

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>TN9002</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/31/2012</b> |
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| N 000  | Initial Comments<br><br>Amended February 7, 2012<br><br>Based on results of a survey for complaint #29186 conducted on January 24-31, 2012, the facility was cited a Type "A" Penalty for failure to be administered in a manner to protect two residents (#1 and #2) from physical and mental abuse; to immediately remove three alleged perpetrators from the facility; to ensure policies were followed to prevent abuse abuse and protect residents.<br><br>The facility's failure placed Residents #1 and #2 and all Residents with Dementia in an environment which was detrimental to their health, safety and welfare.   | N 000  |   |   |
| N 401  | 1200-8-6-.04(1) Administration<br><br>(1) The nursing home shall have a full-time (working at least 32 hours per week) administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents.<br><br>This Rule is not met as evidenced by:<br>Based on interview and review of a facility | N 401  |   |   |

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Division of Health Care Facilities

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| N 401  | <p>Continued From page 1</p> <p>surveillance video, the facility failed to be administered in a manner to protect two Residents (#1 and #2) with Dementia from abuse; to immediately suspend the three alleged perpetrators, Certified Nursing Assistants (#2, #3, and #4); failed to ensure policies were followed for investigation and reporting of the abuse; and failed to ensure Residents were protected from further abuse of five Residents reviewed.</p> <p>The facility's failure has caused abuse of two Residents (#1 and #2) and has placed other Residents at risk for abuse.</p> <p>The facility's failure placed all Residents with Dementia in an environment which was detrimental to their health, safety and welfare.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on November 11, 2011, with diagnoses including Dementia, Anxiety, Depression, Hypertension, Congestive Heart Failure, Malignant Colon Cancer, and History of Cardiovascular Accident.</p> <p>Medical record review of a nursing assessment dated December 8, 2011, revealed the Resident had moderately impaired cognition; had no depressive symptoms; had no behavior symptoms; required extensive assistance with all activities of daily living (ADL) except eating, which required supervision; and used a manual wheelchair for mobility.</p> <p>Continued review of a nursing assessment dated January 12, 2012, revealed the Resident had severely impaired cognition; was depressed; had difficulty focusing attention and had disorganized</p> | N 401  |   |   |

Division of Health Care Facilities

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| N 401  | Continued From page 2<br><br>thinking; required extensive assistance with all ADLs, to include eating; and used a manual wheelchair for mobility.<br><br>Resident #2 was admitted to the facility on March 15, 2004, and readmitted on February 14, 2007, with diagnoses including Alzheimer's Dementia, Hypertension, Anxiety, Depression, and Osteoarthritis.<br><br>Medical record review of a nursing assessment dated October 5, 2011, and January 1, 2012, revealed the Resident had short and long-term memory problems, had severely impaired cognitive skills for daily decision making; had no depressive or behavior symptoms; required extensive assistance to total dependence with all activities of daily living (ADL); and used a manual wheelchair for mobility.<br><br>Interview with Registered Nurse (RN #1) on January 25, 2012, at 9:14 p.m., by telephone, confirmed Certified Nursing Assistant (CNA #1) reported (to RN #1) on January 14, 2012, at approximately 4:00 a.m., CNA's #2, #3, and #4, were abusing Resident #1 by squirting (Resident) with water, to include used toilet water, and had taken pictures and a video with cell phones. Continued interview revealed RN #1 went upstairs around 4:40 a.m., into Resident #1's room. The head of the bed and the wall above the head was soaked and the Resident was wiping (the Resident's) face, and stated, "Trying to get the water out." Continued interview revealed two CNA's (#3, #8) were in the Resident's room, and were asked by RN #1 why the Resident was wet. The CNA's shrugged their shoulders like they didn't know and replied, "She does that a lot (spills water)." Continued interview with RN #1 confirmed CNA's #2, #3, and #4 were not immediately suspended based upon the | N 401  |   |   |

