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F 000	INITIAL COMMENTS A complaint survey was conducted from 11/17/2022 through 11/21/2022. Event ID # ICGO11. Intake # NC00194498 One of the two complaint allegations were substantiated with a deficiency. (F600) Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity J CFR 483.12 at tag F607 at a scope and severity J The tags F600 and F607 constituted Substandard Quality of Care. Non-compliance began on 10/10/2022. The facility came back in compliance effective 10/14/2022. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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 medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		

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

Electronically Signed

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F 600	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to protect a cognitively impaired resident from physical abuse from an employee when a nurse aide (NA #1) slapped a resident on the face for 1 of 3 cognitively impaired residents reviewed for abuse. NA #1 slapped Resident #1 across the face as Resident #1 reached for NA #1 with a hand soiled with feces. Resident #1 did not have the cognition to express an adverse outcome, a reasonable person would have been traumatized by being slapped during care. Findings included: Resident #1 was admitted to the facility on 10/11/2021 and had diagnoses of hemiplegia affecting the left non-dominant side and multiple strokes with damaged brain tissue. Documentation on the most recent quarterly Minimum Data Set assessment dated 10/07/2022 coded Resident #1 as being severely cognitively impaired. Resident #1 was also coded as requiring extensive to total dependence with all activities of daily living. Resident #1 was coded as having range of motion impairment on one side of both upper and lower extremities, in addition to being incontinent of both bowel and bladder. Resident #1 was not coded as having any behaviors. Documentation in a care plan, dated as last reviewed on 10/21/2022, revealed Resident #1 had a focus area for displaying the inappropriate behavior of playing in feces and resistance to care. Some of the interventions included documenting inappropriate behavior, explaining	F 600	Past noncompliance: no plan of correction required.	

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all procedures before starting, allowing adequate time to adjust to changes, monitoring behavior episodes, and attempt to determine underlying causes.

An interview was conducted with Nurse #2 on 11/17/2022 at 1:27 PM. Nurse #2 revealed she frequently worked in the facility on all shifts on all halls of the building, confirming she knew Resident #1 well since the resident's arrival at the facility. Nurse #2 further revealed Resident #1 was alert, could speak, but was confused. Nurse #2 stated Resident #1 had the behavior of playing in her feces since her arrival at the facility for an unknown reason. Nurse #2 confirmed that frequently Resident #1 needed assistance being cleaned up from playing in feces several times a day. Nurse #2 stated Resident #1 had both short- and long-term memory loss that kept her from recalling anything that happened to her for any length of time.

Documentation in a health status note written by Nurse #1 for Resident #1 entered as a late entry dated 10/10/2022 at 7:39 PM stated, "Resident had three episodes of playing in her feces, and another [at 9:00 PM]. I informed resident that I will be calling her [family member] about this behavior, and she stated, "that was lovely." Resident's [family member] made aware."

Documentation in a health status note for Resident #1 dated 10/11/2022 at 11:40 PM revealed, "Called and notified [Responsible Party], [Responsible Party Name], of incident that occurred on 10/10/2022."

Nurse #1 was interviewed on 11/17/2022 at 11:31 AM. Nurse #1 stated on 10/10/2022 she was

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assigned to the hall on which Resident #1 resided from 3:00 PM to 7:00 PM. Nurse #1 revealed the following information about the evening of 10/10/2022. Resident #1 had three episodes of "finger painting" with her stool. Resident #1 had been complaining about her stomach but was not noted to have any abdominal distention or indications of constipation. Nurse Aide (NA) #1 had arrived at the facility at 3:00 PM and was assigned to the hallway which Resident #1 resided. NA #1 and Resident #1 did not get along. Nurse #1 further explained NA #1 knew Resident #1 was cognitively impaired, but Resident #1 seemed to do things to irritate NA #1. While Nurse #1 was on the hallway from 3:00 PM to 7:00 PM, NA #1 had to clean up Resident #1 on three occasions from feces to include the cleaning of her body and changing of her clothing and sheets. Nurse #1 explained on the last episode for which Resident #1 required assistance with being cleaned up from feces, she herself took Resident #1 into the shower room with the assistance of the two personal care assistants (PCA #1 and PCA #2), to give NA #1 a break from care giving to Resident #1 because she appeared frustrated. Nurse #1 passed on the information about Resident #1 playing in feces on multiple occasions on the shift to the next nurse (Nurse #3) in report. Nurse #1 also called a family member of Resident #1 to report the behavioral issue of playing in feces and the resident's complaints of a stomachache. Nurse #1 then left the hallway to go to another part of the building to work at approximately 7:00 PM. Nurse #1 was not notified that night of any other occurrences involving Resident #1.

