. LPN II told R#55, we don't take breaks, I have other residents to take care of. CNA GG stated after LPN II was done, I went to LPN EE and let her know what had happened. LPN EE and I both wrote statements of what happened. During an interview with the Administrator on 1/9/19 at 10:30 a.m. the Administrator was asked if he was aware of the incident with R#55 related to the painful removal of stool from the resident's rectum? The Administrator stated, No I was not aware of that incident, but I will speak with the DON. The Administrator was asked if there was any documentation of an investigation being conducted? The Administrator stated, I will have to get with the DON on that. The facility was unable to provide investigative documentation of 12/23/18 incident. Review of the Nurses Notes dated 12/23/18 at 1:25 p.m. indicated Resident complained of constipation this a. m. (morning) States hasn't had a bowel movement in a week. Large fecal impaction cleared manually. Review of Physician Progress Notes dated from 12/1/18 to 1/9/19 did not indicate the physician was made aware of the incident or an order to dis-impact the resident was requested. Interview was conducted with R#55 at the resident's bedside on 1/9/19 at 10:15 a.m. R#55 was asked if he recalled the incident on 12/23/18, R#55 stated, yes, he did recall that incident, the nurse was very rough with me. R#55 was asked why he had yelled and asked the nurse for a break? R#55 stated, because she was hurting me. When questioned if he could recall who the nurse was, R#55 stated no I don't recall her name. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER OR SUPPLIER Northridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Medical Center Drive Commerce, GA 30529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 1/9/19 at 4:15 p.m. with the DON revealed when asked who collects and investigates the complaints and grievances? The DON stated, I do, the Social Service Director and the Administrator. The DON was questioned concerning the incidents involving R#121 and R#55? The DON stated, I wasn't aware of R#55's incident until today and R#121 I perceived it to be a customer service issue. The DON was asked why she wasn't aware of R#55's situation until today, when LPN EE and CNA GG left written statements on her desk? The DON stated, I was told it was on my desk, but I never received the statements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. 29015 Based on interview and review of facility investigations, it was determined the facility failed to thoroughly investigate the 12/18/18 incident where R#121 was subjected to a painful urinary catheter insertion and verbal threats. The facility failed to develop preventive measures in place to ensure no other vulnerable residents experience abuse from the same nurse. This failure resulted in the 12/23/18 incident in which R#55 was subject painful removal of stool by the same nurse. The sample size was 57. This deficient practice created the potential that abuse would go unrecognized, not addressed, and perpetuate a culture in which abuse could occur. On 1/8/19, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing, and the Regional Nurse Consultant and Regional Nurse Consultant were informed of the immediate jeopardy on 1/8/19 at 5:14 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on 12/18/18. The immediate jeopardy continued through 1/9/19 and was removed on 1/10/19. The immediate jeopardy was related to the facility's noncompliance with the program requirements at 42 C.F. R. 483.12 (a)(a)(1), Freedom from Abuse, Neglect, and Exploitation (F600, Scope/Severity: J); 42 CFR 483. 12(b)(1)?(4), Develop/Implement Abuse/Neglect, etc. Policies (F607, Scope/Severity: J); 42 CFR 483. 12(c)(2)?(4) Alleged Violations-Investigate/Prevent/Correct (F610, Scope/Severity: J); 42 C.F.R. 483. 21(b)(3)(i), Professional Standards (F658, Scope/Severity: J); 42 C.F.R. 483.70, Administration (F835, Scope/Severity: J). Additionally, Substandard Quality of Care was identified at: F600, Freedom from Abuse, Neglect and Exploitation F607, Develop/Implement Abuse/Neglect, etc. Policies F610, Alleged Violations-Investigate/Prevent/Correct A Credible Allegation of Compliance was received on 1/10/19. Based on observations, record reviews, interviews and review of the facility's policies and staff training as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 1/10/19. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of staff treatment of residents. In-service materials and records were reviewed. Observation and interviews were conducted with staff and residents to ensure they demonstrated knowledge of facility Policies and Procedures governing identifying and reporting Abuse, Neglect and Exploitation of residents. The Immediate Jeopardy is outlined as follows: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER OR SUPPLIER: Northridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 Medical Center Drive Commerce, GA 30529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The facility's failure to protect R#121 from abuse were related to lack of a complete investigative procedures of the multiple attempts to insert an indwelling urinary catheter for R#121. During the initial tour of the facility on 1/7/19 the surveyor conducted a family interview and was informed that on 12/18/18 a urinary catheter insertion was attempted at least nine times on R#121. Interviews with staff revealed that during the failed attempts R#121 was screaming spank them . The nurse replied to the resident, I will spank you. The facility did not conduct a full investigation when this incident of alleged abuse was reported to the Director of Nursing (DON) and Administrator by Resident (R) #121's family member and three Certified Nurse Aides (CNA) who were present in the room with R#121 when the incident occurred. The alleged perpetrator, Licensed Practical Nurse (LPN) II, continued to work at the facility until dismissed on 1/9/19. 