Division of Health Care Facilities

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| N 401  | <p>Continued From page 3</p> <p>abuse allegations reported by CNA #1. Continued interview confirmed RN #1 did not notify the DON until January 15, 2012, "around" 3:00 p.m. (more than 24-hours after the allegations of abuse). Continued interview with RN #1 confirmed CNA's #2, #3, and #4 worked their full shifts (6:30 p.m.-7:00 a.m.) beginning on January 16, 2012.</p> <p>Review of a facility surveillance video on January 26, 2012, at approximately 10:30 a.m., in the Director of Nursing's (DON's) office, and in the presence of the Administrator and DON, confirmed CNA's #2, #3, and #4 worked January 16-17, 2012, (between 6:30 p.m.-7:00 a.m.) on the hall where Resident #1 and #2's rooms were located. Continued review of the video confirmed CNA #2 and #6 entered Resident #2's room; Resident #1's room was accessible to the CNA's through a bathroom shared by the Residents (#1 and #2). Both the Administrator and DON confirmed the CNA's (#2, #3, and #4) were working on the hall of Resident #1 and #2, on January 16-17, 2012, (between 6:30 p.m.-7:00 a.m.).</p> <p>Interview on January 26, 2012, at 4:30 p.m., in the conference room, with RN #2 confirmed CNA #2 did show RN #2 a picture of an incontinence pad soiled with feces. RN #2 instructed CNA #2 to delete the picture, but took no action. Continued interview confirmed the RN had observed CNA's #2, #3, and #4 texting and talking on their cell phones during their shifts. RN #2 "reminded" the CNA's not to be using their cell phones. RN #2 confirmed CNA's #2, #3, and #4 were non-compliant with the use of cell phones in the facility.</p> <p>Interview on January 30, 2012, at 2:15 p.m., with</p> | N 401  |   |   |

