STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

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F 000	INITIAL COMMENTS A complaint investigation was conducted from 3/6/2023 to 3/8/2023. Event ID # 4HJV11. The following intakes were investigated NC00197539, NC00197555, NC00198665, NC00198242, NC00197641, and NC00197186. 1 of the 13 complaint allegations resulted in deficiency.	F 000		
F 600 SS=G	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; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff, Nurse Practitioner and Physician interviews the facility failed to protect the resident's right to be free of a suspicious injury for 1 of 3 residents reviewed for abuse, Resident #3. Resident #3 was discovered to have a red area below her right eye with facial swelling on 1/22/2023 at 6:46 am which progressed to bruising under both eyes and bruising in left ear on 1/23/2023. Findings included:	F 600	F600 Affected Resident: Resident #3 currently resides in the facility. She is being monitored by facility staff to prevent any additional injuries to her. Resident #3 careplan interventions were reviewed by the Corporate Nurse Manager to ensure appropriate interventions were in place. This was completed on 3/16/23. Resident #3 did not suffer any persistent adverse effects	3/20/23

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

Electronically Signed | 03/16/2023

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F 600	Continued From page 1 Resident #3, a Spanish speaking resident, was admitted to the facility on 12/30/2020 and her diagnoses included chronic pain, arthritis, heart disease and dementia. A review of Resident #3 medical record revealed a Physician's Order for Aspirin 81 milligrams delayed release daily but no other anticoagulant medications were ordered. Resident #3's Medication Administration Record was reviewed, and a pain scale completed each shift indicated she did not have pain from 1/1/2023 through 1/23/2023 when she discharged to the hospital. Resident #3's Care Plan dated 3/10/2022 indicated she had a behavior of wandering without exit seeking due to dementia. The Care Plan included an intervention to observe frequently and place in supervised area when out of bed. The Care Plan further included Resident #3's primary language was Spanish with impaired cognitions and requires assistance with participating in activities which started on 12/5/2022 with an intervention of encourage resident to interact with Spanish speaking residents, volunteers, family and staff and encourage participation in activities that rely less on verbal communication such as exercise and musical activities. An annual Minimum Data Set (MDS) assessment dated 12/5/2022 indicated Resident #3 was moderately cognitively impaired. The assessment further indicated Resident #3 did not have physically or verbally abusive behaviors towards others or reject care but did wander daily.	F 600	from the alleged deficient practice. Residents with the Potential to be Affected: All residents have the potential to be affected by the alleged deficient practice. The facility Administrator and Director of Nursing reviewed the careplans of any resident who wanders into resident rooms to ensure that there are appropriate interventions in place to prevent resident to resident altercations. Careplan interventions were reviewed and revised as appropriate. This was completed on 3/16/23. In addition, the Director of Nursing or designee interviewed all alert and oriented residents regarding any incidents of injuries of unknown origin, resident to resident or staff to resident abuse. This will completed by 3/18/2023. No resident reported any incidents. A skin assessment was completed on any resident that was unable to be interviewed to determine if there were any injuries of unknown origin or any signs of physical abuse. There were no identified suspicious injuries or other signs of abuse. Systemic changes: The Corporate Compliance Manager educated the Administrator, Director of Nursing and Assistant Director of Nursing/Infection Preventionist on 3/10/2023 and 3/17/2023 on the following. The Director of Nursing and Corporate Nurse Manager educated all facility staff on the following. This will be completed by 3/19/2023.	