2. On 1/9/19 the surveyor was made aware during staff interviews of R#55 receiving a forceful dis-impaction by the same nurse on 12/23/18. The nurse continued to digitally dis-impact the resident when he yelled out in pain Can we take a break, the nurse replied to R#55, We don't take breaks here. The alleged perpetrator refused to stop attempts to dis-impact stool from R#55's rectum when the resident yelled and told the nurse he needed a break because she was hurting him. The resident has a diagnosis of constipation. It was bought to the attention of the Administrator on 1/9/19 that resident #55 received digital stimulation by LPN II without a physician's order, on 12/23/18. The facility began an immediate investigation and an allegation of abuse was sent to the state. The findings include: 1. An interview was conducted with R#121's family on 1/7/19 at 10:00 a.m. during the initial resident pool selection. The family expressed concerns related to LPN II that is currently employed by the facility. The family stated they had reported an incident that occurred on 12/18/18 to the Director of Nursing (DON) involving LPN II attempting at least six times to insert a urinary catheter into the resident while the resident was screaming. They requested the nurse no longer take care of R#121. Although this occurred, LPN II continues to work at the facility on the same unit. Interview with the DON and Administrator on 1/7/19 at 3:30 p.m. revealed when asked if they were aware of the allegation from R#121's family? They both stated, Yes, they were aware of it. They were asked if it had been investigated and if there was any documentation of the investigation? The DON stated she had investigated it and the Administrator and the DON agreed they thought it was a personality conflict between the family and the nurse. But that they were unable provide complete documentation of the investigation. The facility was only able to provide three CNAs' witnesses statements, no other documentation of the investigation. The DON was questioned if there was any further documentation? The DON stated, No, this was all they had. Interview on 1/8/19 at 1:30 p.m. with the DON revealed when asked what type of investigation did the facility conduct following the incident with R#121 and LPN II? The DON stated, I took statements from the CNAs present, and spoke with LPN II and provided counseling for the nurse. The DON was questioned if the facility had interviewed any other staff or residents concerning care they received from LPN II and why after reading the CNA's written statement and speaking with the family did the facility not report the incident or initiate an investigation? The DON stated, No I didn't interview anyone else because after speaking with LPN II, I did not feel the incident was abuse but a customer service issue. The DON was asked for the counseling provided to LPN II but was only able to provide the nurse's orientation training from November 2018. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's staffing schedule for 12/1/18 through 1/7/19 indicated LPN II had continued to work on both nursing units that R#121 and R#55 were located. Although LPN II was no longer assigned to R#121 after the incident was reported, LPN II continued to care for R#55 after the 12/23/18 incident had occurred until the nurse was suspended on 1/7/19. Review of the facility reported incidents since the last annual survey in 2/2018 and the incident/grievance log from 8/2018 through 1/7/18 was conducted and there were no reports that included R#121 or R#121's family. 2. During an interview with CNA GG on 1/9/19 at 9:25 a.m. at the Unit 1B nursing station it was revealed that LPN II was involved in an incident with R#55. While LPN II was manually removing stool from R#55's rectum it became too painful and the resident asked to take a break. LPN II responded We don't take breaks . and proceeded with the procedure. CNA GG immediately reported the incident to the LPN EE CNA GG and LPN EE stated during interviews on 1/9/19 at 9:25 a.m. and 9:45 a.m., respectively, that they had written a statement regarding the incident as it occurred and placed it on the DON's office desk. LPN EE did not report the incident to the Unit Manager (UM), the UM was not available due to the holidays and the nurse did not recall if she had called the DON. An interview with the DON on 1/9/18 at 4:15 p.m. revealed when asked if there was any written statements from the staff concerning R#55's incident with LPN II, the DON stated, No, I wasn't aware of the situation until today. The DON was asked what should the staff do if they need to report an incident such as R#55s? The DON stated, The staff are to notify their Charge Nurse or Unit Manager. If unavailable, they are to notify either the DON or Administrator. The DON was asked what happens next? The DON stated, the facility would start an investigation to see if it was abuse or not. The staff member involved would be suspended during the investigation. A review of the facility's reportable incidents since last survey in 2/2018 and the incident/grievance log failed to indicate R#55's incident had been investigated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29015 