Nurse #3 was interviewed on 11/17/2022 at 8:30 PM. Nurse #3 confirmed she was assigned to the

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hall on which Resident #1 resided on 10/10/2022 from 7:00 PM to 7:00 AM. Nurse #3 revealed she did not know Resident #1 very well and she very infrequently worked at the facility. Nurse #3 explained the following events occurring on 10/10/2022. Nurse #3 was told in report by Nurse #1 that Resident #1 had multiple episodes of "playing in her feces." Nurse #3 overheard Nurse #1 talking to a family member on the telephone about her concerns for Resident #1 relating to feces before Nurse #1 went to another hallway to work. Nurse #3 then went to an adjacent assigned hallways to perform her duties and by the time she returned to the hallway of Resident #1 it was late, approximately 9:30 PM or 10:00 PM. Nurse #3, with a cup of medication in her hand, entered the room of Resident #1. Nurse #3 described Resident #1 as covered in feces to include her arms, hands, walls, and sheets when she entered the room. Nurse #3 left the room and after looking in the hallway found NA #1. Nurse #3 told NA #1 she needed to go into the room of Resident #1 and get her cleaned up. Nurse #3 did not recall if the two PCAs accompanied NA #1 into the room of Resident #1. Nurse #3 did not know how long NA #1 was in the room with Resident #1. Nurse #3 did not know if PCA #1 or PCA #2 were in the resident's room with NA #1. Nurse #3 stated she went down the hallway and was administering medications to the residents at the other end of the hallway. Nurse #3 stated she did not hear anything or see anything else from NA #1 or the two PCAs. Nurse #3 stated she was not approached by any of the nurse aides or PCAs with any concerns.

PCA #1 was interviewed on 11/17/2022 at 10:47 AM. PCA #1 explained on 10/10/2022 she worked in the facility as a personal care assistant (PCA).

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PCA #1 further explained as a PCA she was able to pass out ice and was a "helping hand" for the NA. PCA #1 further explained NA #1 acted as a mentor to her and PCA #2, who were both studying to be NAs. PCA #1 recalled that she went to assist Resident #1 with eating the evening meal between 5:30 PM and 6:00 PM, because this was one of the duties, she was able to do as a PCA. PCA #1 indicated NA #1 came to the door of the room and told her to not feed Resident #1 because she had been playing in "poop." PCA #1 indicated she went on to assist Resident #1 in eating and had cleaned the resident's hands prior to feeding her. PCA #1 revealed the next time she saw Resident #1 was on the last incontinence care rounds when she was asked to come into the room by PCA #2 who had already been in the room. PCA #1 explained Resident #1 had been "playing" in her feces and needed to be cleaned up and have her sheets changed. PCA #1 explained the following events as occurring after she entered the room of Resident #1 at approximately 10:00 PM. PCA #2 left the room to go and get supplies. Resident #1 was not showing any aggression. When PCA #2 returned, Resident #1 was turned to her side and was held there by PCA #1 and PCA #2. Resident #1 reached out her hand to grab NA #1 but did not touch her. At that point NA #1 slapped Resident #1 hard across the face. Resident #1 was confused and looked shocked. Resident #1 said, "Why did you hit me?" The roommate of Resident #1 (Resident #7) woke up and asked what was happening from behind the privacy curtain. Care was then provided to Resident #1 in silence. After leaving the room of Resident #1, PCA #1 told NA #1 she should not have slapped Resident #1 and NA #1 agreed she should not have done that. PCA #1 stated the nurse for the

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hallway had her medication cart outside a resident's closed door down the hallway. PCA #1, PCA #2, and NA #1 had one more room to provide care and entered the room of Resident #3. PCA #1 explained care was provided to Resident #3 with both PCA #2, NA #1 and herself in the room. PCA #1 further explained she could not find the hall nurse to tell her what had happened to Resident #1, and she did not think to tell any of the nurses in the front of the hallway prior to leaving the facility at 11:00 PM. PCA #1 explained she called the Director of Nursing the following day to notify her of the events on the evening of 10/10/2022.