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F 600	Continued From page 2 On 3/8/2023 at 9:38 am an interview was conducted by phone with Nurse #5 and she stated she worked on 1/21/2023 on the 7:00 am to 3:00 pm and 3:00 pm to 11:00 pm shifts and cared for Resident #3. Nurse #5 stated Resident #3 did not have any discoloration or swelling to her face on 1/21/2023. She stated Resident #3 was a wanderer and she would go into other resident's rooms, but she does not remember if she went into another resident's room on 1/21/2023. Nurse #5 stated when Resident #3 wandered and you attempted to stop her, she became combative. Nurse #5 indicated Resident #3 was unsteady when she walks, and she did not have 1 on 1 observation on 1/21/2023 as it did not start until after she returned from the hospital on 1/27/2023. Nurse Aide #3 was interviewed by phone on 3/8/2023 at 11:24 am and she stated she took care of Resident #3 on 1/21/2023 and worked from 3:00 pm to 7:00 pm. Nurse Aide #3 stated she takes care of Resident #3 frequently and the resident constantly wanders on the unit and walks without any problems. Nurse Aide #3 stated Resident #3 will go into another resident's room and when you try to redirect her, she becomes combative. She stated she did not remember Resident #3 going into another resident's room on 1/21/2023 but she was in other rooms caring for residents so she may have. Nurse Aide #1 stated she did not observe any bruising or swelling to Resident #3's face on 1/21/2023. A progress note written by Nurse #1 dated 1/22/2023 at 6:46 am stated Resident #3 was observed to have a red area below her right eye with facial swelling. The note further stated the Nurse Practitioner was notified and the oncoming	F 600	Education included: • A review of the Abuse Policy: • Prevention and Reporting of Abuse, Neglect, Misappropriation of resident property, and exploitation; injuries of unknown origin. • Signs and symptoms of abuse, neglect, misappropriation of resident property and exploitation; • How/When & to Whom to report suspected cases of abuse, neglect, misappropriation of resident property and exploitation, injuries of unknown origin & reasonable suspicion of crimes. • Abuse Reporting Tool, which includes a review of interventions to prevent resident to resident altercations. This education was provided to ensure residents are kept free from abuse and neglect, and to ensure allegations or suspicions of abuse and neglect are thoroughly investigated and documented with appropriate and timely reporting. Any staff out on leave or PRN status will be educated by the ADON/IP, Corporate Nurse Manager, or Director of Nursing prior to returning to duty. Any newly hired staff will be educated by the ADON/IP or Human Resources Coordinator during orientation. All staff will continue to be educated on the above annually. Monitoring: An audit tool was developed which included the following: • Progress notes reviewed • Point of Care Documentation – Behaviors • Care Plan Approaches – Wanderers	

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F 600	Continued From page 3 shift would notify the emergency contact. On 3/6/2023 at 1:30 pm Nurse #1 was interviewed by phone and stated she worked the 11:00 pm to 7:00 am shift on 1/21/2023 and stated Nurse Aide #1 made her aware Resident #3 had an area under her right eye that looked like an insect bite. She stated she went to check on Resident #3 and she had a red area under her right eye and it was slightly swollen. Nurse #1 stated she did not call the Director of Nursing (DON) but documented what she observed and put the information in an incident report the DON would see when she came to work. A signed statement by Nurse #2, which was included in the facility's investigation file, stated she worked 1/22/2023 on the 7:00 am to 3:00 pm shift. The signed statement indicated Nurse Aide #1 reported to Nurse #2 it looked like Resident #3 had bug bites under her eyes. Nurse #2 indicated she noticed discoloration under both eyes and the discoloration could have come from Resident #3 lying on her face because she had just woken up. During an interview by phone with Nurse #2 she stated she worked the 7:00 am to 3:00 pm shift on 1/22/2023 and Nurse Aide #1 told her during the beginning of the shift that Resident #3 had discoloration under her eyes, and she went to check on her. Nurse #2 stated Resident #3 had a little redness under both eyes but they were not swollen. Nurse #2 also stated Resident #3 had been lying on the side of her face and she thought that caused the redness. Nurse #2 stated she did know a few words in Spanish but did not ask Resident #3 if someone had hurt her. Nurse #2 also stated Resident #3 had wandered on 1/22/2023 during her shift but she was not on	F 600	The Administrator, Director of Nursing or designee will review progress notes, behavior monitoring documentation and care plans of residents who wander into other residents' rooms to ensure that there are appropriate interventions in place to prevent any potential resident to resident altercation. The audits will be done weekly x 12 weeks in morning clinical meeting. The results of these audits will determine the need for further monitoring. QAPI All audits will be brought to Quality Assurance and Performance Improvement (QAPI) Committee meeting monthly x 3 months by the Administrator for review and further recommendations to ensure compliance with the plan of correction. Compliance date 3/20/23	

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1 to 1 observation until after she came back from the hospital on 1/27/2023. Nurse #2 stated she did not see Resident #3 go into any other resident rooms that day but she was not with her constantly.

On 3/7/2023 at 9:42 am an interview was conducted by phone with Nurse Aide #1 and she stated she worked on 1/22/2023 on the 7:00 am to 3:00 pm shift and Resident #3 was assigned to her. Nurse Aide #1 stated she reported to Nurse #3 that Resident #3 was red and slightly swollen under her eye, but it did not look like a bruise. Nurse Aide #1 stated she kept Resident #3 with her when she was not in another resident's room providing care but Resident #3 could have wandered into a room when she was assisting another resident.

