STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105410	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PORT ST LUCIE REHABILITATION AND HEALTHCARE	7300 OLEANDER AVE PORT SAINT LUCIE, FL 34952

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to thoroughly investigate 2 of 3 credible allegations of abuse reviewed (Residents #1 and #2). The findings included: Facility policy Abuse & Events revised June 20, 2017 documented, The facility acknowledges the following definitions . 5) Physical Abuse: Includes hitting, slapping, . Conducting an Investigation . The federal regulations clearly require the facility to have evidence that all the alleged violations are thoroughly investigated. The following represents guidance on those components of an investigation that would constitute a thorough investigation. . 4. . Interview staff that cared for the resident at the time of the alleged incident; interview staff on other shifts that may have seen or heard anything . Interview residents in the same room, or residents in the immediate vicinity of where the alleged incident occurred, who might have seen or heard something. Observe and document any unusual demeanor of the person being interviewed. Statements obtained from witnesses need to be very specific, (i.e. what does rough mean to the individual). 1. During an interview on 06/10/20 at 1:05 PM, Staff A, a Patient Care Assistant (PCA), explained that she was assisting the wound care nurse on 05/23/20, and was subsequently asked to assist Staff B, a Certified Nursing Assistant (CNA) change a soiled brief for Resident #1. The PCA stated the CNA turned the resident onto her left side when the resident hit the CNA. The PCA stated the CNA slapped the resident on the hand (demonstrating a firm slap to the top of her own hand) and that the CNA stated to the resident, Don't do that. The PCA stated she did not say anything to the CNA as she was new and was unsure of the protocol. The PCA stated that she did address the resident, telling her that she shouldn't hit the CNA as they were trying to help her, and the resident agreed. The PCA stated she went back to the unit and asked the CNA who trained her about the chain of command. They then went to Staff C, a Registered Nurse (RN) who was the weekend supervisor, and reported the event. The PCA stated the CNAslapped her (the resident) on the hand like you would a toddler. The PCA stated she was asked to do a written statement, and gave verbal statements to the Administrator, Manager on Duty, and another nurse who she could not recall. The Director of Nursing (DON) was asked to provide documented evidence of the facility's investigation for the alleged abuse of Resident #1. Review of the investigation provided by the DON included an Allegation of Abuse/Neglect or Misappropriation of Property Investigation Worksheet, the face sheet, care plan for behaviors, and Social Services Brief Interview for Mental Status assessment for Resident #1, the progress note made by the weekend supervisor of the event on 05/23/20, and two staff statements. The DON confirmed this was the entire investigation. When asked what unit Staff B, the accused CNA worked, the DON stated she mostly worked on the Memory Care unit. During an interview on 06/10/20 at 1:35 PM, the Staffing Scheduler was asked to provide evidence of what units Staff B had worked in the past month. Review of the provided information revealed Staff B worked in the memory care unit most of the time, but had worked on the 600 unit in the last month on 05/14, 05/16, 05/24, 05/29, 05/31, and 06/04/20. The 600 unit is identified by the facility as a long term care unit. During an interview on 06/10/20 at 2:55 PM, Staff D, a Licensed Practical Nurse (LPN) confirmed the 600 unit as long term care, stating that some residents are alert and oriented and could answer questions while others are not. Review of the first staff statement (part of the investigation) revealed a hand written note by Staff A, the PCA and witness to the event. This statement documented, While assisting (Staff B) to change a resident soiled depend, the patient (name of Resident #1) struck the CNA with a closed handed fist. The CNA then with an open hand slapped the patient on the right hand and told her not to do that again. This made me very uncomfortable to watch and I asked a fell ow CNA what the protocol is and who to report it to. When the patient hit the CNA, as a reaction out of frustration, the CNA hit the patient by slapping the patient on the hand. I told the resident that 'It's not nice to hit people, we are trying to help clean you up.' The patient stated, 'You know you're right, I'm sorry I should not have hit her.' Review of the second staff statement revealed a hand written note by Staff B, the CNA who was accused of slapping Resident #1. This statement documented, The nurse ask for help in room [ROOM NUMBER]B She pot he hand in me I remove he hand on me I do not hit her back. The investigation lacked documented evidence the managerial staff interviewed