MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Divine Providence Health Center	H5327004	February 8, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
312 East George Street	8:30 a.m. to 2:30 p.m.	June 28, 2017
Facility City:	**Investigator's Name and Title:**	
Ivanhoe	Pam Hovdet, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	56142	Lincoln

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was physically abused by a staff, alleged perpetrator (AP) when the AP slapped the resident's hand causing a large skin tear.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, abuse occurred when the alleged perpetrator (AP) slapped the resident's hand and the resident sustained a skin tear.

The resident was diagnosed with dementia and severe cognitive impairment. The resident required assistance with all activities of daily living.

One afternoon, the resident was found standing up attempting to get his/her coat out of the closet. A staff member was unsuccessful with convincing the resident to sit back down in the wheelchair, so s/he called on the radio for assistance.

The AP entered the resident's room to assist with the resident. The initial staff member was standing behind the resident trying to get the resident to turn and sit down in the wheelchair. The AP stood to the left of the resident, and also attempted to convince the resident to sit down. The resident refused to sit down and grabbed the AP's left forearm with his/her right hand. The AP slapped the top of the resident's right hand. The contact from the hit made a very loud sound and the resident exclaimed, "Ow! That hurt." The AP replied, "You don't grab people." The AP left the resident's room and reported the hit to the nurse. The staff member noticed blood running from the skin tear on top of the resident's hand, down to the resident's palm. The staff member brought the resident to the nurse, who assessed the resident's hand and noted the resident sustained a 3.6 centimeter (cm) skin tear on top of the right hand where the AP hit the resident. The skin was peeled back and the wound was bleeding. The nurse cleaned and applied a dressing

to the wound.

During an interview, the resident stated the AP slapped the resident's right hand hard enough to cause a 1 1/2 inch skin tear on the top of the hand. Three weeks after the incident, a scar remained on the resident's right hand.

The staff member who was in the room stated the AP's open right hand came down hard and forcefully hit the resident's top right hand causing the skin tear.

When interviewed, the AP stated the resident grabbed the AP's left forearm. The AP's initial thought was to get the resident's hand off the AP's forearm. The AP reacted and slapped the top of the resident's hand causing the skin tear.

When interviewed by the investigator, the nurse stated the AP informed the nurse s/he had just hit the resident. The AP further explained the resident grabbed the AP's arm, and the AP hit the resident's hand and it was bleeding.

During a police investigation, the AP admitted slapping the resident. The officer forwarded his report to the county attorney for a charging decision.

Immediately after the incident, the director of nursing and a social service designee met with the AP, reviewed the facility policy on abuse, and escorted the AP out of the facility. The AP was terminated from employment at the facility.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☒ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility had policies and procedures in place to prevent and report abuse. The AP's was trained on facility policy and procedure including vulnerable adult training. Staffing levels were reviewed for the day and shift the abuse occurred and the staffing level was comparable to other days.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter 4658). No state orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☐ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to,

the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Four

Were residents selected based on the allegation(s)? (•) Yes ( ) No ( ) N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

(•) Yes ( ) No ( ) N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ( ) Yes ( ) No (•) N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: (•) Yes ( ) No ( ) N/A Specify: _____

Did you interview the resident(s) identified in allegation:

(•) Yes ( ) No ( ) N/A Specify: _____

Did you interview additional residents? (•) Yes ( ) No

Total number of resident interviews: Nine

Interview with staff: (•) Yes ( ) No ( ) N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: (•) Yes ( ) No

Total number of staff interviews: Eight

Physician Interviewed: ( ) Yes (•) No

Nurse Practitioner Interviewed: ( ) Yes (•) No

Physician Assistant Interviewed: ( ) Yes (•) No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:
_____	_____	_____	_____	_____	_____

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☒ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ◉ Yes ○ No Specify: By law enforcement of the wound

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Ivanhoe Police Department

Lincoln County Attorney

Ivanhoe City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	R-C 06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	**312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142**

(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 A Post Certification revisit was conducted on 6/2/17 to follow up on deficiencies issued relate to complaint H5327004 Divine Providence Health Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5327004. Divine Providence Health Center was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

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{2 000}	Continued From page 1 signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 9, 2017

Ms. Mary Swanson, Administrator
Divine Providence Health Center
312 East George Street PO Box 136
Ivanhoe, MN 56142

Re: Complaint Number H5327004

Dear Ms. Swanson:

On June 2, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on April 18, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	C 04/18/2017

