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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08E029	A. BUILDING _____ B. WING _____	C 11/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVERNOR BACON HEALTH CENTER	P.O. BOX 559 DELAWARE CITY, DE 19706

(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 complaint survey was conducted at this facility beginning September 2, 2014 and ending November 26, 2014. The facility census on the entrance day of the survey was 54. The survey sample consisted of 18 residents. The survey process included observations, interviews and review of residents' clinical records, facility documents and facility policies and procedures. Abbreviations are as follows: ANHA - Assistant Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MDS - Minimum Data Set (standardized assessment form used in nursing homes; CNA - Certified Nurse's Aide.			
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on clinical record review, review of facility documents and staff interviews it was determined that the facility failed to ensure that one resident	Individual Resident Impacted F 223	**Individual Resident Impacted** The facility failed to ensure that one resident (R1) was free from verbal and physical abuse. The shift supervisor assessment of the resident didn't reveal any injuries. The resident didn't remember the incident. The employee (E12) was removed from resident care.	01/21/15
		Identification of other Residents with Potential to be Affected	**Identification of Other Residents with Potential to be Affected** All other residents have the potential to be affected.	
		System Changes	**System Changes** Nursing Administration and QA Administrator are reviewing and updating the facility's abuse prevention policy to fully include the seven elements of F226. (Screening, training, prevention, identification, investigation, protection, reporting). All of our CNAs are current with their abuse prevention and dementia training required by DLTCRP. Nursing department trainer/educator will be giving an inservice for staff reviewing this training. In addition, training will be completed for the updated abuse prevention policy. Our yearly training will be expanded to include communication skills and anger management. RN supervisors when holding their monthly shift meetings will remind staff if they are feeling stress at work or at home they can talk to their supervisor and there is also the employee assistance program to help them.	

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

Hospital Director — 12-31-14

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.

Del DHA Lic # H1000058

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F 223	Continued From page 1 (R1) out of 18 sampled was free from an incident of verbal and physical abuse. Findings include: Review of a facility incident report dated 9/4/2014 and timed 6:50AM revealed that E12 (CNA) was heard "yelling" the name of R1 as she walked down the corridor approaching him. Once within reach of R1, E12 was observed kicking the sole of R1's foot that rested on the foot pedal of his wheelchair and startled him awake. Next E12 was heard asking R1 "do you need to be changed" and R1 responded "No". This finding was observed and confirmed in a telephone interview conducted on 10/16/2014 at 1:38 PM with E13 (CNA) who observed the allegations of verbal and physical abuse directed toward R1. The facility failed to ensure that R1 was free of verbal and physical abuse. According to the facility "Abuse Prevention Plan" the purpose "...is to outline strategies to prevent abuse to preserve the Rights of residents...facility staff shall ensure that resident/client care and treatment is administered in a safe, professional and humane manner to guarantee the welfare and safety of its residents...". These findings were reviewed and confirmed with E1 (ANHA), E2 (DON) and E3 (ADON) on 10/20/2014 at 4:00 PM.	System Changes	RN supervisors will continue to include and encourage CNAs to be involved with resident care planning and with various committees dedicated to improving resident care. **Success Evaluation** Individual responsible for Action: GBHC's Nursing Administration will conduct: a) Audit/review of abuse and dementia training and if additional training is needed. b) Audit/review shift meeting minutes for staff stress issues. 3) Audit/review of CNA involvement in care planning and other areas to improve resident care. This will be reviewed at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the quarterly Quality Assurance (QA) Committee meetings.	
		Success Evaluation		
		F-224		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	Individual Resident Impacted	**Individual Resident Impacted** The facility failed to ensure that one resident (R1) was free from neglect. The resident failed to receive incontinence care as addressed in his careplan. The shift supervisor when notified immediately ensured the resident received incontinence care. The employee (E12) was removed from resident care.	01/21/15