either the witness or the accused CNA for clarification of the event and/or statements. The investigation lacked any other statements, either written or verbal interviews, from any other staff or residents. During an interview on 06/10/20 at 2:00 PM, Staff C, the weekend supervisor explained she was the Manager on Duty for 05/23/20. Staff C explained that the PCA came to her and said that the CNA tapped her on the back of the hand (demonstrated a light tapping on the top of her own hand). Staff C explained she assessed the resident and found no marks, the CNA denied hitting the resident, but she notified the administrator and sent the CNA home. When asked if the PCA described it as a light tapping as she had just demonstrated, Staff C said yes and stated she felt it was more of a reaction by the CNA. Review of the progress note dated 05/23/20 at 2:01 PM written by the Manager on Duty documented in part, PCA reported that the CNA hit the patient's hand. The investigation lacked any documented statement or clarification from the Manager on Duty. During an interview on 06/10/20 at 3:24 PM the DON was asked who completed the investigation for Resident #1. The DON explained that he and the Administrator interviewed Staff A, the PCA, and he along with the Unit Manager interviewed Staff B, the alleged CNA via phone. The DON stated his recollection was that the PCA described the event as a tapping on the hand of Resident #1. The DON stated he asked the PCA if it was hard or malicious and the PCA stated it was not. The DON agreed they did not have any documented evidence of these interviews. The DON stated they did speak to another staff about the CNA, but did not document it either. The DON asked that the Administrator join the conversation, as he did some of the interviews. At 3:32 PM the Administrator joined the conversation and was asked if he had any written documentation of the staff interviews he completed. The Administrator stated they only interviewed the PCA and the accused CNA, and he depends upon their written statement. He stated the accused denied slapping the resident, the police would not take the case, and so they put a plan in place to keep the accused CNA away from Resident #1. The administrator stated they could not confirm the allegation, and felt the accused CNA was credible. The Administrator stated he told the accused CNA to be careful and watch your Ps and Qs, and to be cognizant of residents that are combative. When asked if the accused CNA received any written disciplinary action, the DON stated that he told the CNA if she did do this it was unacceptable, and gave her a verbal warning. During a phone interview on 06/10/20 at 5:36 PM, Staff B, the accused CNA was asked what happened on 05/23/20 with Resident #1. Staff B explained the wound care nurse had asked her to help with a resident, and then asked her to help with a second resident, Resident #1, who was not on her assignment. The CNA explained the resident needed to be changed and hit her, so she (the CNA) pushed the resident over on her side toward the other woman (the PCA) to have the PCA hold the resident's hands. The CNA stated she finished cleaning up the resident, and when the other woman left (the PCA), she went and told everyone that I hit her (name of Resident #1). The CNA confirmed the resident hit her only once in her arm. When asked specifically if she (the CNA) slapped Resident #1, the CNA stated, No . I do not do that. The facility's investigation lacked any specifics of the incident as described by the accused CNA. 2. During an interview on 06/10/20 at approximately 3:00 PM, Resident #2 stated that one weekend night about three months ago, a CNA (provided name) came into her room and hit her in the eye. Resident #2 stated, I called the cops and wanted her charged with assault. Resident #2 stated she didn't believe the facility did anything about it. Review of the abuse log

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

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) revealed an entry for Resident #2 dated 02/02/20. The DON was asked to provide the investigation for this alleged abuse. Review of the investigation revealed the Investigation Worksheet, that was not completed. The type of allegation, name of alleged individual, the clear brief description of events, and the immediate corrective actions were blank. The rest of the investigation included only a statement from the accused CNA and two nurses who were present. The written statement from the accused CNA revealed the CNA answered the call bell and the resident immediately started yelling at her to get out of the room. The statement documented the CNA went into the room, turned down the heat, opened the blinds and then went over to turn off the call light. The statement documented the resident threw water on the CNA. This statement also documented, I didn't hit her in the eye as she said. The investigation lacked any clarification or interview with the accused CNA, or any other interviews with staff or residents.