Based on interview, record review, and review of the Georgia Practical Nurses Practice Act, it was determined the facility failed to ensure professional standards of care were maintained for two residents (R) (R#121 and R#55) from a sampled 57 residents. Specifically, nursing staff were not following the standard of care related to urinary catheter insertion for R#121 and the treatment for R#55 with constipation. On 1/8/19, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing, and the Regional Nurse Consultant and Regional Nurse Consultant were informed of the immediate jeopardy on 1/8/19 at 5:14 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on 12/18/18. The immediate jeopardy continued through 1/9/19 and was removed on 1/10/19. The immediate jeopardy was related to the facility's noncompliance with the program requirements at 42 C.F. R. 483.12 (a)(a)(1), Freedom from Abuse, Neglect, and Exploitation (F600, Scope/Severity: J); 42 CFR 483. 12(b)(1)?(4), Develop/Implement Abuse/Neglect, etc. Policies (F607, Scope/Severity: J); 42 CFR 483. 12(c)(2)?(4) Alleged Violations-Investigate/Prevent/Correct (F610, Scope/Severity: J); 42 C.F.R. 483. 21(b)(3)(i), Professional Standards (F658, Scope/Severity: J); 42 C.F.R. 483.70, Administration (F835, Scope/Severity: J). Additionally, Substandard Quality of Care was identified at: F600, Freedom from Abuse, Neglect and Exploitation F607, Develop/Implement Abuse/Neglect, etc. Policies F610, Alleged Violations-Investigate/Prevent/Correct A Credible Allegation of Compliance was received on 1/10/19. Based on observations, record reviews, interviews and review of the facility's policies and staff training as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 1/10/19. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of staff treatment of residents. In-service materials and records were reviewed. Observation and interviews were conducted with staff and residents to ensure they demonstrated knowledge of facility Policies and Procedures governing identifying and reporting Abuse, Neglect and Exploitation of residents. The Immediate Jeopardy is outlined as follows: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER OR SUPPLIER Northridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Medical Center Drive Commerce, GA 30529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The facility's failure to protect R#121 from abuse were related to lack of a complete investigative procedures of the multiple attempts to insert an indwelling urinary catheter for R#121. During the initial tour of the facility on 1/7/19 the surveyor conducted a family interview and was informed that on 12/18/18 a urinary catheter insertion was attempted at least nine times on R#121. Interviews with staff revealed that during the failed attempts R#121 was screaming spank them . The nurse replied to the resident, I will spank you. The facility did not conduct a full investigation when this incident of alleged abuse was reported to the Director of Nursing (DON) and Administrator by Resident (R) #121's family member and three Certified Nurse Aides (CNA) who were present in the room with R#121 when the incident occurred. The alleged perpetrator, Licensed Practical Nurse (LPN) II, continued to work at the facility until dismissed on 1/9/19. 2. On 1/9/19 the surveyor was made aware during staff interviews of R#55 receiving a forceful dis-impaction by the same nurse on 12/23/18. The nurse continued to digitally dis-impact the resident when he yelled out in pain Can we take a break, the nurse replied to R#55, We don't take breaks here. The alleged perpetrator refused to stop attempts to dis-impact stool from R#55's rectum when the resident yelled and told the nurse he needed a break because she was hurting him. The resident has a diagnosis of constipation. It was bought to the attention of the Administrator on 1/9/19 that resident #55 received digital stimulation by LPN II without a physician's order, on 12/23/18. The facility began an immediate investigation and an allegation of abuse was sent to the state. The findings include: Review of the Georgia Practical Nurses Practice Act with a copyright date of 2013 documents the following: The practice of licensed practical nursing means the provision of care for compensation, under the supervision of a physician practicing medicine, a dentist practicing dentistry, a podiatrist practicing podiatry, or a registered nurse practicing nursing in accordance with applicable provisions of law. Such care shall relate to the maintenance of health and prevention of illness through acts authorized by the board, which shall include, but not be limited to, the following: A. Participating in the assessment, planning, implementation, and evaluation of the delivery of health care services and other specialized tasks when appropriately trained and consistent with board rules and regulations B. Providing direct personal patient observation, care, and assistance in hospitals, clinics, nursing homes, or emergency treatment facilities, or other health care facilities in areas of practice including, but not limited to: coronary care, intensive care, emergency treatment, surgical care and recovery, obstetrics, pediatrics, outpatient services, home health care, or other such areas of practice . C. Performing comfort and safety measures . D. Administering treatments and medication . