

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2015  
FORM APPROVED  
OMB NO. 0938-0391

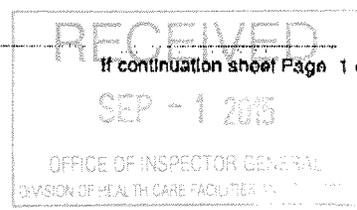
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/06/2015
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NAME OF PROVIDER OR SUPPLIER  TREYTON OAK TOWERS	STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An Abbreviated Survey to investigate complaint KY23619 was initiated on 08/03/15 and concluded on 08/06/15. The Division of Health Care substantiated the allegation with deficiencies cited.	F 000		
F 225 SS-D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated	F 225	1. Resident #1 has been provided care in a manner and in an environment that maintains or enhances dignity and respect in full recognition of her individuality as determined by an interview conducted by the facility Administrator on 8/25/15. C.N.A. #3 was suspended pending investigation 7/17/15 and terminated on 7/21/15. C.N.A. #1 received corrective action on 7/23/15. C.N.A. #2 received a notification of employee counseling on 8/28/15. LPN #1 received a notification of employee counseling on 8/28/15. 2. All residents have the potential to be affected by this deficient practice. 10 interviewable residents were interviewed by facility Administrator on 8/28/15 to determine if there were concerns related to care provided by any staff. There were no concerns reported. 3. Review of facility policy for responding to allegation of abuse was reviewed on 7/17/15 by facility Administrator, at which time need for revision of the policy was identified. Revisions were completed on 7/20/15 by facility Administrator. All nursing staff was educated on revised policy beginning on 7/21/15 and completed on 7/27/15, in servicing of all staff was completed by facility Administrator. 4. To ensure compliance, 10 staff interviews, selected at random, will be completed monthly x2 months and quarterly thereafter x10 months, by Director of Nursing, Assistant Director of Nursing and Administrator. Interview questions include but are not limited to reporting abuse timely and removing the staff member in question from direct care immediately. All interview findings will be reported to QA committee during monthly meeting by Director of Nursing.	8/28/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michael W. Wileman* TITLE: *ADMINISTRATOR* (X6) DATE: *8/28/15*

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.



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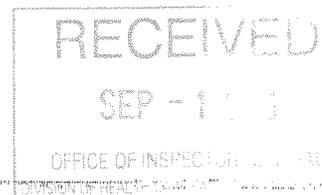
representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, and policy review, it was determined the facility failed to protect residents from potential abuse by not reporting allegations of abuse timely for one (1) of four (4) sampled residents, Resident #1. The facility failed to report to the Administrator or investigate an abuse allegation made on 07/15/15 and the facility allowed the Certified Nursing Assistant (CNA) to continue to care for residents until 07/17/15.

The findings include:

Review of the policy, Resident Abuse, undated, revealed facility staff must report any alleged abuse to the employoo's immediate supervisor who would report the allegation to the Administrator immediately. Staff may also have reported abuse directly to the Administrator. The policy further stated the staff person who observed an incident of resident abuse or suspected resident abuse must report such incidents to the person in charge. Upon receiving the report, the person in charge must have completed a Grievance/Complaint Report form and obtained a written, signed, and dated statement from the person who reported the incident. The person in charge should have then provided that completed information to the

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administrator within twenty-four (24) hours of the occurrence of the incident. Furthermore, the Abuse policy revealed the facility should have immediately escorted any individuals suspected of resident abuse from the building. The facility should have removed the employee from the schedule until the investigation was completed and appropriate action taken.

Review of the facility's Resident Rights, 2014, revealed each resident had the right to be free from abuse, including verbal abuse. If the facility suspected abuse, the facility must have investigated it immediately.

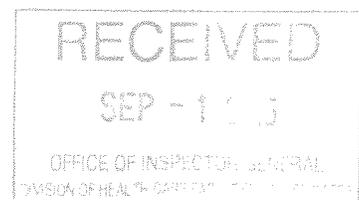
Review of the facility's Initial Investigation due to Allegations of Verbal Abuse, dated 07/17/15, revealed the facility reported an allegation of verbal abuse. The allegation stated CNA #3 allegedly verbally abused Resident #1 on 07/15/15. The Initial Investigation further stated the facility contacted CNA #3 to inform her of her suspension pending an investigation. On 07/17/15, the facility notified the Administrator, family, and other authorities of the allegation.

Review of the facility's staffing schedule, for 07/16/15, revealed CNA #3 worked on 07/16/15.

Review of the clinical record for Resident #1 revealed the facility admitted the resident on 04/08/15 with diagnoses of Dementia, Legal Blindness, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Lower Leg Joint Pain, and Muscle Weakness. Resident #1 was receiving Restorative Therapy.

Review of Resident #1's quarterly Minimum Data Set (MDS) assessment, completed on 06/05/15,

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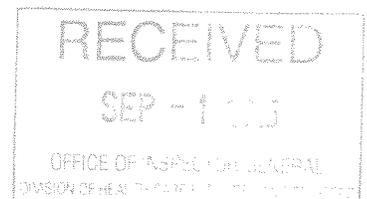
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F 225	<p>Continued From page 3</p> <p>revealed the facility assessed the resident as requiring total staff assistance of two (2) staff to transfer and walk. The resident also required extensive one (1) person assistance for toileting and bathing. The facility conducted a Brief Interview for Mental Status (BIMS) exam and assessed the resident with a BIMS score of ten (10) out of fifteen (15) indicating the resident was interviewable.</p> <p>Review of the Restorative Nursing Notes, dated 07/02/15 and 07/17/15, revealed Resident #1 performed range of motion exercises for upper and lower extremities and ambulation exercises that included walking with assistance. However, the resident often declined to perform the walking exercises due to feeling too tired or sore to complete them.</p> <p>Review of the Care Plan, dated 04/08/15, revealed due to impaired balance with ambulation, cardiac impairment, and visual impairment the resident had a potential for falls and injuries. An intervention dated 04/17/15 stated staff would assist the resident with mobility to the extent needed, including appropriate level of assistance and devices, to meet the needs of the resident. The Care Plan also stated Resident #1 had interventions, dated 06/06/15, to receive restorative therapy for ambulation and range of motion exercises six (6) days per week.</p> <p>Interview with Resident #1, on 08/04/15 at 9:00 AM, revealed a CNA had called him/her "that black motherfucker right there." The resident stated he/she had been walking in the hallway with two (2) CNAs when she felt the urge to use the toilet. The resident stated the CNA told the resident he/she could use the toilet after they had</p>	F 225		



