

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

PRINTED: 03/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/17/2025
NAME OF PROVIDER OR SUPPLIER PAGE REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N AIRPORT ROAD FORT MYERS, FL 33907	
(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 unannounced survey revisit was conducted on _____ at Page Rehabilitation and Healthcare Center, a skilled nursing facility in Fort Myers, Florida. This was the follow up to the complaint survey completed on _____ which identified Immediate Jeopardy. This complaint survey revisit was conducted in conjunction with a new complaint survey. Page Rehabilitation and Healthcare Center has ongoing noncompliance with the Code of Federal Regulations (CFR) 42, Part 483, Subparts B-F, Requirements for Long-Term Care Facilities based on the results of the complaint survey (EQGC11). The following is a description of the noncompliance.	{F 000}		
{F 600} SS=G	Free from _____ and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from _____, Neglect, and _____ The resident has the right to be free from neglect, misappropriation of resident property, and _____ as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary _____ and any physical or chemical _____ not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, _____, or _____	{F 600}		

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

TITLE

(X6) DATE

Electronically Signed

/2025

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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{F 600}	<p>Continued From page 1</p> <p>... corporal punishment, or involuntary ...</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, resident representative and staff interviews, the facility failed to protect the resident's right to be free from ... for 1 (Resident #1) of 3 residents reviewed for and neglect.</p> <p>The findings included:</p> <p>Review of the facility's " Policy-Prevention and Management" with a review date of noted, "The facility prohibits the mistreatment ... and ... of residents ... by anyone including staff ... The facility has designed and implemented processes, which strive to ensure the prevention ... of suspected or alleged resident/patient ... The facility must provide a safe resident environment and protect residents from ... This includes but is not limited to freedom from corporal punishment ..."</p> <p>Review of the facility's incident log revealed on ... the facility initiated an ... investigation involving Resident #1.</p> <p>The investigation noted Resident #1 was admitted to the facility on ... Diagnoses included ... Major ... and ... The resident was moved to the secured unit of the facility (special care unit for people with and ...).</p> <p>On ... at approximately 10:15 a.m., the Social Worker Assistant reported that she witnessed Certified Nursing Assistant (CNA) Staff</p>	{F 600}	<p>This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>F 600</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The CNA was suspended on ... The CNA was terminated on ... The CNA was reported to the Nurse Aide Registry on ... The resident was evaluated by the Psych APRN and The ... Care ARPN on New orders were received for ... 50mg every 6 hours as needed for ... or ...</p> <p>2. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents residing in the Burroughs unit</p>	

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{F 600}	<p>Continued From page 2</p> <p>A hit Resident #1 on the _____ of the _____ with her _____. The Social Worker Assistant told CNA Staff A, "Hey, you cannot do that. What is wrong with you? These residents are here for a reason and if you can't handle them then you should not work here." CNA Staff A replied, "She was cursing me and she bit me." The Social Worker Assistant took Resident #1 with her immediately and sent CNA Staff A to the Administrator's office.</p> <p>Review of the witness statements provided by the facility as part of the _____ investigation revealed on _____ CNA Staff A signed a statement that read, CNA Staff A, "took the resident (Resident #1) to provide care after she finished breakfast. CNA Staff A was trying to push her (Resident #1) in her wheelchair in her room. The resident was pushing _____ against the CNA and then bit CNA Staff A on the right _____. The resident was yelling and screaming. The Social Worker came to the room and stated she "seen me hit the resident and told me I needed to go with her to the Administrator's office. I did not hit the resident at all during any of this incident. This incident occurred in the doorway of the room, not inside the room." The CNA stated the Social Worker was lying on her.</p> <p>The Social Worker Assistant documented on a witness statement dated _____ at 9:30 a.m., "While doing room rounds, a resident was in her bedroom and asked for help. While I was assisting the resident I heard yelling outside the door. A male CNA opened the bedroom I was in. As the door opened, I seen [sic] a female CNA hit resident (Resident #1) in the _____ of her _____. The resident yelled God Dammit they hit me with something hard. I yelled at the CNA, "Hey, you can't do that, what is wrong with you? These</p>	{F 600}	<p>had the potential to be affected. The CNA involved worked full time on that unit only.</p> <p>_____ to _____ skin evaluations were completed on every resident on the Burroughs unit on _____. There were no abnormal findings indicating any type of _____ or neglect.</p> <p>The CNA was suspended on _____ and terminated on _____.</p> <p>All staff were re-educated on the policy and procedure, customer service and resident rights related to _____ by the Nurse Management Team. This training was initiated on _____ and was ongoing until all staff were completed. The completion date was _____.</p> <p>Knowledge verification was completed by administering a post test to all employees.</p> <p>The facility met with the QIO team on _____. The QIO team provided the facility with a De-escalation toolkit and provided training to the ADON, Staff Educator, DON and Administrator.</p> <p>The ADON completed the De-escalation training with all staff. This was completed _____ to 27th, 2025. The staff remaining were removed from the schedule and the training is being offered every Tuesday as part of new hire orientation. The staff remaining will attend at that time and then may resume their normal working schedule. Knowledge verification was completed by administering a pre and post test to all</p>		