PCA #2 was interviewed on 11/17/2022 at 11:25 AM. PCA #2 confirmed she was working on the hallway Resident #1 resided on the 3:00 PM to 11:00 PM shift on 10/10/2022. PCA #2 explained she had been assisting NA #1 all shift and Resident #1 had to be cleaned up after getting feces everywhere on at least 3 occasions. PCA #2 stated that on the very last incontinent care rounds for the evening NA #1 and she had entered the room of Resident #1 to find feces all over everything from the pad, bedding, and the walls. PCA #2 explained NA #1 was irritated and was arguing with Resident #1. PCA #2 revealed that NA #1 stated to Resident #1, "Why did you pull your diaper off? Yes, you do know. Why are you playing? Look at your hands." PCA #2 stated she had left the room to get supplies and PCA #1 came into the room to help. PCA #2 stated she returned to the room, and she was helping to hold NA #1 on her side, when Resident #1 reached out for NA #1. PCA #2 stated NA #1 slapped Resident #1 hard across the face. PCA #2 indicated she was very surprised and asked NA #1 why she would do that, with no response from

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NA #1. PCA #2 also indicated the roommate of Resident #1 (Resident #7) woke up asking what was happening. PCA #2 indicated she, along with NA #1 and PCA #1, continued to assist Resident #1. PCA #2 stated after leaving the room of Resident #1, she again asked NA #1 why she slapped the resident receiving the response, "it was wrong, and she needed to repent." PCA #2 explained she did not notify the nurse on the hall because everything was "cool under her watch." PCA #2 further explained that she did not feel like anything would be done if she told Nurse #1 on the hall, identifying Nurse #1 by her name. PCA #2 stated she decided to wait until the next morning to call the Director of Nursing because she knew then the situation would be taken seriously. PCA #2 stated she, NA #1, and PCA #1 went into the room of one more resident to provide care and everything went without incident. PCA #2 stated she went back into the room of Resident #1 to check on her and make sure the fall mat was in place. PCA #2 stated she was able to see the cheek of Resident #1 was red from where she had been slapped. PCA #2 stated she then left the facility at 11:00 PM with PCA #1 and NA #1 without notifying anybody NA #1 slapped Resident #1. PCA #1 stated she called the Director of Nursing the next day.

Documentation on an annual Minimum Data Set assessment dated 10/5/2022 coded Resident #7 as cognitively intact. Resident #7 was interviewed on 10/17/2022 at 9:55 AM. Resident #7 did not recall being awoken by any disturbances with staff assisting her roommate in the evening.

Documentation on the nursing assignment schedule for 10/10/2022 on the 3:00 PM to 11:00 PM shift revealed NA #1 was assigned to care for

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the hallway and room which Resident #1 resided. NA #1 did not respond to attempts to contact her for an interview.

A telephone interview was conducted with the Director of Nursing (DON) on 11/17/2022 at 2:32 PM. The DON stated nobody called or notified her of any abuse events occurring on the evening of 10/10/2022. The DON revealed on 10/11/2022 PCA #1 and PCA #2 called her at approximately 11:00 AM and proceeded to tell her they were assisting NA #1 with care to Resident #1 and NA #1 slapped the resident. The DON stated she asked the PCAs why they were just telling her and why they did not call her immediately when this happened. The DON indicated the PCAs were "stunned" that she would be upset they had not reported this to her immediately upon the occurrence. The DON indicated she told both the PCAs this was abuse and it had to be reported to a nurse, the DON, and/or the Administrator immediately. The DON revealed she had the PCAs go over what had specifically occurred, and she requested the PCAs stay on the phone while she went to get the facility Administrator. The DON stated she told the two PCAs to come in early for work so their statements could be documented. The DON stated it was her expectation that if a nurse aide was getting agitated, then the nurse on the hall should take over while the nurse aide has time to calm down. The DON thought getting slapped by a nurse aide during care could be traumatizing for a resident but Resident #1 had no recollection of the events of 10/10/2022 when asked the next day.