Division of Health Care Facilities

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| N 401  | Continued From page 4<br><br>the DON in the conference room confirmed the allegations of abuse, as reported to RN #1 by CNA #1 on January 14, 2012, at approximately 4:00 a.m., were not reported immediately to the DON until January 15, 2012, at 4:45 p.m., (over 24-hours later). Continued interview confirmed the CNA's (#2, #3, and #4) were allowed to work after the allegations of abuse and were not suspended immediately to protect the victims or other potential victims.<br><br>Interview on January 26, 2012, at 2:05 p.m., in the conference room with the Administrator confirmed the DON called the Administrator and reported the abuse on January 15, 2012, at 9:03 p.m. Continued interview confirmed the facility failed to report the abuse immediately and failed to suspend CNA's #2, #3, and #4 immediately once the abuse was reported to protect the victims or other potential victims.<br><br>C/O #29186 | N 401  |   |   |
| N1207  | 1200-8-6-.12(1)(g) Resident Rights<br><br>(1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights:<br><br>(g) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified   | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | <p>Continued From page 5</p> <p>immediately as required in T.C.A. §71-6-103;</p> <p>This Rule is not met as evidenced by:<br/>Based on medical record review, review of the facility timeline and investigation, review of facility policy, review of employee time cards, review of a facility surveillance video, and interview the facility failed to protect two Residents (#1 and #2) with Dementia from physical and mental abuse of five Residents reviewed. The facility failed to stop abuse immediately and report the witnessed abuse after Resident #1 was abused, allowing three alleged perpetrators, Certified Nursing Assistants (#2, #3, and #4), to continue to abuse Resident #1 and Resident #2.</p> <p>The facility's failure placed Residents #1 and #2 in an environment which was detrimental to their health, safety and welfare.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on November 11, 2011, with diagnoses including Dementia, Anxiety, Depression, Hypertension, Congestive Heart Failure, Malignant Colon Cancer, and History of Cardiovascular Accident.</p> <p>Medical record review of a Nursing Assessment dated December 8, 2011, revealed the Resident had moderately impaired cognition; had no depressive symptoms; had no behavior symptoms; required extensive assistance with all activities of daily living (ADL) except eating, which required supervision; and used a manual wheelchair for mobility.</p> <p>Continued review of the Nursing Assessment dated January 12, 2012, revealed the Resident</p> | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | <p>Continued From page 6</p> <p>had severely impaired cognition; Depression; had difficulty focusing attention and had disorganized thinking; required extensive assistance with all ADLs, to include eating; and used a manual wheelchair for mobility.</p> <p>Resident #2 was admitted to the facility on March 15, 2004, and readmitted on February 14, 2007, with diagnoses including Alzheimer's Dementia, Hypertension, Anxiety, Depression, and Osteoarthritis.</p> <p>Medical record review of a Nursing Assessment dated October 5, 2011, and January 1, 2012, revealed the Resident had short and long-term memory problems, had severely impaired cognitive skills for daily decision making; had no depressive or behavior symptoms; required extensive assistance to total dependence with all activities of daily living (ADL); and used a manual wheelchair for mobility.</p> <p>Review of a facility timeline and investigation dated January 19, 2012, revealed on January 14, 2012, Certified Nursing assistant (CNA #1) reported to the Registered Nurse (RN #1) that CNA's #2, #3, and #4 had sprayed Resident #1 with water.</p> <p>Continued review of the timeline dated January 19, 2012, revealed the following:</p> <p>January 14, 2012, "Around 4:00 a.m., (CNA #1) reported to (RN #1) that (CNA's #2, #3, and #4) went together in the mornings to spray (Resident #1) with water while (Resident) was asleep. (RN #1) immediately checked (Resident #1). As (RN #1) approached (Resident's) room...(CNA's #2 and #5) were coming out of (Resident's) room...(RN #1) entered (Resident's) room followed by</p> | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | <p>Continued From page 7</p> <p>(CNA's #3 and #8). (Resident's) gown and face were wet. (RN #1) asked the CNA's why (Resident) was wet, and both CNA's (#3, #8) claimed not to know."</p> <p>January 15, 2012, at 4:45 p.m., RN #1 "advised the Director of Nursing (DON) of the allegations of abuse...at 9:03 p.m., the DON called the Administrator about the abuse allegations. (CNA's #2, #3, and #4) were not scheduled to work."</p> <p>January 17, 2012, the Administrator and DON met with CNA #2 to discuss the allegations and the CNA made a partial admission. CNA's #2, #3, and #4 were suspended without pay pending the investigation results and on January 20, 2012, were terminated from employment for the "treatment" of Resident #1.</p> <p>January 22, 2012, CNA's #5 and #8 are terminated for providing misleading information during the investigation.</p> <p>Continued review of the investigation findings dated January 19, 2012 , revealed, "(CNA's #2, #3, and #4) worked together on the top floor of (facility's) healthcare center on the nightshift. Sometime in December (2011), (CNA #2) asked (CNA's #3 and #4), 'what would happen if we sprayed (Resident #1) with water?' All of them (CNA's #2, #3, and #4) thought (Resident's) reaction would be comical. (Resident #1) suffers from Dementia...