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{F 600}	<p>Continued From page 3</p> <p>residents are here for a reason and if you can't handle them then you should not work here." The CNA responded, "She was cursing at me and bit me." I took the resident with me and escorted the CNA to the Administrator."</p> <p>No other staff witnessed the incident.</p> <p>On _____, CNA Staff A was immediately suspended. The facility reported the _____ to law enforcement and Adult Protective Services.</p> <p>On _____ the facility concluded their investigation and verified the allegation of _____.</p> <p>On _____ at 9:10 a.m., attempted to interview Resident #1. She was not able to answer questions related to the incident.</p> <p>On _____ at 9:35 a.m., in an interview, Unit Manager Staff B said Resident #1 was "mostly pleasant but sometimes triggered for being combative during care." She said she was in a morning meeting when the incident was reported to her. The Social Worker Assistant said she saw CNA Staff A hit Resident #1 in the _____ of the _____. Resident #1 said, God Damn I got hit in the _____. When asked, the Unit Manager said she thought the CNA was working at other facilities which could contribute to _____ out.</p> <p>On _____ at 10:39 a.m., in a telephone interview Resident #1's daughter and Health Care Surrogate said her mother was diagnosed with _____ approximately 12 years ago. Her mother sustained two _____ to her _____ and was admitted to the facility for rehabilitation. She was transferred to the memory care unit because she needed the increased supervision. She said her mother was a very hard worker and raised five children. Her _____ has changed over _____.</p>	{F 600}	<p>employees who attended the training.</p> <p>3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.</p> <p>All staff were re-educated on the policy and procedure, customer service and resident rights related to _____ by the Nurse Management Team. This training was initiated on _____ and was ongoing until all staff were completed. The completion date was _____.</p> <p>Knowledge verification was completed by administering a post test to all employees.</p> <p>The facility met with the QIO team on _____. The QIO team provided the facility with a De-escalation toolkit and provided training to the ADON, Staff Educator, DON and Administrator.</p> <p>The ADON completed the De-escalation training with all staff. This was completed _____ to 27th, 2025. The staff remaining were removed from the schedule and the training is being offered every Tuesday as part of new hire orientation. The staff remaining will attend at that time and then may resume their normal working schedule. Knowledge verification was completed by administering a pre and post test to all employees who attended the training.</p> <p>Daily knowledge checks and audits will assess staff adherence to the education provided starting on _____. These will _____.</p>		

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{F 600}	<p>Continued From page 4</p> <p>the years due to the diagnosis of _____'s and multiple _____. She said her mother would have been extremely upset that someone hit her on the _____.</p> <p>On _____ at 11:15 a.m., in an interview the Social Worker Assistant said on _____ she was doing her room rounds. She was in a room assisting a resident when a male CNA opened the bedroom door. As soon as the door was opened, she saw CNA Staff A hit the _____ of Resident #1's _____ with her closed _____, causing the resident's _____ to bend forward. Resident #1 said, "God Damn they hit me in the _____ of the _____ with something hard." She said the incident happened in the hallway. The male CNA was facing her when he opened the door and did not witness the incident. She immediately looked at CNA Staff A's name tag. She made sure Resident #1 was safe. She reported the incident and took CNA Staff A to the Administrator's office. Review of the clinical record for Resident #1 revealed a Certification of Incapacity dated _____ which noted two physicians evaluated Resident #1 and determined that she lacked the capacity to give informed consent and make health care decisions based on advanced stage _____ and _____ (condition where the _____ does not function properly due to underlying _____ imbalance).</p> <p>The care plan initiated on _____ and revised on _____ noted Resident #1 exhibited behaviors of grabbing, yelling, screaming, biting, pushing, kicking, hitting, _____ language, spitting, frequent crying, repetitive movements, pushing and rejection of care. Staff was to monitor behavior episodes and attempt to determine underlying cause. Consider</p>	{F 600}	<p>be completed by the IDT team on an ongoing random basis on all shifts.</p> <p>Social Services is completing daily random audits with residents and/or family members regarding _____ and neglect.</p> <p>4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</p> <p>The results of the knowledge checks and audits will be forwarded to the Director of Nursing for review. The audits will then be forwarded to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue daily for 30 days, twice weekly for 30 days, weekly for 30 days and then monthly for 3 months or until substantial compliance is achieved. The De-escalation training has been added to the new hire orientation packet and will be provided weekly going forward with all new employees.</p> <p>Date of Compliance:</p>	