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER OR SUPPLIER: Northridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 Medical Center Drive Commerce, GA 30529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. An interview on 1/7/19 at 10:00 a.m., with R#121's family revealed approximately the week before last while walking down the hall R#121 could be heard screaming bloody murder. When the family member entered R#121's room she witnessed LPN II attempting at least six times to insert a urinary catheter into R#121, while the resident was still screaming. The family also stated they requested the nurse to stop since the resident was so agitated. However, LPN II told the family member to leave the room and continued to insert the urinary catheter. The family member further stated the incident was reported to the Social Worker (SW) and the Director of Nursing (DON). A review of the resident's electronic record revealed R#121 was admitted to the facility on [DATE] with diagnoses that included vascular dementia with behavioral disturbance, artificial openings of urinary tract, obstructive and reflux uropathy, and neuromuscular dysfunction of bladder. Review of the resident's quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident was assessed to be severely cognitively impaired with limited range of motion of the lower extremities and required the use of an indwelling urinary catheter. Review of the facility's investigation dated 12/18/18 revealed three witness statements from the Certified Nursing Assistants (CNAs) present during the incident with R#121. Review of CNA FF's signed statement dated 12/18/18 indicated that R#121 was agitated and screaming spank them, spank them, spank them! LPN II leaned down and told R#121 I'll spank you back. LPN II looked at R#121, and CNA FF and CNA HH We need to drug R#121 up because I can't deal with the screaming. R#121 is way too agitated, you won't be able to hold R#121's legs open. CNA HH left the room, LPN II told me, you need to go and get someone to help hold R#121's hands while you hold R#121's legs. I don't have time for this, I have other things that I have to do. LPN II proceeded to try and insert the catheter into the clitoris (located above the urethral opening) and the vagina around eight times. LPN II attempted to insert the catheter at least seven more times. (sic) Review of CNA GG's signed statement dated 12/18/18 indicated that CNA GG was asked by CNA FF to help both CNA FF and LPN II insert a new catheter for R#121 because the resident's old catheter was clogged. LPN II attempted to insert the catheter into the clitoris around eight times. LPN II continued to put the catheter into R#121's vagina at least six more times and I was told by both the family and CNA FF to go get LPN EE. LPN EE inserted the catheter.(sic) Review of CNA HH's hand written statement, dated and signed on 12/18/18 indicated that R#121 had become very agitated and was yelling slap them, slap them. LPN responded I'll slap you back. LPN II also got a little tense and told CNA FF and me that We need to drug R#121 up before I do this. CNA HH told LPN II No and CNA FF told LPN II that she could hold resident's legs open for LPN II to insert the catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview was conducted with LPN EE on 1/7/19 at 4:20 p.m. in the Unit 1A nursing station. LPN EE was questioned on what type of orientation or training does the nursing staff receive upon hire? LPN EE stated that the nursing staff receives two weeks of nursing orientation and must complete a skills competency list with their preceptor. All other training is conducted with the education coordinator. LPN EE was asked if they she knew who had conducted the orientation for LPN II? LPN EE stated that she had done the orientation/competency training. LPN EE was asked if there had ever been any concerns prior to the incident with R#121? LPN EE stated, No, there were no issues prior to that incident. LPN EE asked if she had checked LPN II off on the urinary catheter insertion? LPN EE stated, Yes and LPN II did it without any problems. LPN EE did not indicate that she spoke to LPN II regarding the incident, although LPN EE had conducted LPN II's orientation and competency check off. LPN II was interviewed by telephone on 1/8/19 at 5:29 p.m. LPN II was asked what had happened on 12/18/18 during the re-insertion of R#121's urinary catheter? LPN II said the catheter needed to be changed because it was occluded and there was a white milky substance in it. LPN II stated she had attempted two to three times to insert the catheter but stopped after the third attempt. LPN II was asked if R#121 was agitated or upset? LPN II stated the resident was laughing and saying, spank you, spank you, so I replied, I'll spank you back. The nurse was asked if the family was present during the procedure and if so were they concerned? LPN II stated, Yes, the family was there, but didn't seem to be upset or concerned. LPN II was asked what should have happened when the nurse could not get the urinary catheter inserted? LPN II stated, I should have asked for assistance. An Interview on 1/9/19 at 9:07 a.m. with CNA FF revealed when questioned if she recalled the incident with R#121 and LPN II? CNA FF stated LPN II was struggling to get the urinary catheter inserted when R#121's family walked into the room. When the family stated, let me help, LPN II put her hand up and told the family they needed to back up. At one-time LPN II stated, we need to drug R#121 up because she is too agitated. I felt I needed to stay in R#121's room or LPN II would hurt her. A telephone interview on 1/10/18 at 11:25 a.m. with the facility's Medical Director (MD) revealed if the catheter is difficult to place then we would send the resident next door to the hospital. The MD also stated, Even if proficient, if you realize you can't place the catheter, don't continue, ask for help; the nurse should use good decision making. 