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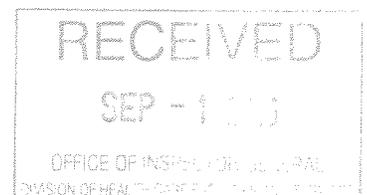
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finished the walking exercises. The resident told the CNA "no" that she needed to use the rest room at that time. Resident #1 stated she became upset with the CNA and was yelling at the CNA. Once they returned to the resident's room, the CNA assisted the resident to the toilet. The CNA walked to the outside of the doorway of the bathroom and, with the door of the bathroom still open, said, "that black mother fucker right there." The resident stated that he/she was sure the CNA was talking to him/her. The resident was unable to identify who the CNA was because the resident was blind. The resident stated he/she was very upset and could not believe someone had talked in that manner to him/her. Resident #1 stated he/she did not report the incident to staff because he/she did not want to get anybody in trouble.

Interview with CNA #2, on 08/04/15 at 1:16 PM, revealed on 07/15/15 she observed CNA #3 point to Resident #1 and say "that motherfucker right there." CNA #2 walked up to two (2) CNAs assisting Resident #1 with walking exercises in the hallway. The resident stated he/she needed to use the bathroom and was becoming agitated. The resident was yelling and picked up her walker and shook it at the CNAs. The CNAs assisted the resident to the bedroom and CNA #3 took Resident #1 to the bathroom. When CNA #3 came out of the bathroom, she pointed in the direction of Resident #1, but did not look at the resident, and the statement. CNA #2 stated after the incident, she left the room and told the nurse on the hall, Licensed Practical Nurse (LPN) #1, there was a situation in Resident #1's room and that CNA #3 called the resident an "M.F.er." CNA #2 admitted she told the LPN in a non-formal way in passing because the nurse

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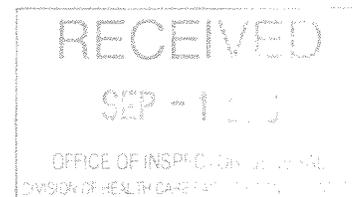
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was orienting a new nurse and administering medications at the time. She did not go back to the nurse to report the incident later in the shift.

Interview with CNA #1, on 08/04/15 at 1:45 PM, revealed on 07/15/15 the CNA heard CNA #3 curse in the resident's room, within the resident's hearing, after she placed the resident in the bathroom. CNA #1 and CNA #3 were giving restorative care to Resident #1 in the hallway when the resident became upset. The CNAs assisted Resident #1 to her room and CNA #3 placed Resident #1 in the bathroom. CNA #1 was standing outside of the resident's door when she heard CNA #3 say "that motherfucker right there." CNA #1 stated she confronted CNA #3 who immediately apologized for her words. CNA #1 stated CNA #3 calmed down and both of the CNAs completed care and left the room together. CNA #1 stated she told LPN #1 there was a situation in the resident's room, but did not go into any details. She said she did not go back to the nurse to report the alleged abuse at any time during the shift. CNA #1 stated the following day the 2nd shift nurse, LPN #2, approached her and asked what had happened.

Interview with LPN #1, on 08/04/15 at 2:15 PM, revealed she did not report an allegation of abuse on 07/15/15. The LPN stated she did recall CNA #2 telling her there was a situation in Resident #1's room. However, she stated she did not recall CNA #1 or CNA #2 telling her that CNA #3 had cursed at the resident. Therefore, she did not know to investigate an allegation of abuse. LPN #1 stated she was the nurse on the hall on 07/15/15. The LPN stated she had been providing orientation training to new nurses that day and was very busy with medication pass at

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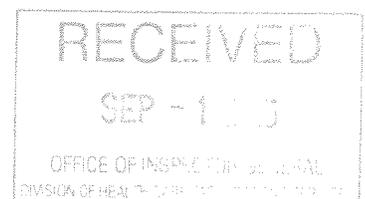
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the time CNA #2 stated there was an incident in the resident's room. The LPN stated she could not recall if she went back to Resident #1's room after the alleged incident, but stated she did not talk with the CNA's about verbal abuse that day. However, the following morning, LPN#1 witnessed the Staff Development Coordinator talking with Resident #1. Later in the afternoon of 07/16/15, CNA #2 approached LPN #1 and reported an allegation of abuse to her at that time. LPN #1 stated since the Staff Development Coordinator had already spoken with Resident #1 about it that morning, he must already know about the abuse allegation and the LPN thought there was nothing left that she needed to do. LPN #1 did not report her conversation with CNA #2 to anybody. She did not follow up with the Staff Development Coordinator about the information she received from CNA #2.