(Resident #1) has a private room. (Resident #1's) room shares a bathroom with (Resident #2's) private room. The bathroom is between (Resident #1's) and (Resident #2's) rooms. Around 4:00 a.m., the CNA's (#2, #3, and #4) entered (Resident #2's) room and went to the bathroom. (CNA #2) filled the syringe with tap</p> | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | Continued From page 8<br><br>water. They (#2, #3, and #4) opened the door between the bathroom and (Resident #1's) room. While standing in the bathroom behind the threshold, (CNA #2) sprayed water on the light fixture and ceiling above (Resident #1). The water then dripped down onto (Resident #1's) shoulder. (Resident #1) woke up and pulled (Resident's) covers up over (Resident's) wet shoulder and went to sleep. The CNA's (#2, #3, and #4) laughed. Together, they (#2, #3, and #4) continued to visit (Resident #1's) room at approximately 4:00 in the morning to spray (Resident #1). By the third visit, they started spraying (Resident) directly. They targeted exposed areas...such as...head, face, and hands. They took turns squirting (Resident #1)... (Resident #1) woke up during these episodes and swore using all types of vulgarities. (Resident #1) would yell at (Resident's spouse's name) and tell spouse to "stop pissing" on (Resident). After using tap water...they decided to use cold water. They collected water from the bottom of ice coolers on the floor. At first they sprayed cold water above the bed and let it drip on (Resident). Later, they sprayed (Resident) directly. Again, they sprayed any exposed areas...usually...face and hands. All three of them took turns spraying (Resident) with the cold water. (Resident) woke up and swore and always blamed (Resident's spouse) during the rant. Next, they decided to use toilet water...(CNA's #2, #3, and #4) each filled the syringe with toilet water and sprayed it onto (Resident). They also squirted (Resident #2) at least twice. Because (Resident #2) did not react, they did not persist in spraying (Resident #2)...Several photographs were taken of (Resident #1). The first photograph was taken by (CNA #3). (Resident #1) was getting into bed with (Resident #2). (CNA #3) thought it was cute. (Resident #1's) buttocks were exposed and (CNA | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | <p>Continued From page 9</p> <p>#3 took a picture with (CNA #3's) cell phone. (CNA #3) showed (CNA #2) the photograph. (CNA #2) asked (CNA #3) to forward the photograph to (CNA #2)...so (CNA #2) could send it to (CNA #2's sibling) who works at a local hospital...(CNA #3) forward the picture, and (CNA #2) sent it to (CNA #2's sibling)...Both (CNA #2 and #3) report the picture has been deleted from their phones. On another occasion, (CNA #2) showed a picture of a Resident's (no name) buttock's with a pad underneath covered with feces to (CNA #7). The CNA asked why (CNA #2) was taking pictures of a Resident. (CNA #2) replied...sent it to (CNA #2's sibling) to show (sibling) what they dealt with every night. This photograph was taken around Christmas. According to (CNA #2) all of the photos have been deleted from (CNA #2's) phone...One evening the CNA's made a video of (Resident #1) while (Resident) was in an agitated state. (Resident) sat up on the edge of (Resident's) bed...breasts were exposed and they showed the video to other CNA's on the floor. The CNA's report the video has been deleted."</p> <p>Review of a written statement (no date), by RN #1 revealed, "On January 14, 2012, CNA #1 informed me of the mistreatment of (Resident #1)...reported that CNA's #2, #4, and #3 would squirt cold water on (Resident) every morning around 4 am (4:00 a.m.) in attempt to wake (Resident) and agitate (Resident) so (Resident) would start cursing...one occurrence CNA #2 squirted (Resident) w/toilet (with toilet) water...the 3 (three) CNA's would enter the bathroom through (Resident #2's) room as to not be noticed since both (Resident #2's) room and (Resident #1's) room share one bathroom. They thought it was funny when (Resident #1 started yelling and cursing...this happened each time the shift</p> | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | Continued From page 10<br><br>worked except when (Resident #1) had PNA (Pneumonia)...said that (CNA #2) had even recorded an incident of this on (CNA #2's) cell phone...After (CNA #1) reported this to me I went upstairs to observe the CNA's...approximately 4:40 a.m...I looked down Resident #1's hallway and saw (CNA #2) and a CNA...I think CNA's name is (CNA #5)...coming out of (Resident #2's) room...they (CNA's #2, #5) had just made it to the end of the hall when I heard (Resident #1's) sentry alarm sound...(CNA's #4 and #8) walked into (Resident #1's) room and I followed them. (Resident #1) was laying in bed moving around and saying something like, 'I'm trying to get the water out.' I looked at the head of...bed...was wet around (Resident #1's) pillow. I then asked the CNA's (#4, #8) in the room why (Resident #1's) pillow and around it was wet. They replied, 'Oh (Resident #1) does that sometimes. Then I looked on the wall above (Resident #1's) head and the wall was covered with water. I asked the CNA's why (Resident #1's) wall was wet and has somebody been squirting water on (Resident #1). They didn't respond but just looked toward the floor and shrugged their shoulders. I then spoke with other staff member on my rotation and they also reported inappropriate behavior they had noticed from (CNA #2)...Addendum to statement given regarding (Resident #1) and morning of January 14, 2012...Our shift was scheduled to be off Saturday night January 14, 2012, and Sunday night January 15, 2012. I then notified the DON on Sunday evening January 15, 2012."<br><br>Review of a written statement dated January 16, 2012, by CNA #3 revealed (CNA #3) denied knowledge or involvement in any Resident abuse. "...I try to treat every Resident as if they were family...We work as a team...I do my job to the best of my ability, and that does not include being | N1207  |   |   |