An interview was conducted with the facility Administrator on 11/21/2022 at 1:05 PM. The facility Administrator stated that she was notified

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at the same time as the Director of Nursing that NA #1 had slapped Resident #1 on the previous night on the evening shift. The Administrator confirmed PCA #1 and PCA #2 had been reeducated on the process for notification after an incident and were suspended pending an investigation. The Administrator stated she worked with the Director of Nursing to implement the reporting, investigation, education, and monitoring pieces of the abuse policies and procedures. The Administrator added that the entire staff had been reeducated on the abuse policies and procedures to include caring for residents who exhibit challenging behaviors, handling frustrated staff, and seeking assistance so that interventions can be put in place to avoid abuse.

The facility was notified of the Immediate Jeopardy on 11/17/2022 at 4:18 PM.

The corrective action plan for noncompliance dated 10/14/2022 was as follows:

F600 Abuse Past Non-Compliance Corrective Action Plan

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On October 11, 2022, around 11:15am, Director of Nursing (DON) was notified by two supportive care aides that they witnessed CNA (Certified Nursing Assistant) #1 hit Resident #1 on October 10th around 10:00pm. Support aides state they were assisting CNA #1 with ADL (activities of daily living) care for the resident.

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On 10/11/2022 Resident #1 was assessed by the Director of Nurses for any injury on the resident's face as a result of the alleged abuse. The assessment revealed that resident #1 had no obvious bruising or redness on her face. On 10/11/2022, the Assistant Director of Nurses completed a full body assessment of Resident #1. There were no obvious injuries, bruises, skin tears, scratches noted on resident #1's skin. One 10/11/2022, the Director of Nurses notified Resident #1's responsible party and the Medical Director of the alleged abuse. On 10/11/2022, the Director of Nurses completed reenactment with the 2 witnesses to the alleged abuse. All staff involved in this abuse allegation were interviewed and suspended pending investigation including the accused CNA and the 2 support aides who witnessed the incident. None of these staff members worked until the investigation was finalized.

On 10/11/2022, the DON and the ADON (Assistant Director of Nurses) interviewed each of the two support aides separately to get details of the alleged abuse. During the interviews, each support care aide also completed a reenactment of the event. The DON and the ADON reeducated each support care aide on the abuse policy on 10/11/2022 at which time each support care was also suspended pending investigation of this event.

On 10/11/ 2022 the DON identified residents that were potentially impacted by this practice by having the assigned nurse complete head to toe audits on all residents with a BIMS (Brief Interview for Mental Status) below 13 on the assigned employee's assignment. The results included: 13 of 13 residents has no areas of

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concern identified related to skin integrity or potential injuries. On 10/11/2022 all residents on the assigned employee's assignment with a BIMS of 13 or above were interviewed by the Social Services Director and were asked if they had any concerns related to verbal or physical abuse. The results included: 2 of 2 residents denied any alleged abuse occurred. On 10/11/2022 the Administrator audited grievances for the last 30 days and Resident Council Minutes for any concerns related to abuse. The results included: There were no grievances or Resident Council Minutes that included any abuse. On 10/11/2022 the DON audited incident reports for the last 30 days for any abuse related incidents. The results included: There were no incident reports that involved abuse. On 10/11/2022 the HR (Human Resources) audited staff employee files that were hired within the last 30 days, to assure that background checks, reference checks, certifications/licenses were reviewed as part of the new hire process. The results included: There were no employees out of compliance with background checks, reference checks, or concerns with certifications/licenses. On 10/11/2022 the HR audited education records of staff hired with in the last 30 days for completed abuse education as part of the new hire orientation process. The results included: There were no employees out of compliance with abuse education.

On 10/12/2022, after gathering more details, the QA (Quality Assurance) Committee convened to discuss the alleged abuse incident and the status of the investigation. On 10/13/2022, there was an additional meeting attended by the DON, Administrator, and the QA Consultant to review the Abuse policy and status of the investigation.