2. Record review for R#55 revealed the resident was admitted to the facility on [DATE] with diagnoses that included colostomy closure and constipation. Review of the resident's admission MDS dated [DATE] revealed the resident had intact cognition and required extensive assistance of two persons for activities of daily living, toileting, and mobility. Review of the Physicians Orders' dated 11/8/18 revealed the resident was to receive Senna (laxative) 8.6 milligrams (mg) one tablet twice a day as needed for constipation; bisacodyl (laxative) enteric coated 5 mg delayed release one tablet daily by mouth for constipation. Additional review of the physician orders failed to reveal an order for manual dis-impaction of stool. A review of R#55's clinical record revealed, LPN II's Nurse Note dated 12/23/18 at 1:25 p.m. resident complained of constipation this a.m. (morning) States hasn't had a bowel movement in a week. Large fecal impaction cleared manually. Large bowel movement later. Resident states feel better. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER OR SUPPLIER Northridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Medical Center Drive Commerce, GA 30529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with CNA GG on 1/9/19 at 9:25 a.m. revealed about a month ago, I was in R#55's room holding him on his side so LPN II could dis-impact the resident. LPN II just walked up to the side of the R#55's bed, put a glove on and some lubrication and started to remove the stool from the resident's rectum. During the procedure, R#55 told LPN II I need a break. LPN II told R#55, We don't take breaks, I have other residents to take care of. Interview with LPN EE on 1/9/19 at 9:45 a.m. revealed that CNA GG came to me and told me that LPN II had refused to stop the dis-impaction when the resident had yelled in pain that he needed a break, but that LPN II didn't stop, saying to the resident we don't take breaks. I immediately went into resident's room and did an assessment. There were no injuries. LPN EE stated, We do not perform dis-impactions at this facility. I would try other interventions such as medications, suppositories and rectal massage but not dis-impaction. If none of that worked, I would contact the Physician. An attempt was made to contact LPN II by telephone for an interview on 1/10/19 at 10:00 a.m. and at 11:30 a. m. related to R#55's incident. There was no answer and the voice mail was full. An interview was conducted with R#55 at the resident's bedside on 1/9/19 at 10:15 a.m. R#55 was asked if he recalled LPN II and initially he stated, No. R#55 was than questioned if he has a problem with constipation and ever needed any help to have a bowel movement? R#55 stated Yes, I do have constipation and sometimes I ask for help. R#55 was questioned if he recalled an incident before Christmas where he yelled at a nurse helping him to stop, he needed a break? The resident stated, Yes, he recalled that incident, the nurse was very rough with me. R#55 was asked why he had yelled and asked the nurse for a break? R#55 stated, because she was hurting me. An interview with the DON on 1/9/18 at 4:15 p.m. revealed dis-impaction would require a doctor's order. The DON stated, The facility does not provide training for dis-impaction, this is not a typical procedure that we do. I am not aware of staff doing dis-impaction. The DON further revealed, There is no policy, because we don't do dis-impactions. The DON was questioned who is responsible for training the staff and are they qualified to conduct training? The training is conducted by the most proficient nurse based on documentation and observations. LPN II was oriented by LPN EE in November. There were no concerns expressed prior to the December incident. Staff Development Coordinator (SDC) gets involved with on-going education. During a telephone interview on 1/10/19 at 11:25 a.m. with the facility's MD revealed, The nurses should not attempt a dis-impaction unless they communicate with the Physician. Dis-impaction should not be a first choice, they should have orders for stool softener/laxative. The MD also stated the rectal exam is a low risk, in general with dis-impaction could develop a tear. The MD further stated, I don't recall anyone asking me about dis-impaction. I recently added a new medication for R#55, he had a problem with constipation in the past. Dis-impaction is not something I would encourage and is not commonly done. A Review of LPN II 's employment records revealed the LPN was hired 11/13/18 and her training included the following: - Patients (sic) Rights: Abuse Reporting on 11/13/18 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER OR SUPPLIER Northridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Medical Center Drive Commerce, GA 30529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Catheter Insertion for Males and Females on 11/19/18 The facility was unable to provide documentation of further performance training for LPN II. Cross reference to F600 The facility implemented the following actions to remove the Immediate Jeopardy: 1. Patient assessment performed by DON on 1/8/19 to determine if any abnormalities in anatomy exist that would make it difficult to insert catheter per procedural guidelines. 5 of 151 residents have catheters and the ADON conducted patient assessments on the 5 of with catheters. 