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F 224	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on review of the clinical record, review of facility incident and investigative reports and staff interviews it was determined that the facility failed to ensure that one [R1] out of 18 residents was free from neglect. Findings include: R1 was admitted to the facility on 2/21/2012 with diagnoses which included dementia (memory loss) and schizophrenia (mental disorder characterized by delusions (false beliefs) and hallucinations (something that is heard, seen, smelled, tasted, or felt that is not really there) and physical agitation). According to the current annual MDS dated 3/6/2014 R1 usually understood most conversation and usually had the ability to express ideas and wants. Additionally the above referenced MDS revealed that R1 also exhibited behavioral symptoms directed toward others, 1 to 3 days out of seven days, and rejection of care 4 to 6 out of seven days but less than daily. Further review of the annual MDS revealed that R1 required limited assistance of one person for transfer, extensive assistance of one person for dressing, hygiene, bathing and toileting, and setup help only for eating. Although R1 required setup help with his wheelchair he was independent off the nursing unit. R1 was also independent on the nursing unit and in his room when seated in his wheelchair. When moving from a seated to standing position or walking with an assistive device R1 was able to stabilize without staff assistance although he was	Identification of Other Residents with Potential to be Affected	**Identification of Other Residents with Potential to be Affected** All other residents have the potential to be affected.	
		System Changes	**System Changes** Cross-reference F 223 Nursing Administration and QA Administrator are reviewing and updating the facility's abuse prevention policy to fully include the seven elements of F226. (Screening, training, prevention, identification, investigation, protection, reporting). *Included in this policy will be neglect, mistreatment and misappropriation.* All of our CNAs are current with their abuse prevention and dementia training required by DLTCRP. *Nursing department trainer/educators will inservice staff to follow the careplan, to notify the supervisor if the plan cannot be followed and to complete documentation accurately.* In addition, training will be completed for the updated abuse prevention policy (including *neglect, mistreatment and misappropriation).* Our yearly training will be expanded to include communication skills and anger management. *RN supervisors when holding their monthly shift meetings will remind staff to follow the careplan, to notify the supervisor if the plan cannot be followed and to accurately complete documentation.* RN supervisors will continue to include and encourage CNAs involvement with resident care planning and with various committees dedicated to improving resident care.	

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F 224	Continued From page 3 not steady. Review of the facility incident report dated 9/4/2014 and timed 6:55 AM revealed that R1 wheeled himself to another nursing unit neighboring his regularly assigned unit and remained there from 12:00 AM through 6:55 AM during the night shift. According to the same incident report dated 9/4/2014 and timed 6:55 AM the nursing unit visited by R1 notified his assigned unit to come and return R1 to his unit for care. In an interview conducted between 11:45 AM and 12:12 PM on 10/15/2014 with E14 (CNA), who was assigned care of R1 on 9/4/2014, she stated that after receiving her assignment she offered R1 care which he refused. She further stated R1 refused another offer of care during first rounds conducted between 1:00 AM and 2:00 AM on 9/4/2014. E14 also stated that as she performed second rounds on her assigned residents beginning approximately at 4:00 AM she observed that R1 was not in his room. However E14 stated that after completing second rounds she proceeded to shower the scheduled residents at 5:00 AM and completed other duties ending at 6:30 AM. During this same interview conducted on 10/15/2014 between 11:45 AM and 12:12 PM E14 confirmed that she did not notify her immediate supervisor of R1's refusal of care or seek her immediate supervisor for further interventions to address R1's behavior. Additionally E14 stated she was aware that R1 was on a neighboring unit, but failed to approach, offer and provide care for R1 until his assigned unit was notified by phone that "someone need to come and change R1" because "he has been on another unit all night and has not received care". E14 failed to provide	F 224 Success Evaluation	**Success Evaluation** Cross-reference F224 Individual responsible for Action: GBHC's Nursing Administration will conduct: a) Audit/review of abuse and dementia training and if additional training is needed. b) *Audit/review shift meeting minutes for addressing following the careplan, to notify the supervisor if the plan cannot be followed and to accurately complete documentation.* c) Audit/review of CNA involvement in care planning and other areas to improve resident care. This will be reviewed at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the quarterly Quality Assurance (QA) Committee meetings.	

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F 224	Continued From page 4 care for R1 between 11:00 PM and 4:00 AM and failed to provide or to offer R1 any care on the night shift between 2:00 AM and 6:30 AM. The facility failed to ensure that R1 received care as addressed in his care plan. E14 also stated she left R1 on the neighboring unit to report off duty as it was the end of the night shift. Review of the care plan updated 9/3/2014 revealed the problem" Potential for Injury: Related To (RT) Resistive Behavior" that included "refusal of nursing care delivered to R1". Among the interventions developed to address the above referenced behavior on all shifts were: "verbal explanation of care being delivered" and "notify nurse for further interventions". The same care plan also addressed the problem "Alteration in elimination: RT bowel and/or bladder toileting" and included the interventions "orient R1 to toileting time and place, provide privacy and time to void, change wet/soiled clothing and clean and dry after incontinent episode". Interventions developed specifically to address the toileting program included "bathroom or offer urinal every three hours (q3h) during night or assist to bathroom" and "document how you found R1 and the result of toileting". Review of the "Assignment Record" dated 9/1/2014 through 10/1/2014 revealed it included interventions transcribed from the above referenced care plan that were initialed as performed by E14 during the night shift on 9/4/2014. However E14 confirmed that she did not notify her immediate supervisor of R1's refusal of care or provide or offer care to R1 following second rounds conducted between 1:00 AM and 2:00 AM until 6:55 AM on the night shift, 9/4/2014.	F 224		