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{F 600}	<p>Continued From page 5</p> <p>location, time of day, persons involved, and situations. Document behavior and potential causes.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment with a target date of revealed the Resident's cognition was severely with a Score of "05".</p> <p>On the , Advanced Practice Registered Nurse documented in a progress note, "Today, I saw the patient as it was reported to me that patient is unstable requiring , assessment. As per collected information, social services reports that patient was observed being hit on the of her by a caregiver while in the hallway. Due to the patient having advanced stage , she does not recall the incident occurring. The patient does, however, report having a and points to the of her where she was alleged to be hit. The patient denies any feelings of fear or and endorses feeling safe. No overt signs of increased , or swings. is persisting with no new behavior . . ."</p> <p>On the Advanced Practice Registered Nurse (APRN) documented in an On-Call progress note the Unit Manager called and reported Resident #1 has been having and and has been getting with little to no relief and requested something stronger for her. 50 milligrams (,) ordered every six hours as needed.</p> <p>Review of the Medication Administration Record for revealed 50</p>	{F 600}		

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{F 600}	Continued From page 6 milligrams was administered to Resident #1 on at 8:40 a.m., for a level of "4". The was effective. On at 2:35 p.m., in an interview the Unit Manager said she contacted the APRN on call on since Resident #1 started to experience and after the incident. On at 2:45 p.m., in an interview the Administrator said the Social Worker Assistant was white as a ghost when she reported the incident to him. She would not leave Resident #1 on the unit and brought her to his office to report the	{F 600}			

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{N 000}	<p>INITIAL COMMENTS</p> <p>An unannounced survey revisit was conducted on _____ at Page Rehabilitation and Healthcare Center, a skilled nursing facility in Fort Myers, Florida.</p> <p>This was the follow up to the complaint survey completed on _____ which identified Immediate Jeopardy.</p> <p>This complaint survey revisit was conducted in conjunction with a new complaint survey.</p> <p>The following is a description of the deficiencies.</p>	{N 000}		
{N 204} SS=G	<p>400.022(1)(o), FS Right to be Free from _____, etc</p> <p>400.022, F. S. (1)(o) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:</p> <p>(o) The right to be free from mental and _____, neglect, _____, corporal punishment, extended involuntary _____, and _____, corporal punishment, extended involuntary _____, and physical and chemical _____, except those _____ authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, _____ may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of _____, and, in the case of use of a chemical _____, a physician shall be consulted</p>	{N 204}		

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X8) DATE /25
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{N 204}	Continued From page 1 immediately thereafter. may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety. This Statute or Rule is not met as evidenced by: Based on record review, resident representative and staff interviews, the facility failed to protect the resident's right to be free from for 1 (Resident #1) of 3 residents reviewed for and neglect. The findings included: Review of the facility's " Policy-Prevention and Management" with a review date of noted, "The facility prohibits the mistreatment . . . and of residents . . . by anyone including staff . . . The facility has designed and implemented processes, which strive to ensure the prevention . . . of suspected or alleged resident/patient . . . The facility must provide a safe resident environment and protect residents from . . . This includes but is not limited to freedom from corporal punishment . . ." Review of the facility's incident log revealed on the facility initiated an investigation involving Resident #1. The investigation noted Resident #1 was admitted to the facility on . Diagnoses included . Major and . The resident was moved to the secured unit of the facility (special care unit for people with and .).	{N 204}	N 204 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The CNA was suspended on . The CNA was terminated on . The CNA was reported to the Nurse Aide Registry on . The resident was evaluated by the Psych APRN and The Care ARPN on . . New orders were received for 50mg every 6 hours as needed for, or . 2. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken; All residents residing in the Burroughs unit had the potential to be affected. The CNA involved worked full time on that unit only. to skin evaluations were completed on every resident on the Burroughs unit on . There were no abnormal findings indicating any type of or neglect.	