Interview with LPN #2, on 08/04/15 at 8:05 PM, revealed on 07/15/15 a CNA reported a possible allegation of abuse to her. She was working second shift when the CNA working with Resident #1 overheard the resident talking with another resident. Resident #1 stated a CNA had cursed at him/her earlier in the day. The CNA reported what she had overheard to LPN #2. The LPN stated she then went and spoke with Resident #1. The resident told LPN #2 he/she was fine and did not want to get anybody in trouble. Resident #1 stated if it happened again she would tell somebody. Resident #1 did tell the LPN directly what had happened. LPN #2 called the Staff Development Coordinator, who was the acting Shift Supervisor at the time. The Staff Development Coordinator advised the LPN to write an incident report and place it under his office door. He stated he would talk with the

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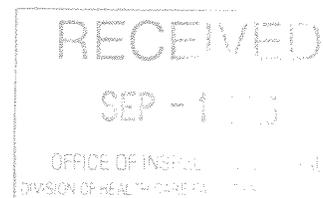
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resident the following morning. The following day, on 07/16/15, LPN #2 spoke with the Staff Development Coordinator who told her the resident might have been confused. He stated residents with diagnoses of Dementia and Oxygen Dependence often become confused. LPN #2 stated she did not feel comfortable with the answer and continued to ask various CNAs if they had any information about the alleged verbal abuse. On 07/17/15, LPN #2 spoke with CNA #1, who described to her the incident between Resident #1 and CNA #3 on 07/15/15. LPN #2 reported the new information to the Staff Development Coordinator.

Interview with Staff Development Coordinator, on 08/05/15 at 4:45 PM, revealed he had received an allegation of verbal abuse and did not immediately report the allegation to the Administrator. The staff Development Coordinator stated he was also functioning as the Shift Supervisor on 07/15/15 when the alleged incident took place. The Staff Development Coordinator stated he spoke with LPN #2 on the evening of 07/15/15. LPN #2 stated a CNA had overheard Resident #1 speaking with another resident about a staff person cursing at the resident. The Staff Development Coordinator instructed the LPN to initiate an incident report and to assess the resident's mental status and wellbeing. On the morning of 07/16/15, he spoke with Resident #1 about the allegation of verbal abuse. At that time, the resident first denied any verbal abuse and then stated he/she did not want to get anybody in trouble. After the speaking with the resident, he then talked with several staff on the unit who all denied any knowledge of the alleged incident. The Staff Development Coordinator did not check the schedule to find out

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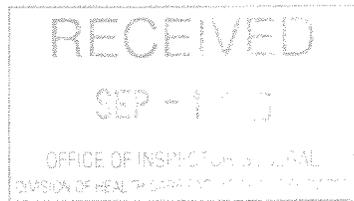
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who worked with the resident when the alleged incident took place. Next, he spoke with the DON who told him the resident might have been confused because the resident had diagnoses of Dementia and Oxygen Dependence. The DON told him residents with those conditions often become confused and might have been unaware of what they are saying. The Staff Development Coordinator stated he ended his investigation after speaking with the DON and did not report the allegation to the Administrator. The Staff Development Coordinator revealed the allegation of verbal abuse was reported to him for the second time on 07/17/15 at about 2:30 PM. At that time LPN #2 reported CNA #3 had cursed at Resident #1 on 07/15/15. The LPN had talked with another CNA who had witnessed CNA #3 cursing. At this time, The Staff Development Coordinator reported the new information to the DON and the Social Service Director. They informed the Administrator of the allegation of abuse and began the investigation procedure, including suspending the alleged perpetrator of the abuse. The Staff Development Coordinator revealed the delay in reporting abuse placed the resident at increased risk of further abuse and harm because the perpetrator was able to continue working with the resident for a full day before staff reported the abuse.

Interview with the Administrator, on 08/06/15 at 8:45 AM, revealed the facility reported an allegation of abuse more than forty-eight (48) hours after the incident took place. The Administrator stated he was on vacation the week of the incident and the facility did not inform him of the allegation of verbal abuse until Friday, 07/17/15 at approximately 2:45 PM. During the forty-eight (48) hour delay, the facility placed the

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resident at increased risk of further abuse because the alleged perpetrator of the abuse was able to continue to work with the resident the remainder of that shift and the following day. The facility did not comply with the regulation of reporting allegations of abuse immediately and was not within 24 hours.

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F 226  
SS-D 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  
  
The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

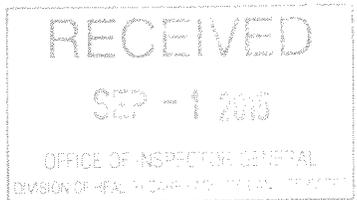
F 226

1. Resident #1 has been provided care in a manner and in an environment that maintains or enhances dignity and respect in full recognition of her individuality as determined by an interview conducted by the facility Administrator on 8/26/15. C.N.A. #3 was suspended pending investigation 7/17/15 and terminated on 7/21/15. C.N.A. #1 received corrective action on 7/23/15. C.N.A. #2 received a notification of employee counseling on 8/28/15. LPN #1 received a notification of employee counseling on 8/28/15.  
2. All residents have the potential to be affected by this deficient practice. 10 interviewable residents, selected at random, were interviewed by facility Administrator on 8/28/15 to determine if there were concerns related to care provided by any staff. There were no concerns reported.  
3. Review of facility policy for responding to allegation of abuse was reviewed on 7/17/15 by facility Administrator, at which time need for revision of the policy was identified. Revisions were completed on 7/20/15 by facility Administrator. All nursing staff was educated on revised policy beginning on 7/21/15 and completed on 7/27/15. In servicing of all staff was completed by facility Administrator.  
4. To ensure compliance, 10 staff interviews, selected at random, will be completed monthly x2 months and quarterly thereafter x10 months, by Director of Nursing, Assistant Director of Nursing and Administrator. Interview questions include but are not limited to reporting/investigating abuse timely and protecting resident in the event of alleged abuse. All interview findings will be reported to QA committee during monthly meeting by Director of Nursing.