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		F226		01/21/15
F 224	Continued From page 5 The facility failed to ensure that R1 was free from neglect and failed to ensure that R1 was offered care in accordance with his comprehensive assessment and plan of care. These findings were reviewed and confirmed with E1 (ANHA), E2 (DON) and E3 (ADON) on 10/20/2014 at 4:00 PM.	Individual Resident Impacted	**Individual Resident Impacted** The facility developed policies that failed to completely address the seven components required to achieve a holistic approach in the prevention of abuse. (Screening, training, prevention, identification, investigation, protection, reporting).	
F 226 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on review of facility policies and procedures and staff interviews it was determined that the facility developed policies that failed to completely address seven out of seven components required to achieve a holistic approach in the prevention of abuse. Findings include: Review of the facility policies "Abuse Prevention Plan" and "Incident Reporting System" revealed that seven out of seven components were not completely addressed: 1. The facility policies failed to have procedures to Screen potential employees by obtaining a history of abuse, neglect or mistreating residents, obtaining information from previous and/or current employers and checking with the appropriate licensing boards and registries.	Identification of Other Residents with Potential to be Affected	**Identification of Other Residents with Potential to be Affected** All residents have the potential to be affected.	
		System Changes	Cross-reference F223 & F224 Nursing Administration and QA Administrator are reviewing and updating the facility's abuse prevention policy to fully include the seven elements of F226. (Screening, training, prevention, identification, investigation, protection, reporting). Included in this policy will be neglect, mistreatment and misappropriation prevention. Nursing department trainer/educator will completed an inservice for the updated abuse prevention policy. Included in this policy will be neglect, mistreatment and misappropriation prevention. The abuse prevention policy will be reviewed with all new staff and annually. RN supervisors when holding their monthly shift meetings will review with staff the seven components required to achieve a holistic approach in the prevention of abuse. (Screening, training, prevention, identification, investigation, protection, reporting).9	

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F 226	Continued From page 6 2. The facility policies failed to have procedures to Train employees through orientation and on-going sessions on issues related to abuse prohibition practices such as: appropriate interventions to deal with aggressive and/or catastrophic reactions of residents; how staff should report their knowledge related to allegations without fear of reprisal; how to recognize signs of burnout, frustration and stress that may lead to abuse; and what constitutes abuse, neglect and misappropriation of resident property. 3. The facility policies failed to have procedures to address Prevention by providing residents, families and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution, and provide feedback regarding the concerns that have been expressed; identify, and correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. 4. The facility policies failed to have procedures to address the identification of events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse; and to determine the direction of the investigation. 5. The facility policies failed to have procedures for investigation of different types of incidents; and to identify the staff member responsible for the initial reporting, investigation of alleged violations and reporting of results to the proper authorities.	F 226	RN supervisors will continue to include and encourage staff to be involved with resident care planning and with various committees dedicated to improving resident care. **Success Evaluation** **Success Evaluation** Individual responsible for Action: GBHC's Nursing Administration will conduct: a) Audit/review of abuse and dementia training and if additional training is needed. b) Audit/review shift meeting minutes for reviewing the seven components. 3) Audit/review of staff involvement in care planning and other areas to improve resident care. This will be reviewed at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the quarterly Quality Assurance (QA) Committee meetings.	

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		F498		01/21/15
F 226	Continued From page 7 6. The facility policies failed to have procedures for Protection of residents from harm during an investigation. 7. The facility policies failed to have procedures for Reporting all alleged violations and all substantiated incidents to the state agency and to all other agencies as required , and take all necessary corrective actions depending on the results of the investigation; report to the State nurse aide registry of licensing authorities any knowledge it has of any actions by a court of law; and analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. These findings were reviewed with E1 (ANHA), E2 (DON) and E3 (ADON) on 10/20/2014 at 4:00 PM.	Individual Resident Impacted	**Individual Resident Impacted** The facility failed to ensure that E7 (CNA/former employee) demonstrated competency in skills pertaining to immediate reporting of alleged abuse, neglect and mistreatment to his immediate supervisor.	
		Identification of Other Residents with Potential to be Affected	**Identification of Other Residents with Potential to be Affected** All residents have the potential to be affected.	
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on review of facility incident reports, review of facility documents and written statements, clinical record reviews and staff interviews it was determined that the facility failed to ensure that E7 (CNA/former employee) demonstrated competency in skills pertaining to the immediate reporting of alleged abuse, neglect	System Changes	Cross-reference F223, F224 & F226 Nursing Administration and QA Administrator are reviewing and updating the facility's abuse prevention policy to fully include the seven elements of F226. (Screening, training, prevention, identification, investigation, protection, reporting). Included in this policy will be neglect, mistreatment and misappropriation prevention. Nursing department trainer/educator will completed an inservice for the updated abuse prevention policy. Included in this policy will be neglect, mistreatment and misappropriation prevention. The abuse prevention policy will be reviewed upon hire and annually. Nursing Administration and the trainer/educators are working on updating the CNA orientation skill competencies check sheet and return demonstration. This will be completed upon hire and annually.	