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{N 204}	<p>Continued From page 2</p> <p>On at approximately 10:15 a.m., the Social Worker Assistant reported that she witnessed Certified Nursing Assistant (CNA) Staff A hit Resident #1 on the of the with her . The Social Worker Assistant told CNA Staff A, "Hey, you cannot do that. What is wrong with you? These residents are here for a reason and if you can't handle them then you should not work here." CNA Staff A replied, "She was cursing me and she bit me." The Social Worker Assistant took Resident #1 with her immediately and sent CNA Staff A to the Administrator's office.</p> <p>Review of the witness statements provided by the facility as part of the investigation revealed on CNA Staff A signed a statement that read, CNA Staff A, "took the resident (Resident #1) to provide care after she finished breakfast. CNA Staff A was trying to push her (Resident #1) in her wheelchair in her room. The resident was pushing against the CNA and then bit CNA Staff A on the right . The resident was yelling and screaming. The Social Worker came to the room and stated she "seen me hit the resident and told me I needed to go with her to the Administrator's office. I did not hit the resident at all during any of this incident. This incident occurred in the doorway of the room, not inside the room." The CNA stated the Social Worker was lying on her.</p> <p>The Social Worker Assistant documented on a witness statement dated at 9:30 a.m., "While doing room rounds, a resident was in her bedroom and asked for help. While I was assisting the resident I heard yelling outside the door. A male CNA opened the bedroom I was in. As the door opened, I seen [sic] a female CNA hit resident (Resident #1) in the of her . The resident yelled God Dammit they hit me with</p>	{N 204}	<p>The CNA was suspended on and terminated on .</p> <p>All staff were re-educated on the policy and procedure, customer service and resident rights related to by the Nurse Management Team. This training was initiated on and was ongoing until all staff were completed. The completion date was Knowledge verification was completed by administering a post test to all employees.</p> <p>The facility met with the QIO team on . The QIO team provided the facility with a De-escalation toolkit and provided training to the ADON, Staff Educator, DON and Administrator.</p> <p>The ADON completed the De-escalation training with all staff. This was completed to 27th, 2025. The staff remaining were removed from the schedule and the training is being offered every Tuesday as part of new hire orientation. The staff remaining will attend at that time and then may resume their normal working schedule. Knowledge verification was completed by administering a pre and post test to all employees who attended the training.</p> <p>3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.</p>	
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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) COMPLETE DATE
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{N 204}	<p>Continued From page 3</p> <p>something hard. I yelled at the CNA, "Hey, you can't do that, what is wrong with you? These residents are here for a reason and if you can't handle them then you should not work here." The CNA responded, "She was cursing at me and bit me." I took the resident with me and escorted the CNA to the Administrator."</p> <p>No other staff witnessed the incident. On _____, CNA Staff A was immediately suspended. The facility reported the _____ to law enforcement and Adult Protective Services. On _____ the facility concluded their investigation and verified the allegation of _____.</p> <p>On _____ at 9:10 a.m., attempted to interview Resident #1. She was not able to answer questions related to the incident.</p> <p>On _____ at 9:35 a.m., in an interview, Unit Manager Staff B said Resident #1 was "mostly pleasant but sometimes triggered for being combative during care." She said she was in a morning meeting when the _____ incident was reported to her. The Social Worker Assistant said she saw CNA Staff A hit Resident #1 in the _____ of the _____. Resident #1 said, God Damn I got hit in the _____. When asked, the Unit Manager said she thought the CNA was working at other facilities which could contribute to _____ out.</p> <p>On _____ at 10:39 a.m., in a telephone interview Resident #1's daughter and Health Care Surrogate said her mother was diagnosed with _____ approximately 12 years ago. Her mother sustained two _____ to her _____ and was admitted to the facility for rehabilitation. She was transferred to the memory care unit because she needed the increased supervision. She said her mother was a very hard worker and raised</p>	{N 204}	<p>All staff were re-educated on the policy and procedure, customer service and resident rights related to _____ by the Nurse Management Team. This training was initiated on _____ and was ongoing until all staff were completed. completion date was _____. The training will be provided every Tuesday as Knowledge verification was completed by administering a post test to all employees.</p> <p>The facility met with the QIO team on _____. The QIO team provided the facility with a De-escalation toolkit and provided training to the ADON, Staff Educator, DON and Administrator.</p> <p>The ADON completed the De-escalation training with all staff. This was completed _____ to 27th, 2025. The staff remaining were removed from the schedule and the training is being offered every Tuesday as part of new hire orientation. The staff remaining will attend at that time and then may resume their normal working schedule. Knowledge verification was completed by administering a pre and post test to all employees who attended the training.</p> <p>Daily knowledge checks and audits will assess staff adherence to the education provided starting on _____. These will be completed by the IDT team on an ongoing random basis on all shifts.</p> <p>Social Services is completing daily random audits with residents and/or family members regarding _____ and neglect.</p>	
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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 83608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 02/17/2025
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{N 204}	<p>Continued From page 4</p> <p>five children. Her _____, has changed over the years due to the diagnosis of _____'s _____ and multiple _____. She said her mother would have been extremely upset that someone hit her on the _____.</p> <p>On _____ at 11:15 a.m., in an interview the Social Worker Assistant said on _____ she was doing her room rounds. She was in a room assisting a resident when a male CNA opened the bedroom door. As soon as the door was opened, she saw CNA Staff A hit the _____ of Resident #1's _____ with her closed _____, causing the resident's _____ to bend forward. Resident #1 said, "God Damn they hit me in the _____ of the _____ with something hard." She said the incident happened in the hallway. The male CNA was facing her when he opened the door and did not witness the incident. She immediately looked at CNA Staff A's name tag. She made sure Resident #1 was safe. She reported the incident and took CNA Staff A to the Administrator's office. Review of the clinical record for Resident #1 revealed a Certification of Incapacity dated _____ which noted two physicians evaluated Resident #1 and determined that she lacked the capacity to give informed consent and make health care decisions based on advanced stage _____ and _____ (condition where the _____ does not function properly due to underlying _____ imbalance).</p> <p>The care plan initiated on _____ and revised on _____ noted Resident #1 exhibited behaviors of grabbing, yelling, screaming, biting, pushing, kicking, hitting, _____ language, spitting, frequent crying, repetitive movements, pushing and rejection of care. Staff was to monitor behavior episodes and attempt to determine underlying cause. Consider</p>	{N 204}	<p>4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</p> <p>The results of the knowledge checks and audits will be forwarded to the Director of Nursing for review. The audits will then be forwarded to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue daily for 30 days, twice weekly for 30 days, weekly for 30 days and then monthly for 3 months or until substantial compliance is achieved. The De-escalation training has been added to the new hire orientation packet and will be provided weekly going forward with all new employees.</p> <p>Date of Compliance:</p>	