2. On 1/8/19 Patient #121's plan of care was reviewed by DON and updated to reflect that if patient becomes agitated during a procedure that the procedure is to be discontinued and re-approached at a later time to decrease the risk for increasing the patient's anxiety. On 1/9/19, 24/25 (96%) LPN's and 10/11 (90%) RN's received this education from the education coordinator. In total 34/36 (94%) Licensed nurses were educated. 3. Education was provided to six of six licensed nurses on 7-7 am shift regarding the following subjects on 1/8/19 by Education Coordinator: a. Importance of following professional standards when providing care to patients. b. Procedure for insertion of Foley catheter including assessment of anatomy to determine abnormalities prior to initiation of procedure. c. Identifying signs and symptoms of patient anxiety during care. d. Recognizing need to stop procedures or care if a patient refuses or shows signs and symptoms of pain or anxiety. 4. Nurse in questions related to R#121 and R#55 regarding professional services was suspended on 1/7/19 pending outcomes of the investigation. 5. Termination of charge nurse in question related to patient R#121 and R#55 was initiated on 1/9/19. Systemic Changes 1. Education began on 1/7/19 and competed on 1/9/19 provided on professional services and standards related to catheter insertion and digital evacuation of hard stool. 24/25 (96%) LPN's and 10/11 (90%) RN's received this education. In total 34/36 licensed nurses received this education. 2. Professional competencies began on 1/7/19 by the DON, ADON and education coordinator, on professional services and standards related to catheter insertion. 24/25 (96%) LPN's and 10/11 (90%) RN's received this education. In total 34/36 licensed nurses received this education. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3, Remedial education to be provided to licensed nurses as opportunities for improvement are identified by education coordinator starting on 1/9/19. 4. All finding will be addressed through the center's QAPI process on a monthly bases under the directions of the Administrator. The State Survey Agency (SSA) validated the Allegation of Compliance (AOC) Jeopardy Removal as follows: 1. Review of the facility AOC documentation verified on 1/8/19 the DON and ADON performed assessments on five of five residents that had catheters including R#121 to assess any abnormalities that persist that would impede catheter insertion. The survey team had already assessed these residents during the initial pool process. Training on the professional standards related to catheter insertion and evacuation of hard stool was reviewed by in-service roster and interviews with Registered Nurse (RN) DD, LPN EE, LPN JJ, LPN LL, LPN MM and LPN NN on 1/10/19 between 2:00 p.m. and 4:00 p.m. 2. Review of the facility AOC documentation for When a patient becomes agitated during a procedure, the procedure is to be discontinued and re-approached later to decrease the risk of increasing the patient's anxiety. This training was provided to LPNs and RNs by the Education Coordinator on 1/8/19. This was verified by R#121's care plan and interviews with staff nurses, LPN EE, LPN JJ, RN DD, LPN LL, LPN MM, and LPN NN currently providing resident care on 1/10/19 between 2:00 p.m. and 4:00 p.m., and by the training roster signed by all licensed staff. 3. Review of the facility AOC documentation related to the systemic changes indicated the facility, specifically the DON, ADON, and Education Coordinator began educating licensed staff (Registered Nurses and Licensed Practical Nurse) beginning 1/7/19 through 1/9/19 on the following subjects: a. Importance of following professional standards when providing care to patients b. Procedure for insertion of Foley catheter including assessment of anatomy to determine abnormalities prior to initiation of procedure c. Identifying signs and symptoms of patient anxiety during care d. Recognizing need to stop procedures or care if a patient refuses or shows signs and symptoms of pain. This education was validated through staff education rosters dated 1/7/19 through 1/9/19 indicating the attendance by staff for training. Interviews were conducted on 1/10/19 from 2:00 p.m. to 4:00 p.m. by surveyors with RN DD, LPN EE, LPN JJ, LPN LL, and LPN NN verifying the training provided by the facility through verbal demonstration of the Foley catheter procedures, abnormalities in residents anatomy, identifying patient anxiety during care and what to do to ease resident's anxiety, and to stop if resident refuses treatments or is exhibiting signs of pain. 4. LPN II in relation to R#121 and R#55 regarding professional services was suspended pending investigation on 1/7/19. This was verified through review of staff schedule for 1/7/19 through 1/11/19 and observations of staffing during the survey process from 1/7/19 through 1/10/19. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER OR SUPPLIER Northridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Medical Center Drive Commerce, GA 30529	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. LPN II was terminated by the Administrator on 1/9/19 as verified through observations and staffing schedules for 1/9/19 through 1/10/19 and interview with the DON on 1/9/19 at 4:15 p.m. in the conference room. Systemic Changes: 1. Review of the facility's AOC indicated beginning 1/7/19 through 1/9/19 staff nurses were educated on professional services and standards related to catheter insertion and digital evacuation of hard stool. On 1/10/19 from 2:00 p.m. to 4:00 p.m. surveyors interviewed nursing staff (LPN EE, LPN JJ, RN DD, LPN LL, LPN MM and LPN NN) concerning their training related to catheter insertion and digital evacuation of hard stool. The nursing staff confirmed that the staff does not conduct digital evacuation of hard stool, they would contact the physician first and request assistance when having difficulty with inserting an indwelling catheter. 