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F 498	Continued From page 8 and mistreatment to his immediate supervisor. Findings include: The facility policy, "Abuse Prevention Plan", stated " ...3. All new employees will have abuse prevention training upon the initiation of their employment ...III. Responsibility: 1. Employee ...is required to report any suspected act of abuse. Employees are required to know the facility policy on abuse prevention ... " . Although E7 acknowledged in a signed statement that he attended a training session on 6/10/2014 for reporting "any incident of residents' abuse, neglect, mistreatment, misappropriation of property, and significant injury", the facility failed to ensure that E7 immediately reported any allegations of abuse involving 11 residents to his immediate supervisors during his initial and two extended orientations. These findings were reviewed with E1 (QAA/ANHA), E2 (DON), and E3 (ADON) on 10/20/2014.	F 498	RN supervisors when holding their monthly shift meetings will review with staff the seven components required to achieve a holistic approach in the prevention of abuse. (Screening, training, prevention, identification, investigation, protection, reporting). RN supervisors will continue to include and encourage staff to be involved with resident care planning and with various committees dedicated to improving resident care. **Success Evaluation** Individual responsible for Action: GBHC's Nursing Administration will conduct: a) Audit/review of abuse and dementia training and skill competencies/demonstration. b) Audit/review shift meeting minutes for reviewing the seven components. 3) Audit/review of staff involvement in care planning and other areas to improve resident care. This will be reviewed at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the quarterly Quality Assurance (QA) Committee meetings.	
		Success Evaluation		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Governor Bacon Health Center

DATE SURVEY COMPLETED: November 26, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from September 2, 2014 through November 26, 2014. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 54.The survey sample totaled 18 residents Abbreviations are as follows: ANHA – Assistant Nursing Home Administrator ; DON – Director of Nursing; ADON – Assistant Director of Nursing, RN – Registered Nurse.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware.**		

Provider's Signature _____ Title _____ Date 12-31-14

Del Lic # H1000038

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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STATE SURVEY REPORT

NAME OF FACILITY: Governor Bacon Health Center **DATE SURVEY COMPLETED: November 26, 2014**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/26/2014, F223, F224, F226 and F498.		
3201.3.0	**General Requirements**		
3201.3.2	**Each nursing facility shall develop written policies pertaining to the service provided.** Based on review of facility policies and procedures and staff interview it was determined that the facility failed to ensure that policies were developed pursuant to the Skilled and Intermediate Care Nursing Facilities Regulations. Findings include: Review of the facility policy and procedure manual revealed the absence of policies and procedures that addressed some of the focus areas of the survey that included performance of a bed bath, how to handle difficult behaviors exhibited by residents, and the transfer of a resident with or without usage of a mechanical lift. Additionally the ninth edition of the reference manual		

Provider's Signature _____ Title _____ Date _____

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Governor Bacon Health Center **DATE SURVEY COMPLETED: November 26, 2014**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	"Lippincott Manual of Nursing" utilized by the facility failed to include and to address policies developed specifically for a bed bath, difficult resident behavior and the transfer of residents with or without a mechanical lift. These findings were reviewed with E1 (ANHA), E2 (DON) and E3 (ADON) on 10/20/2014 at 4:00 PM.	Cross refer to the CMS 2567-L complaint survey report date completed 11/26/2014; F- 223, F-224, F-226, F-498	01/21/2015
3201.9.0	**Records and Reports**		
3201.9.6	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Cate Residents Protection. The method of reporting shall be as directed by the Division.** **This requirement is not met as evidenced by:** Based on clinical record review, review of facility documents and staff interview it was determined that the facility failed to immediately report an incident of alleged abuse sustained by one resident (R18) out of 18 sampled to the Division of Long		

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	Term Care Residents Protection (DLTCRP). Findings include: Review of a facility incident report submitted to the Division of Long Term Care Residents Protection on 7/28/2014 at 12:54 PM revealed it was received approximately 22 hours following an allegation of physical abuse that occurred on 7/272014 at 3: 05 PM when E15 was accused by R18 of hitting her arm. The facility failed to immediately report an incident of alleged physical abuse within eight hours to (DLTCRP). This finding was reviewed with and confirmed by E1 (ANHA) on 11/26/2014 at 1:45 PM.		

Provider's Signature _____ Title _____ Date _____