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F 600	Continued From page 12 There were no additional findings at that time. Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed. On 10/11/2022 the DON/SDC (Staff Development Coordinator) began in-service of all staff (including agency) on the abuse prohibition/reporting policy. This training will include all current staff including agency. This training included: Abuse Types, reporting abuse allegations immediately to Nurse/DON/Administrator, assuring resident safety, zero tolerance of retaliation of reporting allegations of abuse, addressing challenging behaviors and catastrophic reactions, along with notification. The Director of Nursing will ensure that any of the above identified staff (all staff including agency) who does not complete the in-service training by 10/14/2022 will not be allowed to work until the training is completed. The DON or designee will monitor the abuse process to ensure residents are free from abuse and the Social Services Director or designee will interview 4 random staff members each week, varying shifts/departments related to the abuse policy and reporting requirements to ensure staff are following the abuse policy weekly for 2 weeks and monthly for 3 months for compliance with timely reporting of all allegations of abuse to the Administrator/DON. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action	F 600		

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	345311	A. BUILDING _____ B. WING _____	C 11/21/2022

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F 600	Continued From page 13 initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS (Minimum Data Set) Coordinator, Therapy, HIM (Health Information Management), and the Dietary Manager. Date of Corrective Action Plan: 10/14/2022 On 11/17/2022 the facility's corrective action plan for immediate jeopardy removal effective 10/14/2022 was validated by the following: Staff interviews revealed they had received education on identifying resident abuse and immediate notification of abuse. Confirmation was made that skin assessments were completed on all cognitively impaired residents and alert and oriented residents were interviewed with no concerns identified. The facility's corrective action plan was validated as to be completed as of 10/14/2022.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		

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F 607	Continued From page 14 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to implement their abuse policies and procedures with immediate notification of a supervisor of staff-to-resident abuse, immediate protection of the resident and other residents, and immediate examination of the resident and other residents potentially affected by physical abuse for 1 of 3 cognitively impaired residents reviewed for abuse. NA #1 slapped Resident #1 across the face as Resident #1 reached for NA #1 with a hand soiled with feces. PCA #1 and PCA #2, witnesses to the abuse, did not notify a supervisor immediately resulting in a lack of immediate protection of Resident #1, a lack of a physical assessment of Resident #1, and the other residents in the care of NA #1 at the time of the abuse. Findings included:	F 607	Past noncompliance: no plan of correction required.	

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Documentation in the facility Abuse Policies and Procedures dated as last reviewed on 9/2022, stated under the policy in part that it was the responsibility of the employees to promptly report any incident or suspected incident of resident abuse to facility management. The documentation in the Abuse Policies and Procedures further revealed under definitions, "Physical abuse is defined as hitting, slapping, pinching, kicking, etc." Documentation under the heading "Abuse Investigation" the policies and procedures revealed immediate actions must be taken to protect the residents partially including taking steps to prevent further potential abuse and upon receiving reports of physical abuse a licensed nurse or physician shall immediately examine the resident. Additional documentation under the heading "Investigation Guidelines" revealed all residents would be assessed by the staff for indicators/criteria for abuse, neglect, and exploitation.

Resident #1 was admitted to the facility on 10/11/2021 and had diagnoses of hemiplegia affecting the left non-dominant side and multiple strokes with damaged brain tissue.

Documentation on the most recent quarterly Minimum Data Set assessment dated 10/07/2022 coded Resident #1 as being severely cognitively impaired.

Documentation in the training record for PCA #1 revealed she received abuse policy and procedure training on 9/19/2022 at the facility.

PCA #1 was interviewed on 11/17/2022 at 10:47 AM. PCA #1 explained on 10/10/2022 she worked in the facility as a personal care assistant (PCA).