8/28/15

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, and review of the facility's policies, it was determined the facility failed to have an effective system in place to ensure their Abuse policy was implemented for one (1) of four (4) sampled residents, Resident #1. The facility failed to report and investigate an abuse allegation according to their abuse policy. In addition, the facility failed to protect the resident from further abuse per the facility policy when the facility allowed CNA #3 to continue to care for the resident.

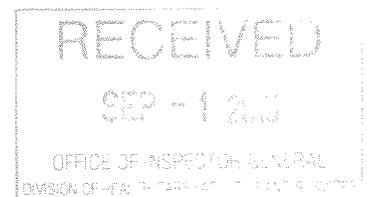
The findings include:  
  
Review of the policy, Resident Abuse, undated, revealed the facility would have provided training to each employee as part of orientation and in ongoing sessions regarding recognizing, intervening, and reporting abuse. The facility



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/06/2015
NAME OF PROVIDER OR SUPPLIER  TREYTON OAK TOWERS			STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 10 should have provided training to all staff on appropriate interventions to deal with aggressive resident reactions. The facility should have provided training on what constitutes abuse and how staff should have reported their knowledge related to allegations of abuse. Per the Abuse policy, facility staff should have reported any alleged abuse to the employee's immediate supervisor who would have then reported the allegation immediately to the Administrator. Staff may have also reported abuse directly to the Administrator. The policy further stated the staff person who observed an incident of resident abuse or suspected resident abuse needed to have reported the incident to the person in charge. Upon receiving the report, the person in charge would have completed a Grievance/Complaint Report form and obtained a written, signed and dated statement from the person reporting the incident. The person in charge would have provided that completed form to the administrator within twenty-four (24) hours of the occurrence of the incident. Additionally, the Abuse policy revealed the facility should have immediately escorted any individuals suspected of resident abuse from the building. The facility should have removed the employee from the schedule until the investigation was completed and appropriate action taken.  Review of the facility's Initial Investigation due to Allegations of Verbal Abuse, dated 07/17/15, revealed the facility would report an allegation of verbal abuse. The allegation stated CNA #3 allegedly verbally abused Resident #1 on 07/15/15. The Initial Investigation further stated the facility contacted CNA #3 on 07/17/15 to inform her of her suspension pending an investigation. On 07/17/15, the facility notified the	F 226			



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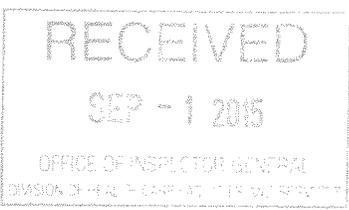
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NAME OF PROVIDER OR SUPPLIER  TREYTON OAK TOWERS	STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203
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F 226	<p>Continued From page 11</p> <p>Administrator, family, and other authorities of the allegation.</p> <p>Review of the clinical record revealed the facility admitted Resident #1 on 04/08/15 with diagnoses of Dementia, Legal Blindness, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Lower Leg Joint Pain, and Muscle Weakness. Resident #1 was receiving Restorative Therapy.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS) assessment, completed on 06/05/15, revealed the facility assessed the resident as requiring total two (2) person staff assistance to transfer and walk. The resident also required extensive one (1) person assistance for toileting and bathing. The facility conducted a Brief Interview for Mental Status (BIMS) exam and assessed the resident to have a BIMS score of ten (10) out of fifteen (15) indicating the resident was interviewable.</p> <p>Interview with Resident #1, on 08/04/15 at 9:00 AM, revealed a CNA had called him/her "that black mother fucker right there." The resident stated he/she had been walking in the hallway with two (2) CNA's and felt the urge to use the toilet. The CNA told the resident he/she could use the toilet after they had finished the walking exercises. The resident told the CNA "no" he/she needed to use the rest room at that time. Resident #1 stated he/she became upset with the CNA and was yelling at the CNA. Once they returned to the resident's room, the CNA assisted the resident to the toilet and walked out of the bathroom saying, "that black mother fucker right there." The resident stated that he/she was sure the CNA was talking to him/her. The resident was unable to identify the CNA by name because</p>	F 226		
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F 226	<p>Continued From page 12</p> <p>he/she was blind. The resident stated he/she was very upset and angry because he/she could not believe someone had talked that way to him/her. Resident #1 stated he/she did not report the cursing because he/she did not want to get anybody in trouble.</p> <p>Interview with CNA #2, on 08/04/15 at 1:16 PM, revealed on 07/15/15 CNA #3 pointed to Resident #1 and said, "that mother fucker right there." CNA #2 stated she witnessed CNA #3 standing in the resident's bedroom, outside of the bathroom doorway. She stated CNA #3 pointed in the direction of Resident #1, looked away, and cursed out loud. CNA #2 left the room a few minutes later and informed Licensed Practical Nurse (LPN) #1 there was a situation in Resident #1's room and CNA #3 called the resident an "M.F.er". CNA #2 stated she gave the LPN this information in an informal way, in passing, and did not give any details. She stated LPN #1 was training another nurse on passing medications at the time. CNA #2 did not go back to the nurse to report the incident later in the shift.</p> <p>Interview with CNA #1, on 08/04/15 at 1:45 PM, revealed on 07/15/15 the CNA heard CNA #3 curse within Resident #1's hearing. CNA #1 and CNA #3 were giving restorative care to Resident #1 when the resident became upset. The CNAs assisted Resident #1 to her room and CNA #3 placed Resident #1 in the bathroom. CNA #1 was standing outside of the resident's door when she heard CNA #3 exit the bathroom and say, "that mother fucker right there." CNA #1 stated when she left the resident's room she told LPN #1 there was a situation in the room. The CNA stated she did not report the alleged abuse to the nurse at that time and she did not go back to the</p>	F 226		