An interview was conducted with Nurse #3 on 3/8/2023 at 1:53 pm and she stated she worked from 7:00 am until 11:00 pm on 1/21/2023 and 1/22/2023. Nurse #3 stated Resident #3's right eye was swollen and red on Sunday, but it was not bruised. She stated she did not remember what time it was when she found the redness under Resident #3's eye. Nurse #3 stated it looked like Resident #3 had rubbed her eye and caused the swelling and redness. Nurse #3 stated Resident #3 wanders and goes into other resident's rooms and will pick up other resident's belongings. Nurse #3 stated none of the other residents had been aggressive with Resident #3 when she wandered into their rooms before, and they would put their light on for staff to redirect her. Nurse #3 stated Resident #3 does speak a little English but she will not use English, and Nurse #3 stated she thinks some of her aggressiveness comes from Resident #3 not

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understanding the staff.

Nurse Aide #2 was interviewed on 3/6/2023 at 12:13 pm, while an observation was made of Resident #3, and stated she was assigned to Resident #3 on 1/23/2023 on the 7:00 am to 3:00 pm shift. Nurse Aide #2 stated she reported to Nurse #4 that Resident #3 had black and blue bruises to both her eyes and her left ear when I checked on her at the beginning of the shift on 1/23/2023. She stated she had not worked the weekend before and had not seen Resident #3 since the Friday before which was 1/20/2023. During the interview and observation Resident #3 sat in her wheelchair in her room and did not attempt to get up and did not have any behaviors. Nurse Aide #2 stated Resident #3 does not speak English except to say hello and the person that speaks Spanish is not working today. Resident #3 smiles when spoken to but speaks only Spanish. Nurse Aide #2 stated Resident #3 was on 1 on 1 observations since she returned from the hospital on 1/27/2023 but had not been on 1 on 1 observation before she went to the hospital on 1/23/2023.

During an interview with Nurse #4 by phone on 3/7/2023 at 9:04 am he stated he worked 1/23/2023 and when his shift began at 7:00 am Nurse Aide #2 reported that Resident #3 had bruising to her eyes and left ear. He stated he went to look at Resident #3's face and found that she had bruising on her eyes that were dark black and blue and a darker black bruise on her left ear. He stated it looked like someone had slapped her with an open hand. Nurse #4 also stated the bruising did not look new but looked like it had been there a few days. Nurse #4 indicated he had notified the Director of Nursing

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of the bruising around 9:00 am when she arrived at work, and the Director of Nursing had done the incident report and called the Family Member. He stated he had also called the Family Member to notify her of the bruising to Resident #3's face and ear.

On 3/7/2023 at 2:07 pm an interview was conducted by phone with the Family Member, and she stated she saw Resident #3 on Saturday, 1/21/2023, and she did not have any injuries. She stated on Monday, 1/23/2023, she received a call from Nurse #4 and he stated Resident #3 had marks under her eyes and he thought someone had hit her face. She stated she came to the facility and when she got to Resident #3's doorway she could see that her eyes were blackened. The Family Member stated she asked Resident #3 what happened to her face and Resident #3 stated the girl threw something at me, but Resident #3 could not tell her who it was or what they had thrown. The Family Member stated she told the Director of Nursing what Resident #3 had told her.

On 3/7/2023 at 11:42 am a telephone interview was held with the previous Assistant Administrator, who no longer worked at the facility, and she stated it was reported to the DON by nursing that Resident #3 had bruising under her eyes and in her ear on 1/23/2023. She stated Resident #3 had redness under her eyes the day before and they thought the redness was from something else and did not suspect abuse. The Assistant Administrator stated the next day another resident reported to the DON that her roommate had thrown something at Resident #3.