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>TN9002</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/31/2012</b> |
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| N1207  | <p>Continued From page 11</p> <p>a part of Resident abuse."</p> <p>Review of a written statement dated January 16, 2012, by CNA #4 revealed (CNA #4) denied witnessing or involvement in any type of Resident abuse. "...all rounds and call lights are answered as a team...I treat every Resident with respect and as if it were me, how I would want to be treated."</p> <p>Review of a facility email dated January 16, 2012, at 11:23 a.m., from the Administrator to the Human Resources Director, revealed the Administrator had received a call from CNA #1 on the morning of January 16, 2012. CNA #1 had stated to the Administrator that sometime after December 20, 2011, CNA #1 witnessed CNA #2 get a syringe from a LPN, and CNAs #1, #3, #4, and #6 witnessed CNA #2 use ice water and toilet water from a commode to squirt one of the Residents (no Resident named). CNA #1 revealed to have reported the abusive actions to RN #1 on or about January 13, 2012. When CNA #1 was asked by the Administrator why CNA #1 did not stop the abuse and report the abuse immediately, CNA #1 revealed was afraid of CNA #2.</p> <p>Review of a facility email dated January 16, 2012, at 11:35 a.m., from CNA #1 to the Administrator, revealed the statement was in reference to an alleged abuse which occurred "late December 2011 or early January 2012." CNA #1 alleged CNA #2 obtained a saline flush syringe from an Licensed Practical Nurse (LPN), and used ice water from a cooler and water from a toilet to squirt a Resident (no resident(s) named). CNA #1 revealed did not remember precisely when it was done, but did reveal to "think this was probably the first or second week in January but (CNA #1</p> | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | <p>Continued From page 12</p> <p>could not remember precisely." CNA #1 revealed the abuse was witnessed along with another new coworker and revealed, "...Because of threatening comments made by CNA #2, CNA #1 was fearful for (CNA#1's) personal safety and home..." Continued review of the emailed statement revealed the next week (handwritten date indicated January 14, 2012) CNA #1 reported the alleged abuse to RN #1, as witnessed by CNA #1.</p> <p>Review of a written statement (no date), by CNA #6 revealed Resident #1 "has been getting aggravated up in the morning hours by CNA's #3, #2, and #4...syringes are being used by squirting water on (Resident)..."</p> <p>Review of a written statement (no date), by CNA #7 revealed "(CNA #2) approached me while I was on break...wanted to show me a picture on (CNA's) cell phone...the picture was of a Resident's (no name) bare butt and on the pad was feces. I asked why...took that picture...CNA #2 replied, 'I text it to my (sibling) to show...what we go through at night.'"</p> <p>Review of a typed, unsigned statement dated January 17, 2012, titled "Meeting with (CNA #2)" revealed, "(DON) present along with myself... (Administrator)...(CNA #2) ...to the facility at 7am (7:00 a.m.) to meet with (DON) and I...was advised of the allegations...denied...After initially denying the allegations...finally admitted squirted water on this Resident (#1) and had taken a photo of (Resident's bare buttocks and had text it to (CNA #2's sibling)...used a syringe to spray...did not know why (CNA #2) did this...'just being stupid I guess.' (CNA #2 said...text picture to (sibling)...said...sprayed the water on Resident to wake (Resident) at 4am (4:00 a.m.) to hear</p> | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | <p>Continued From page 13</p> <p>Resident fuss and yell, getting mad at having being awakened...(CNA #2) further stated that the two (sisters-CNA's #3, #4) were present...and (CNA's #1 and #6) had observed the water squirting...(CNA #2) denied the picture still exists...(Administrator) viewed (cell phone) pictures, none of which appeared to be...bare buttocks and no facial pictures of any Residents of (facility)...CNA #2 had what appeared to be personal or family photos...(Administrator) advised (CNA #2) that these actions are unlawful...(Administrator) informed...at this point on administrative leave...(Administrator) requested statement..."</p> <p>Review of a written statement (no date), by CNA #2 revealed, "...I squirted water on the ceiling above the bed..."</p> <p>Review of the facility policy "Resident Abuse Prevention" (no date), pages 27 through 29, revealed, "Each Resident has the right to be free from abuse...Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff..."Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...Resident Abuse Reporting, Investigation, and Protection:...It is the intent of (facility) to ensure that all Residents are free from abuse by providing a safe, secure environment. Reporting:...Employees are to immediately report to their supervisor any allegation of abuse...Incidents include: staff-to-Resident...Any employee, who is made aware of alleged/suspected abuse acts, must immediately report the situation...Protection: When an employee is alleged or suspected to have committed an abusive act, the accused employee shall be immediately suspended without pay by</p> | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | <p>Continued From page 14</p> <p>the supervisor pending the investigation of the allegations..."</p> <p>Review of the facility policy "Cellular Phone Policy" (no date), pages 68 through 69, revealed, "Policy: (Facility) prohibits the use of personal cellular phones in any (facility) owned building during working hours...Procedures: Use of Personal Cellular Phones: Employees will be required to keep personal cellular phones in their vehicles...If an employee is caught with their personal cellular phone in a (facility)...during working hours the cellular phone will be taken from them by their supervisor and will not be returned to them until the end of their shift...Violations of this policy will be subject to the highest forms of discipline, including termination..."</p> <p>Review of Employee Time Cards dated January 13, 2012, through January 14, 2012, and January 16, 2012, through January 17, 2012, revealed CNA's #2, #3, and #4 were not immediately suspended after the allegations of abuse were initially reported to RN #1 on January 14, 2012, at approximately 4:00 a.m.</p> <p>CNA #2 worked beginning at 6:24 p.m., on January 13, 2012, ending at 6:53 a.m., on January 14, 2012; and worked beginning at 6:23 p.m., on January 16, 2012, ending at 6:54 a.m., on January 17, 2012.</p> <p>CNA #3 worked beginning at 6:24 p.m., on January 13, 2012, ending at 6:54 a.m., on January 14, 2012; and worked beginning at 6:28 p.m., on January 16, 2012, ending at 6:54 a.m., on January 17, 2012.</p> <p>CNA #4 worked beginning at 6:24 p.m., on</p> | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | <p>Continued From page 15</p> <p>January 13, 2012, ending at 6:54 a.m., on January 14, 2012; and worked beginning at 6:28 p.m., on January 16, 2012, ending at 6:54 a.m., on January 17, 2012.</p> <p>Review of a facility surveillance video on January 26, 2012, at approximately 10:30 a.m., in the DON's office, and in the presence of the Administrator and DON, confirmed CNA's #2, #3, and #4 worked January 16-17, 2012, (between 6:30 p.m.-7:00 a.m.) and worked on the hall where Resident #1's and #2's rooms were located. Continued review of the video confirmed CNA #2 and #6 entered Resident #2's room; Resident #1's room was accessible to the CNA's through a bathroom shared by the Residents (#1 and #2). Both the Administrator and DON confirmed the CNA's (#2, #3, and #4) were working on the hall of Resident #1 and #2, on January 16-17, 2012, (between 6:30 p.m.-7:00 a.m.).</p> <p>Interview with CNA #4 on January 25, 2012, at 1:05 p.m., in the conference room, confirmed Resident #1 was squirted, using a syringe with tap water, ice water, and toilet water from the Resident's commode, by CNA's #2, #3, and #4. Continued interview revealed other staff were present and observed the Resident being squirted by CNA's #2, #3, and #4, on different occasions, to include CNA's #1 and #6 (observed in December 2011 or January 2012); CNA's #5 and #8 (observed in January 2012); and LPN #1 (observed in January 2012). Continued interview confirmed Resident #2 was squirted with tap water "one time by each of us" (CNA's #2, #3, and #4) and (Resident #2) gave no response other than barely mumbled. CNA #4 denied knowledge or involvement of any pictures or videos. CNA #4 confirmed "squirting the</p> | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | Continued From page 16<br><br>(Residents) was abuse."<br><br>Interview with CNA #3 on January 25, 2012, at 1:38 p.m., in the conference room, confirmed Resident #1 was squirted, using a syringe with tap water, ice water, and toilet water from the Resident's commode, by CNA's #2, #3, and #4, starting sometime between November 2011 and December 2011. "It didn't happen every night, but did happen once-to-two times a week." CNA #3 stated the squirting was initially done to see what Resident #1 would do. When "squirted with water, (Resident #1) would get aggravated and yell...I guess it was (Resident's) Dementia...would cuss and say all kinds of stuff, such as calling out for (spouse)." CNA #3 confirmed "I took a picture of Resident #1 getting into bed with Resident #2...Resident #1 had a hospital gown on and it was open in the back, exposing (Resident #1's) naked buttocks as (Resident #1) got into the bed...I thought it was cute." CNA #3 stated showed the picture to CNA #2, who requested a text copy of the picture; CNA #3 confirmed did send a text copy of the picture to CNA #2. Continued interview revealed CNA #3 observed CNA #2 video Resident #1 with a cell phone, while sitting up on the bedside, with the hospital gown down and around the waist with the Resident's breasts exposed. Continued interview confirmed Resident #2 was squirted with tap water by (CNA's #2, #3, and #4) during the month of December 2011. "(Resident #2) didn't respond to the squirting, so the squirting stopped." Continued interview revealed other staff were present and observed the Resident being squirted by CNA's #2, #3, and #4, to include CNA's #1 and #6 (observed in December 2011); CNA's #5 and #8 (observed in January 2012); and LPN #1 (observed in December 2011). CNA #3 revealed LPN #1 upon observing the CNA's | N1207  |   |   |