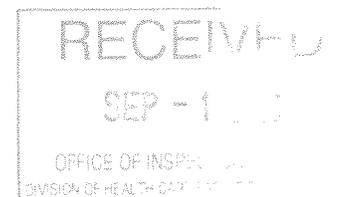
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F 226	<p>Continued From page 13</p> <p>nurse to report the alleged abuse during that shift.</p> <p>Interview with LPN #1, on 08/04/15 at 2:15 PM, revealed the LPN did not report an allegation of abuse on 07/15/15. LPN #1 stated she was the nurse on the hall on 07/15/15. The LPN stated CNA #2 informed her of a situation in Resident #1's room. However, she stated she did not recall CNA #1 or CNA #2 telling her that CNA #3 had cursed at the resident. Therefore, she did not know to investigate an allegation of abuse at that time. She further stated she could not recall if she went back to Resident #1's room after the alleged incident, but stated she did not talk with the CNA's about verbal abuse that day. On the morning of 07/16/15, LPN #1 witnessed the Staff Development Coordinator spending time talking with Resident #1 in the resident's room. Later in the afternoon of 07/16/15, CNA #2 reported to the LPN she had witnessed the possible verbal abuse of Resident #1 the previous day. LPN #1 stated she figured this was the reason the Staff Development Coordinator was talking with Resident #1 and that someone in the facility had already reported the incident. Therefore, she stated she believed the Staff Development Coordinator was already investigating the situation and did not report her conversation with CNA #2.</p> <p>Interview with LPN #2, on 08/04/15 at 8:05 PM, revealed on the second shift of 07/15/15 a CNA reported a possible allegation of abuse to LPN #2. The CNA reported she had overheard Resident #1 talking to another resident about a CNA cursing at him/her earlier in the day. After the CNA gave the report, LPN #2 interviewed Resident #1. The resident stated he/she was fine and did not want to get anybody in trouble.</p>	F 226		



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F 226	<p>Continued From page 14</p> <p>Resident #1 stated if it happened again she would tell somebody. Resident #1 declined to tell the LPN directly what had happened. LPN #2 then called the Staff Development Coordinator, who was the acting Shift Supervisor at the time. LPN #2 stated he told her to write an incident report, place it under his office door, and that he would talk with the resident the following morning. LPN #2 spoke with the Staff Development Coordinator on 07/16/15 and he told the LPN the resident might have been confused at the time she made the allegation, citing her diagnoses of Dementia and Oxygen Dependence. LPN #2 stated she continued to ask several CNAs if they had any information about the incident. On 07/17/15, CNA #1 reported what had happened with Resident #1 on 07/15/15. LPN #2 reported the new information to the Staff Development Coordinator.</p> <p>Interview with the Staff Development Coordinator, on 08/05/15 at 4:45 PM, revealed he had received an allegation of verbal abuse and did not immediately report the allegation to the Administrator. The staff Development Coordinator stated he was also functioning as the Shift Supervisor on 07/15/15 when the alleged incident took place. The staff Development Coordinator began conducting an investigation into the allegation of verbal abuse after speaking to LPN #2 on the evening of 07/15/15. On the morning of 07/16/15, the Staff Development Coordinator interviewed Resident #1 and several staff members who were working on the hall. He did not report the allegation of abuse to the Administrator at that time. The Staff Development Coordinator stated he was unfamiliar with the abuse policy, did not refer to the abuse policy for guidance, and initiated an investigation without contacting the DON or</p>	F 226		

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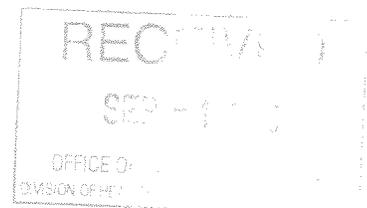
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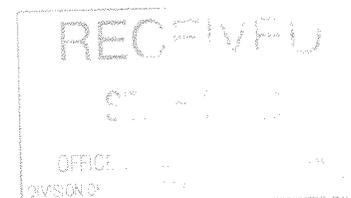
F 226	<p>Continued From page 15</p> <p>Administrator or placing the alleged perpetrator on administrative leave. After his initial investigation revealed no evidence of verbal abuse, the Staff Development Coordinator took the incident report and discussed his initial investigation findings with the DON. The Staff Development Coordinator stated the DON told him that the resident had diagnoses of Dementia and Oxygen Dependent and residents with those conditions often become confused and unaware of what they are saying. The Staff Development Coordinator stated he did not pursue the allegation further and did not report the allegation to the Administrator. On 07/17/15 at about 2:30 PM, LPN #2 reported to the Staff Development Coordinator that CNA #3 had cursed at Resident #1 on 07/15/15. He reported the new information to the DON. He and the DON reported the allegation to the Social Service Director and initiated an investigation into the allegation of verbal abuse. At this time, they informed the Administrator of the allegation of abuse. The Staff Development Coordinator further revealed the lack of immediate staff reporting of the incident placed Resident #1 at increased risk of further abuse and harm because the perpetrator was able to continue working with the resident for a full day before staff reported the abuse. He also stated he should have reported the allegation when the LPN first reported it to him. The Staff Development Coordinator stated that he did not at the time because, instead of looking up the abuse policy, he discussed the incident with the DON and dismissed the event without further investigation after not getting information suggesting abuse may have taken place. He stated the delay in reporting abuse placed the resident at risk of increased distress and abuse because the perpetrator of the abuse continued</p>	F 226		
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F 226	Continued From page 16 to work with the resident through the next day, 07/16/15, following the incident.  Interview with the Administrator, on 08/06/15 at 8:45 AM, revealed the facility did not follow its policies and procedures for reporting and investigating an allegation of abuse. The facility reported the allegation more than forty-eight (48) hours after the incident took place. During that time, the facility placed the resident at increased risk of abuse because the perpetrator of the abuse was able to continue to work with the resident the remainder of that shift and the following day. This did not comply with the policy that stated the facility would place an employee suspected of abuse on paid administrative leave from the time of the allegation until the conclusion of the abuse investigation. The facility did not comply with the regulations pertaining to reporting abuse allegations immediately and was not within 24 hours. The Administrator stated that he found fault with the policy in that staff had to report to someone, who had to report to someone else, who had to report to him. The Administrator stated this chain of command type flow of information causes information to become lost and diluted. The Administrator stated the facility trained staff on how to identify and report abuse. However, the facility's system experienced a breakdown in reporting abuse from both of the CNAs who witness the abuse. The Staff Development Coordinator and DON had another breakdown of the system when LPN #2 reported the abuse on the evening of 07/15/15.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a	F 241		