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PCA #1 further explained as a PCA she was able to pass out ice and was a "helping hand" for the NA. PCA #1 further explained NA #1 acted as a mentor to her and PCA #2, who were both studying to be NAs. PCA #1 recalled that she went to assist Resident #1 with eating the evening meal between 5:30 PM and 6:00 PM, because this was one of the duties, she was able to do as a PCA. PCA #1 indicated NA #1 came to the door of the room and told her to not feed Resident #1 because she had been playing in "poop." PCA #1 indicated she went on to assist Resident #1 in eating and had cleaned the resident's hands prior to feeding her. PCA #1 revealed the next time she saw Resident #1 was on the last incontinence care rounds when she was asked to come into the room by PCA #2 who had already been in the room. PCA #1 explained Resident #1 had been "playing" in her feces and needed to be cleaned up and have her sheets changed. PCA #1 explained the following events as occurring after she entered the room of Resident #1 at approximately 10:00 PM. PCA #2 left the room to go and get supplies. Resident #1 was not showing any aggression. When PCA #2 returned, Resident #1 was turned to her side and was held there by PCA #1 and PCA #2. Resident #1 reached out her hand to grab NA #1 but did not touch her. At that point NA #1 slapped Resident #1 hard across the face. Resident #1 was confused and looked shocked. Resident #1 said, "Why did you hit me?" The roommate of Resident #1 (Resident #7) woke up and asked what was happening from behind the privacy curtain. Care was then provided to Resident #1 in silence. After leaving the room of Resident #1, PCA #1 told NA #1 she should not have slapped Resident #1 and NA #1 agreed she should not have done that. PCA #1 stated the nurse for the

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hallway had her medication cart outside a resident's closed door down the hallway. PCA #1 revealed she did not think the nurse was available if she was in the room with another resident. PCA #1, PCA #2, and NA #1 had one more room to provide care and entered the room of Resident #3. PCA #1 explained care was provided to Resident #3 with both PCA #2, NA #1 and herself in the room. PCA #1 stated NA #1 was very kind to Resident #3 and performed care without any other incident to Resident #3. PCA #1 revealed she did go back in the room of Resident #1 to check on her because she was told by PCA #2, Resident #1 had a red mark on her face where she was slapped. PCA #1 denied seeing the red mark on the face of Resident #1 at that time. PCA #1 further explained she could not find the hall nurse to tell her what had happened to Resident #1, and she did not think to tell any of the nurses in the front of the hallway prior to leaving the facility at 11:00 PM. PCA #1 explained she called the Director of Nursing the following day to notify her of the events on the evening of 10/10/2022. PCA #1 explained she was told by the Director of Nursing she had to report a nurse aide slapping a resident immediately to a nurse or to call her directly no matter the time of day.

Documentation in the training record for PCA #2 revealed she received abuse policy and procedure training on 9/23/2022 at the facility.

PCA #2 was interviewed on 11/17/2022 at 11:25 AM. PCA #2 confirmed she was working on the hallway Resident #1 resided on the 3:00 PM to 11:00 PM shift on 10/10/2022. PCA #2 explained she had been assisting NA #1 all shift and Resident #1 had to be cleaned up after getting feces everywhere on at least 3 occasions. PCA

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#2 stated that on the very last incontinent care rounds for the evening NA #1 and she had entered the room of Resident #1 to find feces all over everything from the pad, bedding, and the walls. PCA #2 explained NA #1 was irritated and was arguing with Resident #1. PCA #2 revealed that NA #1 stated to Resident #1, "Why did you pull your diaper off? Yes, you do know. Why are you playing? Look at your hands." PCA #2 stated she had left the room to get supplies and PCA #1 came into the room to help. PCA #2 stated she returned to the room, and she was helping to hold NA #1 on her side, when Resident #1 reached out for NA #1. PCA #2 stated NA #1 slapped Resident #1 hard across the face. PCA #2 indicated she was very surprised and asked NA #1 why she would do that, with no response from NA #1. PCA #2 also indicated the roommate of Resident #1 (Resident #7) woke up asking what was happening. PCA #2 indicated she, along with NA #1 and PCA #1, continued to assist Resident #1. PCA #2 stated after leaving the room of Resident #1, she again asked NA #1 why she slapped the resident receiving the response, "it was wrong, and she needed to repent." PCA #2 explained she did not notify the nurse on the hall because everything was "cool under her watch." PCA #2 further explained that she did not feel like anything would be done if she told Nurse #1 on the hall, identifying Nurse #1 by her name. PCA #2 stated she decided to wait until the next morning to call the Director of Nursing because she knew then the situation would be taken seriously. PCA #2 stated she, NA #1, and PCA #1 went into the room of one more resident to provide care and everything went without incident. PCA #2 stated she went back into the room of Resident #1 to check on her and make sure the fall mat was in place. PCA #2 stated she was able