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>TN9002</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/31/2012</b> |
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| N1207  | <p>Continued From page 17</p> <p>squirt the Resident "laughed." CNA #3 confirmed "squirting (Residents #1 and #2) was abuse...although I didn't take the picture to be mean, it was abuse."</p> <p>Interview with CNA #1 on January 25, 2012, at 3:15 p.m., in the conference room, revealed CNA #1 witnessed CNA #2 obtain a saline-filled syringe from LPN #1, around the first week in January 2012. Continued interview with CNA #1 revealed CNA #2 squirted Resident #1 with the saline, then tap water, then proceeded to the Resident's bathroom and filled the syringe with toilet water from the commode and squirted Resident #1. CNA #1 was "shocked and had never seen anything like this before." CNA #1 reported the abuse on January 14, 2012, before 4:00 a.m.</p> <p>Interview on January 25, 2012, at 3:45 p.m., in the conference room, with CNA #5 revealed on the night shift of January 13, 2012, beginning at 6:30 p.m., and ending on January 14, 2012, at 7:00 a.m., CNA's #5, #2, #3, #4, #and #8 were sitting and charting at a table beside the upstairs nurse's station. CNA #2 stated, "Let's go get (Resident #1) riled (to annoy, anger, or irritate) up." Continued interview revealed the CNA's got up and proceeded to the Resident's room. Prior to entering Resident #1's room, CNA #2 commented something about "needing just the right syringe." CNA's #5, #3, and #8 entered Resident #1's room; CNA's #2 and #4 disappeared. The Resident was sitting on the bedside, and then lay down in the bed. A stream of water shot out from the bathroom toward Resident #1, hitting the wall above the Resident's bed. CNA #5 reported was unable to see into the bathroom, but based upon CNA #2's statement at the table just minutes prior to this, CNA #5</p> | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | <p>Continued From page 18</p> <p>determined CNA's #2 and #4 were in the bathroom. CNA #5 confirmed this behavior was abusive to the Resident.</p> <p>Interview with CNA #7 on January 25, 2012, at 5:00 p.m., in the conference room, confirmed "sometime in December" CNA #2 showed a picture of a Resident on their side, naked buttocks showing, and feces on a pad under the Resident. Continued interview with CNA #7 revealed CNA #7 asked CNA #2 "Why would you take a picture like that," and CNA #2 replied "To show my (sibling) what we deal with every night." CNA #7 reported the picture was of a Resident. Continued interview with CNA #7 confirmed, "I knew it was abuse when I was viewing the picture and I should have reported it."</p> <p>Interview with RN #1 on January 25, 2012, at 9:14 p.m., by telephone, confirmed CNA #1 reported (to RN #1) on January 14, 2012, at approximately 4:00 a.m., CNA's #2, #3, and #4, were abusing Resident #1 by squirting (Resident) with water, to include used toilet water, and had taken pictures and a video with cell phones. Continued interview revealed RN #1 was "in shock" from CNA #1's allegations and went upstairs around 4:40 a.m., into Resident #1's room. RN #1 stated the head of the bed and the wall above the head was soaked and the Resident was wiping (the Resident's) face, stated, "Trying to get the water out." Continued interview revealed two CNA's (#3, #8) were in the Resident's room, and were asked by RN #1 why the Resident was wet. The CNA's shrugged their shoulders like they didn't know and replied, "She does that a lot (spills water)." Continued interview with RN #1 confirmed CNA's #2, #3, and #4 were not immediately suspended based upon the abuse allegations reported by CNA #1.</p> | N1207  |   |   |