2. Review of the facility's AOC indicated professional competencies were conducted starting on 1/7/19 by the DON, ADON and Education Coordinator. Interviews were conducted during the AOC verification process on 1/10/19 from 2:00 p.m. to 4:00 p.m. with the following nurses: LPN EE, LPN JJ, RN DD, LPN LL, LPN MM, and LPN NN. The nursing staff was asked to verbally explain the process for urinary catheter procedures related to insertion, identifying correct anatomy and when to request assistance. 3. Review of the facility's AOC indicated remedial education was to be provided to licensed staff as opportunities for improvement starting on 1/9/19. Interviews were conducted on 1/10/19 between 2:00 p.m. and 4:00 p.m. with LPN EE, LPN JJ and LPN NN concerning identifying and reporting abuse 4. Review of the facility's AOC indicated all findings will be addressed through the center's QAPI process monthly under the direction of the Administer. This was validated through review of the ad hoc QAPI meeting documentation on 1/8/19 revealed a Performance Improvement Project was developed and presented during the QAPI meeting for identifying, addressing and investigation of abuse. An interview was conducted on 1/10/19 at 1:23 p.m. with the Administrator in the Administrator's office. The Administrator stated, The systematic analysis and actions were discussed during the ad hoc QAPI meeting. The QAPI Committee recognizes that any change that is made has the potential to have broader impact than intended. QA Event (Just do it) reports will be reviewed by QAPI Committee to ensure this tool is used for QA events in absence of system/process problems. The QA Event tool (Just Do it form) should not be used in place of the Performance Improvement Plans (PIPs).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 29015 Based on record review and interviews it was determined that Administration failed to ensure that the facility was administered in a manner that enabled it to use its resources effectively and efficiently to ensure each resident attained or maintained the highest possible level of physical, mental and psychological well-being. The Administration failed to conduct a thorough investigation of an employee's verbal threats and physical abusive actions for Resident (R) #121 on 12/12/18 while attempting to insert an indwelling urinary catheter and for disregarding R #55's complaints of pain during a rectal dis-impaction to remove stool on 12/23/18. The facility census was 151 residents. On 1/8/19, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing, and the Regional Nurse Consultant and Regional Nurse Consultant were informed of the immediate jeopardy on 1/8/19 at 5:14 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on 12/18/18. The immediate jeopardy continued through 1/9/19 and was removed on 1/10/19. The immediate jeopardy was related to the facility's noncompliance with the program requirements at 42 C.F.R. 483.12 (a)(a)(1), Freedom from Abuse, Neglect, and Exploitation (F600, Scope/Severity: J); 42 CFR 483.12(b)(1)?(4), Develop/Implement Abuse/Neglect, etc. Policies (F607, Scope/Severity: J); 42 CFR 483.12(c)(2)?(4) Alleged Violations-Investigate/Prevent/Correct (F610, Scope/Severity: J); 42 C.F.R. 483.21(b)(3)(i), Professional Standards (F658, Scope/Severity: J); 42 C.F.R. 483.70, Administration (F835, Scope/Severity: J). Additionally, Substandard Quality of Care was identified at: F600, Freedom from Abuse, Neglect and Exploitation F607, Develop/Implement Abuse/Neglect, etc. Policies F610, Alleged Violations-Investigate/Prevent/Correct A Credible Allegation of Compliance was received on 1/10/19. Based on observations, record reviews, interviews and review of the facility's policies and staff training as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 1/10/19. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of staff treatment of residents. In-service materials and records were reviewed. Observation and interviews were conducted with staff and residents to ensure they demonstrated knowledge of facility Policies and Procedures governing identifying and reporting Abuse, Neglect and Exploitation of residents. The Immediate Jeopardy is outlined as follows: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The facility's failure to protect R#121 from abuse were related to lack of a complete investigative procedures of the multiple attempts to insert an indwelling urinary catheter for R#121. During the initial tour of the facility on 1/7/19 the surveyor conducted a family interview and was informed that on 12/18/18 a urinary catheter insertion was attempted at least nine times on R#121. Interviews with staff revealed that during the failed attempts R#121 was screaming spank them . The nurse replied to the resident, I will spank you. The facility did not conduct a full investigation when this incident of alleged abuse was reported to the Director of Nursing (DON) and Administrator by Resident (R) #121's family member and three Certified Nurse Aides (CNA) who were present in the room with R#121 when the incident occurred. The alleged perpetrator, Licensed Practical Nurse (LPN) II, continued to work at the facility until dismissed on 1/9/19. 