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5327004. As a result, the following deficiency is issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 223 SS=G	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of five residents reviewed (R1) was free from abuse when a nursing assistant slapped the resident on his right hand causing a skin tear. Findings include: R1's medical record was reviewed and the admission record identified diagnoses of dementia, Parkinson's disease and generalized anxiety disorder.	F 223		

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 223	Continued From page 1 R1's quarterly Minimum Data Set (MDS) dated 11/7/16, indicated R1 required extensive assistance with activities of daily living (ADL's). The Brief Interview for Mental Status (BIMS) score dated 11/7/16, identified R1 had severe cognitive impairment. R1's nursing progress note dated 1/18/17, indicated nursing assistant (NA)-F reported to registered nurse (RN)-D he/she slapped R1's hand when R1 grabbed NA-F's arm. Seconds later, NA-D brought R1 to RN-D to assess a bleeding skin tear on R1's right hand from NA-F's slap. RN-D and the director of nursing (DON) cleaned the 3.6 centimeter (cm) long skin tear and applied 5 steri strips. An interview with NA-E was conducted on 2/8/17, at 10:15 a.m. and established NA-E requested assistance with getting R1 to sit down in his/her wheelchair. NA-F entered R1's room to assist and while attempting to get R1 to sit down, R1 grabbed NA-F's left forearm with the right hand. NA-E stated NA-F took his/her open right hand and forcefully slapped the top of R1's right hand, making a loud noise. "R1 said "ow that hurts." NA-F replied aggresively to R1, "you don't grab people" and then left the room. NA-E was able to get R1 settled in the wheelchair and noticed the top of R1's right hand was bleeding and the skin was peeled back. NA-E took R1 to the nurses desk to report the incident and have RN-D assess the skin tear. NA-E then went to the DON to report NA-F's treatment towards R1. An interview with the social service designee (SSD) was conducted on 2/8/17, at 1:20 p.m. The SSD stated the DON and SSD reviewed the	F 223		

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F 223	Continued From page 2 facility's Vulnerable Adult Policy immediately with NA-F, prior to suspending and escorting NA-F out of the facility that same day. An interview with the administrator was conducted on 2/8/17, at 1:45 p.m. The administrator stated staff receive annual training on the Vulnerable Adult Policy, and the policy indicates Divine Providence will not condone abuse of any resident. The administrator notified the police, physician and R1's family of the incident. An interview with R1 was conducted on 2/8/17, at 2:15 p.m. R1 stated that NA-F slapped his hand and caused a 1 1/2 inch tear on his hand when NA-F's fingernail went under his skin. An interview with RN-D was conducted on 2/10/17, at 12:55 p.m. RN-D stated NA-E brought R1 to the nurses desk for medical attention for a bleeding wound on the top of his right hand. RN-D used gauze to stop the bleeding and clean the skin tear measuring 3.6 cm long. RN-D and the DON applied five steri strips to close the skin tear. An interview with the DON was conducted on 3/1/17, at 10:25 a.m. The DON stated NA-F admitted to slapping R1 on the right hand due to frustration. The DON notified the administrator, completed an investigation, and terminated NA-F on 1/18/17 . An interview with NA-F was conducted on 3/1/17, at 10:50 a.m. NA-F stated while trying to get R1 to sit down in the wheelchair R1 grabbed his/her left forearm with his right hand. NA-F slapped the top of R1's right hand with an open right hand and	F 223		

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F 223	Continued From page 3 then pried the resident's hand off to get R1 to let go of the forearm. NA-F acknowledged this was wrong and reported to the DON. A document titled, "mandatory for all departments to attend training session" dated 7/19/16, indicated NA-F attended Vulnerable Adult review training. A Divine Providence Health Center Employee Certification of Compliance was signed by NA-F when hired on 3/18/14 indicated NA-F had been provided with education regarding Divine Providence Health Center's Corporate Compliance Code of Conduct and understood the purpose of the Corporate Compliance Program. An Employee/Supervisor Conference letter dated 1/19/17, indicated on 1/18/17, NA-F violated facility policy in regard to Vulnerable Adults and Resident's rights and due to the violation NA-F was terminated effective 1/18/17. The "Divine Providence Health Center Vulnerable Adult Abuse Prevention Plan" last revised on 11/2016, defined abuse as conduct which is not an accident or therapeutic conduct with produces or could reasonably be expected to produce physical pain or injury or emotional distress, including but not limited to, the following: Hitting, slapping, kicking pinching, biting or corporal punishment of a VA.	F 223		

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5327004. As a result, the following correction order is issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of five residents reviewed (R1) was free from maltreatment when a nursing assistant abused the resident when the	21850		

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DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