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F 241 Continued From page 17  
manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

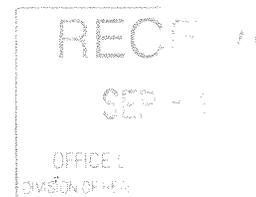
This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure staff carried out care that maintained dignity for one (1) of four (4) sampled residents, Resident #1. Staff failed to speak respectfully to and about Resident #1 while providing restorative care and toileting care.

The findings include:  
Review of the Residents' Rights policy, undated, revealed the facility should have protected and promoted the residents right to a dignified existence and self-determination. Residents had a right to communication with, and access to, persons and services. Residents had the right to refuse treatment. The facility should treat residents with consideration, respect, and full recognition of the resident's dignity and individuality, including in care for their personal needs.

Observation of Resident #1, on 08/04/15 at 9:00 AM, revealed the resident was in his/her room and was completing care with the assistance of a Certified Nursing Assistant (CNA). Staff had pulled the curtain in the room to provide the care and pulled the curtain back per the resident's request once she completed the care. Resident #1 was sitting in a wheelchair wearing an Oxygen nasal cannula. Interactions were appropriate and the resident had no signs of distress or

F 241 1. Resident #1 has been provided care in a manner and in an environment that maintains or enhances dignity and respect in full recognition of her individuality as determined by an interview conducted by the facility Administrator on 8/25/15. C.N.A. #3 was suspended pending investigation 7/17/15 and terminated on 7/21/15. C.N.A. #1 received corrective action on 7/23/15. C.N.A. #2 received a notification of employee counseling on 8/28/15. LPN #1 received a notification of employee counseling on 8/28/15.  
2. All residents have the potential to be affected by this deficient practice. All resident care plans will be reviewed by 9/1/15 to ensure each includes an approach to care related to resident rights/dignity. 10 interviewable residents, selected at random, were interviewed by facility Administrator on 8/28/15 to determine if there were concerns related to care provided by any staff. There were no concerns reported.  
3. Training related to resident rights and dignity will be completed for all nursing staff by 9/7/15. Each staff member must complete and pass a post test to ensure effectiveness of training.  
4. To ensure compliance, 10 interviewable residents, selected at random, will be interviewed monthly x2 months and quarterly thereafter x10 months, by Director of Nursing, Assistant Director of Nursing and Administrator. Interview questions include but are not limited to being treated with dignity and respect by staff, ability to express grievances/concerns without fear and provision of privacy during care. All interview findings will be reported to QA committee during monthly meeting by Director of Nursing.

9/7/15



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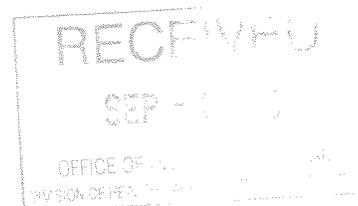
Continued From page 18  
discomfort with staff at this time.

Review of the clinical record revealed the facility admitted Resident #1 on 04/08/15 with diagnoses of Dementia, Legal Blindness, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Lower Leg Joint Pain, and Muscle Weakness. Resident #1 was receiving Restorative Therapy.

Review of Resident #1's quarterly Minimum Data Set (MDS) assessment, completed on 06/05/15, revealed the facility assessed the resident as requiring total staff assistance to transfer and walk. The resident also required extensive one (1) person assistance for toileting and bathing. The facility conducted a Brief Interview for Mental Status (BIMS) exam and assessed the resident to have a BIMS score of ten (10) out of fifteen (15) indicating the resident was interviewable.

Interview with Resident #1, on 08/04/15 at 9:00 AM, revealed the resident heard a CNA calling him/her "that black mother fucker right there." The resident stated he/she had been walking in the hallway with two (2) CNA's when he/she felt the urge to use the toilet. The resident stated the CNA told the resident he/she could use the toilet after they had finished the walking exercises. The resident told the CNA "no" that he/she needed to use the rest room at that time. Resident #1 stated he/she became upset with the CNA and was yelling at the CNA. Once they returned to the resident's room, the CNA assisted the resident to the toilet. The CNA then walked out of the bathroom and said, "that black mother fucker right there." The resident stated that he/she was sure the CNA was talking to him/her. The resident was unable to identify the CNA by name due to he/she was blind. The resident

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/06/2015
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NAME OF PROVIDER OR SUPPLIER  TREYTON OAK TOWERS	STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203
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F 241

Continued From page 19

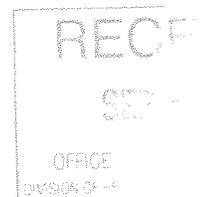
stated he/she could not believe someone had spoken to him/her in such a disrespectful way and was very upset and angry about it. Resident #1 stated he/she did not report it to anyone because she did not want to get anybody in trouble.

Interview with CNA #2, on 08/04/15 at 1:16 PM, revealed on 07/15/15 the CNA observed CNA #3 point to Resident #1 and say "that mother fucker right there." CNA #2 stated CNA #3 was standing in the resident's bedroom, outside of the bathroom doorway. She stated CNA #3 pointed in the direction of Resident #1, but did not look at the resident when she said it. CNA #2 stated she worked with Resident #1 later that day and the following day. During those interactions, the resident appeared angry and at times refused care from CNA #2.