2. On 1/9/19 the surveyor was made aware during staff interviews of R#55 receiving a forceful dis-impaction by the same nurse on 12/23/18. The nurse continued to digitally dis-impact the resident when he yelled out in pain Can we take a break, the nurse replied to R#55, We don't take breaks here. The alleged perpetrator refused to stop attempts to dis-impact stool from R#55's rectum when the resident yelled and told the nurse he needed a break because she was hurting him. The resident has a diagnosis of constipation. It was bought to the attention of the Administrator on 1/9/19 that resident #55 received digital stimulation by LPN II without a physician's order, on 12/23/18. The facility began an immediate investigation and an allegation of abuse was sent to the state. The findings include: On 1/7/19 at 3:30 p.m. an interview was conducted with the Administrator and the DON in the Administrative office outer room. The Administrator and DON were made aware of an interview with family of R#121 and an incident that occurred on 12/18/18. They stated they had been made aware by the surveyor of a concern for abuse on 12/18/18. Both the Administrator and DON stated that they were aware of the incident and they had investigated but determined that abuse did not occur, rather it was a personality conflict. The Administrator stated that they would begin another investigation related to abuse and report to the appropriate authorities. Review of the investigation that was conducted on 12/18/18 revealed three statements written by the nursing aides who witnessed the abuse to R#121, however there were no statements from the family member or the nurses involved in the incident. The facility was unable to provide documentation that LPN II received any type of counseling or re-training following this incident. The Administrator stated that he did not personally investigate, the DON had taken the lead on the discussion, and it was believed that abuse had not occurred. During the investigation of the incident on 12/18/18 with R#121 an additional incident was identified for possible abuse involving R#55 and LPN II. This incident occurred on 12/23/18. Interview on 1/8/19 at 5:15 p.m. with the Administrator revealed that he was made aware of the allegation of abuse for R#121 but that he felt that the DON had conducted an investigation and determined that abuse had not occurred. The Administrator further stated that R#121 was known to scream and yell out as part of her behaviors. The Administrator was not able to state whether or not R#121's comprehensive care plan had been reviewed to determine if her behavior had been addressed as it pertained to changing out her Foley catheter when needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Administrator's job description revealed, in part, the following documentation; Essential Regulatory Functions 7. Operates the Nursing Center in accordance with the established guidelines of the Organization and in compliance with federal, state and local regulations. 18. Assumes responsibility for and honors patients' rights to fair and equitable treatment, self-determination, individuality, privacy, property and civil rights, including the right to wage complaints. 19. Assumes responsibility for procedural guidelines relative to the prevention and reporting patient abuse. 20. Reviews, investigates and arbitrates patient complaints and grievances and makes available to supervisor written reports of action taken. 22. Maintains appropriate documentation in regard to accidents/incidents. 31. Ensures that all associates, patients, visitors and the general public follow established policies and procedures. Cross Refer F600 The facility implemented the following actions to remove the Immediate Jeopardy: The Regional [NAME] President was to provide education to the Administrator and DON on job description, roles, and responsibilities and duty to ensure the safety of all the residents. Also, the Regional [NAME] President was to provide education on the abuse, neglect, and exploitation policy and procedure to the Administrator and DON. The Administrator and DON were to be re-educate on their roles in the Quality Assurance Performance Improvement process. The State Survey Agency (SSA) validated the Allegation of Compliance (AOC) Jeopardy Removal as follow: The AoC presented for validation documented that the Regional [NAME] President (RVP) would provide education to the Administrator and the DON on their job descriptions, roles and responsibilities and duties to ensure the safety of residents. Education was also provided on 1/8/19 at 10:00 p.m. on abuse, neglect and exploitation policy and procedures to the Administrator and DON. A performance evaluation review document was acknowledged and reviewed on 1/8/19 by the Administrator and the RVP as received. The Administrator job description was reviewed, signed and dated on 1/9/19 by the Administrator and the RVP. The facility document Job Description: Nursing Services. Director of Nursing was reviewed, signed and dated by the DON and RVP on 1/8/19. During the interview with the Administrator and the RVP conducted on 1/10/19 at 2:53 p.m. in the Administrators office the RVP confirmed that he had reviewed with the Administrator and the DON their job descriptions and job expectations. Review of the facility's AoC revealed the RVP provided education to the Administrator and the DON on 1/8/19 regarding their roles and responsibilities of the QAPI process. This education was verified by interview with the Administrator and the RVP on 1/10/19 at 2:53 p.m. during a meeting in the Administrator's office. 34575