(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
21850	Continued From page 2 nursing assistant slapped the resident's right hand causing a skin tear. Findings include: R1's medical record was reviewed and the admission record identified diagnoses of dementia, Parkinson's disease and generalized anxiety disorder. R1's quarterly Minimum Data Set (MDS) dated 11/7/16, indicated R1 required extensive assistance with activities of daily living (ADL's). The Brief Interview for Mental Status (BIMS) score dated 11/7/16, identified R1 had severe cognitive impairment. R1's nursing progress note dated 1/18/17, indicated nursing assistant (NA)-F reported to registered nurse (RN)-D he/she slapped R1's hand when R1 grabbed NA-F's arm. Seconds later, NA-D brought R1 to RN-D to assess a bleeding skin tear on R1's right hand from NA-F's slap. RN-D and the director of nursing (DON) cleaned the 3.6 centimeter (cm) long skin tear and applied 5 steri strips. An interview with NA-E was conducted on 2/8/17, at 10:15 a.m. and established NA-E requested assistance with getting R1 to sit down in his/her wheelchair. NA-F entered R1's room to assist and while attempting to get R1 to sit down, R1 grabbed NA-F's left forearm with the right hand. NA-E stated NA-F took his/her open right hand and forcefully slapped the top of R1's right hand, making a loud noise. "R1 said "ow that hurts." NA-F replied aggresively to R1, "you don't grab people" and then left the room. NA-E was able to get R1 settled in the wheelchair and noticed the top of R1's right hand was bleeding and the skin	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21850	Continued From page 3	21850		

was peeled back. NA-E took R1 to the nurses desk to report the incident and have RN-D assess the skin tear. NA-E then went to the DON to report NA-F's treatment towards R1.

An interview with the social service designee (SSD) was conducted on 2/8/17, at 1:20 p.m. The SSD stated the DON and SSD reviewed the facility's Vulnerable Adult Policy immediately with NA-F, prior to suspending and escorting NA-F out of the facility that same day.

An interview with the administrator was conducted on 2/8/17, at 1:45 p.m. The administrator stated staff receive annual training on the Vulnerable Adult Policy, and the policy indicates Divine Providence will not condone abuse of any resident. The administrator notified the police, physician and R1's family of the incident.

An interview with R1 was conducted on 2/8/17, at 2:15 p.m. R1 stated that NA-F slapped his hand and caused a 1 1/2 inch tear on his hand when NA-F's fingernail went under his skin.

An interview with RN-D was conducted on 2/10/17, at 12:55 p.m. RN-D stated NA-E brought R1 to the nurses desk for medical attention for a bleeding wound on the top of his right hand. RN-D used gauze to stop the bleeding and clean the skin tear measuring 3.6 cm long. RN-D and the DON applied five steri strips to close the skin tear.

An interview with the DON was conducted on 3/1/17, at 10:25 a.m. The DON stated NA-F admitted to slapping R1 on the right hand due to frustration. The DON notified the administrator, completed an investigation, and terminated NA-F

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21850	Continued From page 4 on 1/18/17 . An interview with NA-F was conducted on 3/1/17, at 10:50 a.m. NA-F stated while trying to get R1 to sit down in the wheelchair R1 grabbed his/her left forearm with his right hand. NA-F slapped the top of R1's right hand with an open right hand and then pried the resident's hand off to get R1 to let go of the forearm. NA-F acknowledged this was wrong and reported to the DON. A document titled, "mandatory for all departments to attend training session" dated 7/19/16, indicated NA-F attended Vulnerable Adult review training. A Divine Providence Health Center Employee Certification of Compliance was signed by NA-F when hired on 3/18/14 indicated NA-F had been provided with education regarding Divine Providence Health Center's Corporate Compliance Code of Conduct and understood the purpose of the Corporate Compliance Program. An Employee/Supervisor Conference letter dated 1/19/17, indicated on 1/18/17, NA-F violated facility policy in regard to Vulnerable Adults and Resident's rights and due to the violation NA-F was terminated effective 1/18/17. The "Divine Providence Health Center Vulnerable Adult Abuse Prevention Plan" last revised on 11/2016, defined abuse as conduct which is not an accident or therapeutic conduct with produces or could reasonably be expected to produce physical pain or injury or emotional distress, including but not limited to, the following: Hitting, slapping, kicking pinching, biting or corporal punishment of a VA. SUGGESTED METHOD OF CORRECTION:	21850		

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21850	Continued From page 5 The director of nursing or designee, could review the VA policy and procedures and provide staff education. The director of nursing or designee, could conduct random audits to complete. TIME PERIOD TO CORRECT: Twenty-one (21) days	21850		