Division of Health Care Facilities

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| N1207  | <p>Continued From page 19</p> <p>Continued interview confirmed RN #1 did not notify the DON until January 15, 2012, "around" 3:00 p.m. (more than 24-hours after the allegations of abuse). Continued interview with RN #1 confirmed CNA's #2, #3, and #4 worked their full shifts (6:30 p.m.-7:00 a.m.) beginning on January 16, 2012.</p> <p>Interview with CNA #2 on January 26, 2012, at 11:30 a.m., in the conference room, confirmed the squirting of Resident #1 started in December 2011. CNA #2 pulled a pocket calendar from the CNA's purse, opened it, flipped through it to the month of December 2011 and pointed to the date of December 19, 2011, and confirmed, "I came in on the 19th and the squirting of (Resident #1) started around 4:30 a.m., during the round to get Residents up...on the first night of the squirting, CNA's #3, #4, #1, and #6 were present...I pulled up the tap water into a syringe and squirted the light fixture above the Resident's bed hoping the water would drip onto (Resident #1)...little drops trickled onto (Resident's) shoulder and (Resident) pulled the covers up and went back to sleep, so we left the room...on other occasions, we (CNA's #2, #3, #4) used tap water, then ice water from the bottom of the ice chest on the hall, then toilet water from the commode until (Resident #1) was awake and agitated...(Resident) would curse and yell out, "(Spouse's name) leave me the hell alone." "I nicknamed (Resident) ("spouse's name")." Continued interview revealed CNA #2 took a picture "during the first two weeks of November (2011)" of an incontinence pad soiled with feces with no Resident(s) in the picture. CNA #2 stated showed the picture of the soiled incontinence pad to RN #2 and revealed RN #2 did not counsel CNA #2 for having a cell phone on duty. CNA #2 confirmed CNA #3 took a picture on a cell phone of Resident #1's naked</p> | N1207   |   |                    |   |

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>TN9002</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/31/2012</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>APPALACHIAN CHRISTIAN VILLAGE</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2012 SHERWOOD DRIVE<br/>JOHNSON CITY, TN 37601</b> |   |   |
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| N1207  | Continued From page 20<br><br>buttocks. CNA #2 requested CNA #3 to text the picture to CNA #2, to "show my (sibling)." CNA #2 recalled seeing and getting this picture from CNA #3 sometime in November or December 2011, "It was prior to December 16, 2011, because that's when I got my new cell phone and I lost all the pictures I had." CNA #2 confirmed to have used a cell phone to video Resident #1 during an agitated state "around" the last of December 2011; during the "rant" Resident #1 was "sitting up on the edge of the bed with a hospital gown on...(Resident's) breasts were very large and during the rant, they may have been exposed." Continued interview revealed "we all had our cell phones with us...in our pockets, on the floor, in Residents' rooms..." Continued interview revealed CNA #2 showed the video to CNA #1, and then deleted it. CNA #2 revealed LPN #1 gave CNA #2 a saline filled syringe from a medicine cart on the hall. Continued interview confirmed LPN #1 was present and observed the CNA's (#2, #3, and #4) squirting Resident #1 on one occasion. When the surveyor asked what LPN #1 did to correct the abusive action or to protect the Resident in response to squirting the Resident, CNA #2 replied, "Nothing." Continued interview with CNA #2 confirmed all three CNA's worked a full shift from 6:30 p.m. to 7:00 a.m., on January 13-14, 2012, and January 16-17, 2012. Upon reporting to work on January 16, 2012, CNA #1 confirmed, "We were not reassigned, or told we could not go on the hall where Residents #1 and #2 were, and we were not told we couldn't provide care to them...this was never mentioned." CNA #2 confirmed, "Squirting the Residents, taking pictures and making the video was abuse and we thought it was funny...we should not have done this."<br><br>Interview with RN #1 on January 26, 2012, at | N1207  |   |   |