An interview was conducted with the Director of

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Nursing (DON) on 3/6/2023 at 3:31 pm and she stated when she came to work on Monday, 1/23/2023, she reviewed the 24 hour activity report from the weekend and saw the note that Nurse #1 wrote on 1/22/2023 and immediately went to look at Resident #3 and she had Nurse #4 with her. The DON stated there was a little redness and swelling under Resident #3's eyes and she thought Resident #3 may have been against the bed rail and caused the redness. The DON stated she spoke to Nurse #2 who was working in the facility and was assigned to Resident #3 on Sunday, 1/22/2023, and Nurse #2 indicated that Nurse Aide #1 had reported redness under Resident #3's eyes but the she thought the redness and swelling was from the way she sleeps on her face. The DON stated she checked on Resident #3 again between 1:00 pm and 3:00 pm and stated the areas under her eyes had changed to a blue color and she also had a blue area in her left ear. The DON stated Resident #3 went to the hospital that evening. The DON indicated on Tuesday, 1/24/2023, she was asked to go to Resident #7's room and the Resident #7 stated that Resident #3 had wandered into her room and Resident #7's roommate, Resident #8, had thrown something and hit Resident #3. The DON stated she reported the injury of unknown origin on 1/23/2023 when Resident #3's discoloration began to be blue and reported the incident as resident to resident abuse on 1/24/2023 when Resident #7 reported that Resident #8 had thrown something at Resident #3. The DON stated Resident #3 had a history of wandering and had gone into other residents rooms before but she did not do it routinely. The DON indicated Resident #8 was admitted to the hospital on 1/24/2023 before Resident #7 had reported the

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incident and she had not been able to interview her. The DON stated when she found the swelling and red areas on Resident #3's face on 1/23/2023 she tried to use the translator application on her phone but Resident #3 was not able to communicate with it, the DON stated the two staff members who could translate were not working.

On 3/8/2023 at 3:14 pm the Director of Nursing stated the Restorative Aide who spoke Spanish went to Resident #3's room with her on Monday, 1/23/2023, and asked her if she was in pain and what happened to her face.

On 3/8/2023 at 3:20 pm the Restorative Aide was interviewed and stated the Director of Nursing had asked her to speak with Resident #3 on 1/23/2023 since she spoke Spanish and she asked her if she was in pain and what happened to her face. The Restorative Aide stated Resident #3 stated she was not in pain and was incoherent when she asked what happened to her face, her words were jumbled and did not make sense.

The Nurse Practitioner (NP) was interviewed by phone on 3/7/2023 at 1:27 pm and she saw Resident #3 on 1/23/2023 between 9:00 am and 12:00 pm after nursing had reported she had bruising under her eyes, she did not remember the specific time. The NP stated there was a very small vertical abrasion to Resident #3's middle, upper lip, a peanut sized bruised area below each eye and a pea sized black area to her left inner ear and Resident #3 was swollen under her eyes but not in her ear. The NP stated she questioned nursing and they did not know of any injuries. She stated it looked like Resident #3 had run into a door and hit her lip and eyes, and the injuries did not worry her that the resident had been abused. The NP stated that it would be out of character for Resident #8, the resident accused

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of throwing something at Resident #3, to throw anything at another resident and Resident #8 had never had behaviors before.

During an interview with the Physician by phone on 3/7/2023 at 3:18 pm she stated she saw Resident #3 on Monday, 1/23/2023, around 12:00 pm. She stated she had dark black, blue bruising under her left eye and in her left ear. She stated the bruising did not look old and it looked like it had happened recently and she was concerned that it was abuse. The Physician stated she had questioned staff to see if she had a fall or if she had been hit and they did not know at that time.

An interview was conducted with the Administrator on 3/8/2023 at 2:20 pm and he stated he was partially involved with the investigation of Resident #3's facial bruising. He stated Resident #3 ambulates and they felt she had walked into something, or she could have gotten fatigued and fallen, and they really didn't know what had happened to her on 1/23/2023 when the redness under her eyes changed to bruising. The Administrator stated Resident #3 went to the hospital at the Family Members request and the next morning another resident reported to him that her roommate had hit that woman. The Administrator stated the resident did not name Resident #3 as the person that was hit, she just stated that woman. The Administrator stated after we found the bruises we did not go back and interview the staff because we seemed to have an eyewitness.