Interview with CNA #1, on 08/04/15 at 1:45 PM, revealed on 07/15/15 the CNA heard CNA #3 curse about Resident #1 within the resident's hearing. CNA #1 and CNA #3 were giving restorative care to Resident #1, they were walking in the hallway with the resident, when the resident became upset and agitated. The CNAs assisted Resident #1 to her room and CNA #3 placed Resident #1 in the bathroom. CNA #1 was standing outside of the resident's door when she heard CNA #3 say "that mother fucker right there." CNA #1 stated CNA #3 did not treat Resident #1 with dignity while the resident was escalating in neither the hallway nor when CNA #3 assisted the resident to the bathroom and then cursed. This was disrespectful.

Interview with CNA #4, on 08/05/15 at 3:30 PM, revealed should have been treated Resident #1

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F 241	<p>Continued From page 20</p> <p>with dignity and respect. CNA #4 stated she works with Resident #1 frequently and sometimes the resident would become upset. When this happens, the CNA talks to the resident calmly and attempts to redirect the resident. She stated this usually worked to calm the resident. The CNA stated it was important to treat Resident #1 with dignity by introducing one's self when entering the room, telling the resident what care was being given, and speak calmly with Resident #1.</p> <p>Interview with Minimum Data Set (MDS) Nurse, on 08/05/15 at 3:42 PM, revealed CNA #3, who was the restorative CNA, did not preserve the dignity of Resident #3 on 07/15/15. The MDS Nurse stated she was also the Restorative Therapy Supervisor. She stated if a resident became upset while receiving restorative care, the restorative CNA should stop what they were doing, give the resident reassurances, and try to calm the resident. Further, the MDS Nurse stated if a CNA was feeling frustrated with a resident, the CNA should have asked another CNA to take over, ensure the resident was safe, and step away from the situation. The MDS nurse stated CNA #3 did not reassure Resident #1 of his/her safety nor did the CNA step away from the resident when the CNA was feeling frustrated. Instead, CNA #3 allegedly cursed in front of the resident and did not treat Resident #1 with dignity. The MDS Nurse stated the restorative CNAs' had been reporting a pattern of increased resistance leading up to the incident, but that she had not observed the restorative CNAs' providing care to the resident to further assess the situation. The MDS Nurse stated restorative CNAs' should also be reporting increased resident resistance to the nurse on the</p>	F 241		



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Continued From page 21  
hallway. The MDS Nurse stated she did not discuss the mounting concerns with the DON or Interdisciplinary Team members.

Interview with Staff Development Coordinator, on 08/05/15 at 4:45 PM, revealed the facility did not protect Resident #1's dignity on 07/15/15. He stated Restorative CNAs completed restorative care and reported restorative tasks to the MDS Nurse. However, Restorative CNAs reported any care issues to the Charge Nurse. The Staff Development Coordinator stated CNAs should have used reassuring cues with Resident #1 when the resident became upset. Instead, CNAs #3 cursed in front of the resident. This did not protect the resident's dignity. Further, the facility allowed CNA #3 to continue to work with Resident #1 the rest of the shift and the following day after the incident. This also did not protect the resident's dignity or welfare.

Interview with the Administrator, on 08/06/15 at 8:45 AM, revealed the facility did not protect Resident #1's dignity during and following the incident on 07/15/15. The Administrator stated Resident #1 became increasingly upset in the hallway while receiving restorative care. At that time, the resident stated she needed to use the bathroom; the CNAs did not immediately agree with the resident's wishes and did not speak calmly and reassuringly to the resident. Instead, CNA #3 spoke in an aggravated tone to the resident in the hallway. The resident continued to escalate during this exchange. After the CNAs assisted the resident to the bathroom, the CNA cursed at or about the resident within the earshot of the resident. This should not have happened because the CNAs should have recognized what was occurring and taken a time out. Other staff

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F 241	Continued From page 22 should have stepped in when they witnessed the altercation escalating.	F 241		
F 282 SS-4D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to implement the care plan for one (1) of four (4) sampled residents, Resident #4, with regard to monitoring and assisting the resident with managing cognitive loss due to symptoms of dementia.</p> <p>The findings include:</p> <p>Interview with the Administrator, on 08/05/15 at 4:30 PM, revealed the facility used the Resident Assessment Instrument (RAI) Version 3.0 User Manual, dated September 2010, as policy for development and maintenance of resident care plans. Review of the RAI Version 3.0 Manual revealed the facility would have communicated the goals and their accompanying approaches to direct care staff. The manual revealed the care plan should have been oriented towards preventing avoidable declines and managing risk factors to the extent possible.</p> <p>Review of the clinical record for Resident #1, revealed the facility admitted the resident on</p>	F 282	<p>1. Resident #1 has been provided care in a manner and in an environment that maintains or enhances dignity and respect in full recognition of her individuality as determined by an interview conducted by the facility Administrator on 8/25/15. C.N.A. #3 was suspended pending investigation 7/17/15 and terminated on 7/21/15. C.N.A. #1 received corrective action on 7/23/15. C.N.A. #2 received a notification of employee counseling on 8/28/15. LPN #1 received a notification of employee counseling on 8/28/15.</p> <p>2. All residents dependent upon staff for care as outlined by each individual plan of care had the potential to be affected by this deficient practice. All resident care plans were reviewed by Director of Nursing and Lead C.N.A. for completion and accuracy beginning on 8/5/15 and completed on 8/10/15.</p> <p>3. All C.N.A.s were re-educated by Director of Nursing, Assistant Director of Nursing and lead C.N.A. on how to access and interpret resident care plans via kiosk, point of care. Training began on 8/24/15 and completed on 8/31/15. Effectiveness of the training was measured by returned demonstration and verbalization of understanding by each C.N.A.</p> <p>4. To ensure ongoing compliance of care plan implementation; observation of care audits will be completed by Director of Nursing, Assistant Director of Nursing and Licensed nurse shift supervisors, each shift, daily x14 days; each shift two times weekly x2 weeks, each shift weekly x2 weeks and each shift monthly x3 months. All observation of care audit findings will be reported to QA committee monthly by Director of Nursing.</p>	9/1/15