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to see the cheek of Resident #1 was red from where she had been slapped. PCA #2 stated she had PCA #1 go into the room of Resident #1 to visualize her face, but PCA #1 relayed to her she did not see the red area on her face. PCA #2 stated she then left the facility at 11:00 PM with PCA #1 and NA #1 without notifying anybody NA #1 slapped Resident #1. PCA #2 stated she did not think it was appropriate to call the Director of Nursing so late at night and she did not know the nurses at the front of the building to tell them. PCA #2 stated she called the Director of Nursing the next day after she knew both her and PCA #1 would be available to speak to her. PCA #2 denied having the knowledge she needed to notify a nurse or the Director of Nursing immediately of a resident being slapped until the Director of Nursing told her when she called the Director of Nursing on 10/11/2022.

Documentation on the nursing assignment schedule for 10/10/2022 on the 3:00 PM to 11:00 PM shift revealed NA #1 was assigned to care for the hallway and room which Resident #1 resided. NA #1 did not respond to multiple attempts to contact her for an interview.

A telephone interview was conducted with the Director of Nursing (DON) on 11/17/2022 at 2:32 PM. The DON stated nobody called or notified her of any abuse events occurring on the evening of 10/10/2022. The DON revealed on 10/11/2022 PCA #1 and PCA #2 called her at approximately 11:00 AM and proceeded to tell her they were assisting NA #1 with care to Resident #1 and NA #1 slapped the resident. The DON stated she asked the PCAs why they were just telling her and why they did not call her immediately when this happened. The DON indicated the PCAs

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were "stunned" that she would be upset they had not reported this to her immediately upon the occurrence. The DON indicated she told both the PCAs this was abuse and it had to be reported to a nurse, the DON, and/or the Administrator immediately. The DON revealed she had the PCAs go over what had specifically occurred, and she requested the PCAs stay on the phone while she went to get the facility Administrator. The DON stated she told the two PCAs to come in early for work so their statements could be documented. The DON then revealed she immediately went to the room to assess Resident #1. The DON indicated Resident #1 had no recollection of the previous evening and did not have any redness or bruising on her body or face. The DON explained the facility policies and procedures for abuse were initiated at that point for assessment of the residents, protection of the residents, notification of authorities, resident responsible party, the physician, and the state offices. The DON explained skin assessments were initiated for the residents on the assignment of NA #1 and interviews were conducted with the alert and oriented residents. Education was initiated with all the staff on abuse policies and procedures while the facility initiated an investigation taking statements from the witnesses and the suspension of NA #1, PCA #1 and PCA #2. The DON revealed after multiple attempts to contact NA #1 she was able obtain a verbal statement from her during which NA #1 indicated Resident #1 was very uncooperative on the evening of 10/10/2022 but she did not hit her. The DON stated she had been unable to contact NA #1 since that conversation with her to notify her of her termination after the investigation was completed.

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An interview was conducted with the facility Administrator on 11/21/2022 at 1:05 PM. The facility Administrator stated that she was notified at the same time as the Director of Nursing that NA #1 had slapped Resident #1 on the previous night on the evening shift. The Administrator confirmed PCA #1 and PCA #2 had been reeducated on the process for notification after an incident and were suspended pending an investigation. The Administrator stated she worked with the Director of Nursing to implement the reporting, investigation, education, and monitoring pieces of the abuse policies and procedures. The Administrator added that the entire staff had been reeducated on the abuse policies and procedures to include caring for residents who exhibit challenging behaviors, handling frustrated staff, and seeking assistance so that interventions can be put in place to avoid abuse.

The facility was notified of the Immediate Jeopardy on 11/17/2022 at 5:45 PM.

The corrective action plan for noncompliance dated 10/14/2022 was as follows:

F607 Abuse Past Non-Compliance Corrective Action Plan

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On October 11, 2022, around 11:15am, Director of Nursing (DON) was notified by two supportive care aides that they witnessed CNA (Certified Nursing Assistant) #1 hit resident #1 on October 10th around 10:00pm. Support aides state they

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were assisting CNA #1 with ADL (Activities of Daily Living) care for the resident.