Division of Health Care Facilities

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>APPALACHIAN CHRISTIAN VILLAGE</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2012 SHERWOOD DRIVE<br/>JOHNSON CITY, TN 37601</b>                  |                    |   |
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| N1207  | <p>Continued From page 21</p> <p>6:05 p.m., in the conference room, revealed the RN was "shocked" when (RN #1) saw the CNA's (#2, #3, and #4) at work on January 16, 2012. Upon informing the RN of the video and the surveyor observing the three CNA's working on the hall of Residents #1 and #2, RN #1 confirmed, "The Charge Nurses could not ensure the CNA's were not on the victims' hall; this all could have been avoided if they (CNA's #2, #3, and #4) had not been allowed to work."</p> <p>Interview with RN #2 on January 26, 2012, at 4:30 p.m., in the conference room, confirmed CNA #2 did show RN #2 a picture of an incontinence pad soiled with feces. RN #2 stated instructed CNA #2 to delete the picture, but took no action. Continued interview confirmed the RN had observed CNA's #2, #3, and #4 texting and talking on their cell phone during their shifts. RN #2 stated "reminded" the CNA's not to be using their cell phones. RN #2 confirmed CNA's #2, #3, and #4 were non-compliant with the use of cell phones in the facility.</p> <p>Interview with LPN #1 on January 26, 2012, at 8:30 p.m., in the conference room, revealed LPN #1 stated, "There's a lot of "hustle and bustle" on night shift and I don't remember giving a CNA a syringe." Continued interview with LPN #1 confirmed, I did see CNA #1 with a personal cell phone...(the cell phone) had a mood app (application) on it, like a "mood ring"...you put your thumb on it and it would tell you your mood." LPN #1 stated when (LPN #1) placed a thumb on the app, it said "I was loved."</p> <p>Interview with CNA #6 on January 30, 2012, at 5:00 p.m., in the conference room confirmed the first time CNA #6 witnessed CNA #2, #3, and #4 squirting Resident #1 was on December 20,</p> | N1207   |   |                    |   |

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>TN9002</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  |                    | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/31/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>APPALACHIAN CHRISTIAN VILLAGE</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2012 SHERWOOD DRIVE<br/>JOHNSON CITY, TN 37601</b>                  |                    |   |
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| N1207  | <p>Continued From page 22</p> <p>2012, at approximately 3:00 a.m. - 4:00 a.m. "(Resident #1) would sit up in bed and cuss and yell "get the hell out of here...quit pissing on me." Continued interview with CNA #6 confirmed, "Yes, this was abuse...No, I didn't report it."</p> <p>Interview with CNA #2's sibling on January 31, 2012, at 6:00 p.m., by telephone, confirmed the sibling did not receive a text from CNA #2, but was shown a picture on the CNA's cell. The picture was of a Resident with a hospital gown on, with the naked buttocks exposed. CNA #2 confirmed to the sibling the picture was of a Resident in CNA #2's care at the facility where CNA #2 worked. "This picture was shown to me by CNA #2 sometime during the month of November 2011."</p> <p>Interview on January 30, 2012, at 2:15 p.m., with the DON in the conference room confirmed the allegations of abuse, as reported to RN #1 by CNA #1 on January 14, 2012, at approximately 4:00 a.m., were not reported immediately to the DON until January 15, 2012, at 4:45 p.m., over 24-hours later. Continued interview confirmed the CNA's (#2, #3, and #4) were allowed to work after the allegations of abuse and were not suspended immediately to protect the victims or other potential victims. Continued interview with the DON confirmed residents #1 and #2 were abused; the facility failed to immediately suspend the alleged perpetrators (CNA's #2, #3, and #4), report the allegations and protect the victims and other potential victims.</p> <p>Interview on January 26, 2012, at 2:05 p.m., in the conference room with the Administrator confirmed the DON called the Administrator and reported the abuse on January 15, 2012, at 9:03 p.m. The Administrator stated squirting the</p> | N1207   |   |                    |   |

Division of Health Care Facilities

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| N1207  | Continued From page 23<br>residents was "unlawful" and was abuse. Continued interview confirmed the facility failed to protect residents #1 and #2 from abuse when facility staff failed to follow and enforce the facility's abuse and cell phone policies.<br>C/O #29186 | N1207   |   |                    |   |