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{N 204}	<p>Continued From page 5</p> <p>location, time of day, persons involved, and situations. Document behavior and potential causes.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment with a target date of revealed the Resident's cognition was severely with a Score of "05".</p> <p>On the , Advanced Practice Registered Nurse documented in a progress note, "Today, I saw the patient as it was reported to me that patient is unstable requiring , assessment. As per collected information, social services reports that patient was observed being hit on the of her by a caregiver while in the hallway. Due to the patient having advanced stage , she does not recall the incident occurring. The patient does, however, report having a and points to the of her where she was alleged to be hit. The patient denies any feelings of fear or and endorses feeling safe. No overt signs of increased , or swings. is persisting with no new behavior . . ."</p> <p>On the Advanced Practice Registered Nurse (APRN) documented in an On-Call progress note the Unit Manager called and reported Resident #1 has been having and and has been getting , with little to no relief and requested something stronger for her. 50 milligrams (,) ordered every six hours as needed.</p> <p>Review of the Medication Administration Record for revealed 50 milligrams was administered to Resident #1 on</p>	{N 204}		
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{N 204}	<p>Continued From page 6</p> <p>at 8:40 a.m., for a level of "4". The was effective.</p> <p>On at 2:35 p.m., in an interview the Unit Manager said she contacted the APRN on call on since Resident #1 started to experience and after the incident.</p> <p>On at 2:45 p.m., in an interview the Administrator said the Social Worker Assistant was white as a ghost when she reported the incident to him. She would not leave Resident #1 on the unit and brought her to his office to report the</p> <p>Class II</p>	{N 204}		