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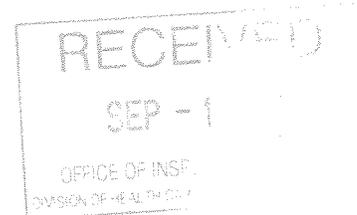
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F 282	<p>Continued From page 23</p> <p>04/08/15 with diagnoses of Dementia, Legal Blindness, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Lower Leg Joint Pain, and Muscle Weakness. Resident #1 was receiving Restorative Therapy.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS) assessment, completed on 06/05/15, revealed the facility assessed the resident as requiring total staff assistance of two (2) staff to transfer and walk. The resident also required extensive one (1) person assistance for toileting and bathing. The facility conducted a Brief Interview for Mental Status (BIMS) exam and assessed the resident to have a BIMS score of ten (10) out of fifteen (15) indicating the resident was interviewable.</p> <p>Review of the Care Plan, dated 04/08/15, revealed the resident had a potential for falls with injuries due to impaired balance with ambulation, cardiac impairment, and visual impairment. An intervention dated 04/17/15 stated staff were to assist the resident with mobility to the extent needed to meet the needs of the resident, including toileting and ambulation, with appropriate assistive devices and a gait belt. The Care Plan additionally included approaches to assist the resident with managing cognitive loss due to Dementia. Those approaches included calming the resident if he/she showed signs of distress, and to respect the resident's right to make decisions.</p> <p>Interview with Resident #1, on 08/04/15 at 9:00 AM, revealed a CNA had not been calm with him/hor and had treated the resident disrespectfully. The resident stated he/she had been walking in the hallway with two (2) CNAs'</p>	F 282		
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F 282	<p>Continued From page 24</p> <p>when he/she felt the urge to use the toilet. The resident stated the CNAs told the resident he/she could use the toilet after they had finished the walking exercises. The resident told the CNAs "no" that he/she needed to use the rest room at that time. Resident #1 stated he/she became upset with the CNAs and was yelling at the CNAs. Once they returned to the resident's room, the CNAs assisted the resident to the toilet. The CNAs walked to the outside of the doorway of the bathroom and said, "that black mother fucker right there." The resident stated that he/she was sure the CNA was talking to him/her. The resident stated he/she was unable to identify the CNAs by name because he/she was blind. The resident stated he/she could not believe someone had talked to him/her so disrespectfully and that it made him/her feel upset and angry.</p> <p>Interview with CNA #2, on 08/04/15 at 1:16 PM, revealed on 07/15/15 she witnessed CNA #3 acting in a way that was not calming to Resident #1 while the resident was upset. CNA #2 stated she approached Resident #1 and the two (2) CNAs in the hallway after hearing Resident #1 yelling and becoming aggressive. The CNAs assisted Resident #1 to her room and CNA #3 assisted Resident #1 to the bathroom. As CNA #3 exited the bathroom she pointed in the direction of Resident #1, not looking at the resident, and cursed.</p> <p>Interview with CNA #1, on 08/04/15 at 1:45 PM, revealed she witnessed CNA #3 acting in a way that was not calming to Resident #1 nor respectful of the resident's choices. CNA #1 and CNA #3 were performing restorative ambulation with Resident #1 when the resident stated he/she needed to use the bathroom. CNA #3 told the</p>	F 282		

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F 282 Continued From page 25

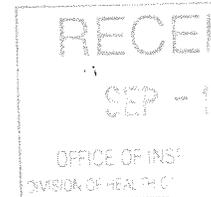
resident he/she could use the bathroom after walking. Resident #1 became upset. The CNA assisted Resident #1 to her room and CNA #3 placed Resident #1 in the bathroom. As CNA #3 was walking out of the resident's bathroom, she cursed. This did not ensure the dignity of the resident. CNAs #3 was not calming toward Resident #1.

Interview with the Minimum Data Set (MDS) Nurse, 08/05/15 at 3:42 PM, revealed staff was to stop what they were doing and give the resident reassurance should the resident become upset per the care plan. The MDS Nurse was responsible for the development and updating of the care plans and care plan approaches. She stated Resident #1 would sometimes become upset about receiving care and that staff were to follow the care plan to respect the resident's choices in declining care and were to speak calmly to the resident if he/she was showing signs of distress.

Interview with the Staff Development Coordinator, on 08/05/15 at 4:45 PM, revealed the CNA staff did not follow the care plan to speak calm and reassure Resident #1 when he/she exhibited signs of distress. The CNAs should have followed the care plan to use reassuring cues and other CNAs should have intervened when CNA #3 was not speaking to Resident #1 in a reassuring manor. He further revealed the lack of immediate staff reporting and intervention of the incident placed Resident #1 at increased risk of abuse and harm.

Interview with the Administrator, on 08/06/15 at 8:45 AM, revealed the staff did not follow the care plan to calm and reassure Resident #1 when they

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F 282	Continued From page 26 did not immediately consent to the resident's wishes to use the bathroom. In addition, when Resident #1 became upset, staff did not speak in a calm and reassuring manner for the resident's care plan. Instead, CNA #3 became aggravated and spoke in an aggravating tone of voice to the resident in the hallway, escalating the resident further. Then, CNA #3 cursed toward Resident #1. This was neither respectful nor calming to the resident. The facility placed the resident at increased risk of abuse and injury due to not respecting the resident's wishes and talking calmly to the resident.	F 282		