On 10/11/2022 Resident #1 was assessed by the Director of Nurses for any injury on the resident's face as a result of the alleged abuse. The assessment revealed that resident #1 had no obvious bruising or redness on her face. On 10/11/2022, the Assistant Director of Nurses (ADON) completed a full body assessment of Resident #1. There were no obvious injuries, bruises, skin tears, scratches noted on resident #1's skin. One 10/11/2022, the Director of Nurses notified Resident #1's responsible party and the Medical Director of the alleged abuse. On 10/11/2022, the Director of Nurses completed reenactment with the 2 witnesses to the alleged abuse. All staff involved in this abuse allegation were interviewed and suspended pending investigation including the accused CNA and the 2 support aides who witnessed the incident. None of these staff members worked until the investigation was finalized.

On 10/11/2022, the DON and the ADON interviewed each of the two support aides separately to get details of the alleged abuse. During the interviews, each support care aide also completed a reenactment of the event. The DON and the ADON reeducated each support care aide on the abuse policy on 10/11/2022 at which time each support care was also suspended pending investigation of this event.

On 10/11/ 2022 the DON identified residents that were potentially impacted by this practice by having the assigned nurse complete head to toe audits on all residents with a BIMS (Brief Interview Mental Status) below 13 on the

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assigned employee's assignment. The results included: 13 of 13 residents has no areas of concern identified related to skin integrity or potential injuries. On 10/11/2022 all residents on the assigned employee's assignment with a BIMS of 13 or above were interviewed by the Social Services Director and were asked if they had any concerns related to verbal or physical abuse. The results included: 2 of 2 residents denied any alleged abuse occurred. On 10/11/2022 the Administrator audited grievances for the last 30 days and Resident Council Minutes for any concerns related to abuse. The results included: There were no grievances or Resident Council Minutes that included any abuse. On 10/11/2022 the DON audited incident reports for the last 30 days for any abuse related incidents. The results included: There were no incident reports that involved abuse. On 10/11/2022 the HR (Human Resources) audited staff employee files that were hired within the last 30 days, to assure that background checks, reference checks, certifications/licenses were reviewed as part of the new hire process. The results included: There were no employees out of compliance with background checks, reference checks, or concerns with certifications/licenses. On 10/11/2022 the HR audited education records of staff hired with in the last 30 days for completed abuse education as part of the new hire orientation process. The results included: There were no employees out of compliance with abuse education.

On 10/12/2022, after gathering more details, the QA (Quality Assurance) Committee convened to discuss the alleged abuse incident and the status of the investigation. On 10/13/2022, there was an additional meeting attended by the DON,

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Administrator, and the QA Consultant to review the Abuse policy and status of the investigation. There were no additional findings at that time.

Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed.

On 10/11/2022 the DON/SDC (Staff Development Coordinator) began in-service of all staff (including agency) on the abuse prohibition/reporting policy. This training will include all current staff including agency. This training included: Abuse Types, reporting abuse allegations immediately to Nurse/DON/Administrator, assuring resident safety, zero tolerance of retaliation of reporting allegations of abuse, addressing challenging behaviors and catastrophic reactions, along with notification.

The Director of Nursing will ensure that any of the above identified staff (all staff including agency) who does not complete the in-service training by 10/14/2022 will not be allowed to work until the training is completed.

The DON or designee will monitor the abuse process to ensure residents are free from abuse and the Social Services Director or designee will interview 4 random staff members each week, varying shifts/departments related to the abuse policy and reporting requirements to ensure staff are following the abuse policy weekly for 2 weeks and monthly for 3 months for compliance with timely reporting of all allegations of abuse to the Administrator/DON. Reports will be presented to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345311	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROXBORO HEALTHCARE & REHAB CENTER	901 RIDGE ROAD ROXBORO, NC 27573

(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 607	Continued From page 25 the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS (Minimum Data Set) Coordinator, Therapy, HIM (Health Information Management), and the Dietary Manager. Date of Corrective Action Plan: 10/14/2022 On 11/17/2022 the facility's corrective action plan for immediate jeopardy removal effective 10/14/2022 was validated by the following: Staff interviews revealed they had received education on resident abuse and immediate notification of abuse. Confirmation was made that skin assessments were completed on all cognitively impaired residents and alert and oriented residents were interviewed with no concerns identified. The facility's corrective action plan was validated as to be completed as of 10/14/2022.	F 607		