On 3/7/2023 at 2:07 pm an interview with the Family Member revealed she asked the facility to send her mother to the hospital when she came to see Resident #3 after Nurse #4 notified her of

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F 600	Continued From page 10 Resident #3's injuries. A hospital History and Physical dated 1/24/2023 stated the circumstances surrounding the bruising to Resident #3's eyes was not apparent, and the facility had stated she may have walked into something as she is able to walk on her own. The hospital History and Physical further stated the hospital Physician could not rule out elder abuse however the Physician felt it was less likely given Resident #3's ability to walk unassisted. Resident #3's hospital Discharge Summary dated 1/27/23 indicated she was sent to the hospital on 1/23/2023 when her daughter visited her and noticed she had two black eyes and was complaining of generalized pain. The Discharge Summary further indicated Resident #3's Computed Tomography (CT) scan was negative for facial fractures, cervical thoracic and lumbar fractures, no abdominal thoracic fractures, and no pelvic fractures. Resident #3 also had X-rays of her knees and femur bilaterally with no acute fractures. Resident #7's annual Minimum Data Set assessment date 1/23/2023 indicated she was mildly cognitively impaired. Resident #8's quarterly Minimum Data Set assessment date 1/9/2023 indicated she was cognitively intact.	F 600		
F 610 SS=G	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		3/20/23

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F 610	Continued From page 11 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, Nurse Practitioner, and Physician interview the facility failed to complete a thorough investigation to determine the possible cause of a suspicious injury for 1 of 3 residents reviewed for abuse (Resident #3). A red area below Resident #3's right eye and facial swelling was identified on 1/22/2023 at 6:46 am which progressed to black and blue bruising under both eyes and left ear on 1/23/2023. Findings included: The facility's Abuse, Neglect, Misappropriation of Resident Property, and Exploitation Policy revised on 1/19/2023 stated the Administrator is responsible to ensure complaints of abuse, including injuries of unknown origin are investigated. The policy further stated during the investigation staff members on all shifts who have had contact with the resident during the period of the alleged incident are interviewed.	F 610	F610 Affected Resident: Resident #3 currently resides in the facility. Upon re-admission to facility, resident remained on one on one care until 3/15/2023. No known and/or witnessed events noted during this time. Resident continues being closely monitored by facility staff to prevent any additional adverse events. Resident #3 did not suffer any persistent adverse effects from the alleged deficient practice. Residents with the Potential to be Affected: All residents have the potential to be affected by the alleged deficient practice. The facility Administrator and Director of Nursing reviewed 100% of the reported injuries of unknown origin to ensure that they were fully investigated. These investigations included interviews with	

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F 610	Continued From page 12 Resident #3 was admitted to the facility on 12/30/2020 and her diagnoses included chronic pain, arthritis, heart disease and dementia. On 3/8/2023 at 9:38 am an interview was conducted by phone with Nurse #5, and she stated she worked on 1/21/2023 on the 7:00 am to 3:00 pm and 3:00 pm to 11:00 pm shifts and cared for Resident #3. Nurse #5 stated Resident #3 did not have any discoloration or swelling to her face on 1/21/2023. She stated Resident #3 was a wanderer and she would go into other resident's rooms, but she did not remember if she went into another resident's room on 1/21/2023. Nurse #5 stated when Resident #3 wandered and you attempted to stop her, she became combative. Nurse #5 indicated Resident #3 was unsteady when she walked. Nurse #5 stated no one had interviewed her or asked her for a statement regarding Resident #3's demeanor or if she had bruises when she cared for her on 1/21/2023 from 7:00 am to 11:00 pm. Nurse Aide #3 was interviewed by phone on 3/8/2023 at 11:24 am and she stated she took care of Resident #3 on 1/21/2023 and worked from 3:00 pm to 7:00 pm. Nurse Aide #3 stated she took care of Resident #3 frequently and she constantly wandered on the unit and walked without any problems. Nurse Aide #3 stated Resident #3 would go into another resident's room and when you tried to redirect her, she became combative. She stated she did not remember Resident #3 going into another resident's room on 1/21/2023 but she was in other rooms caring for residents so she may have. Nurse Aide #3 stated she did not observe any bruising or swelling on Resident #3's face on	F 610	alert and oriented residents. Skin assessment will be completed for those residents who were not able to be interviewed or who were not alert and oriented. This will be completed by 3/19/2023. All injuries of unknown origin have been fully investigated. No other resident suffered any adverse effects related to the alleged deficient practice. Systemic changes: The Corporate Compliance Manager educated the Administrator, the Corporate Nurse Manager, the Director of Nursing and Assistant Director of Nursing/Infection Preventionist, on 3/10/2023 and 3/17/2023. Corporate Nurse Manager educated facility Nurse Practitioners, Medical Director on 3/16/23 and Attending Physician on 3/17/2023. The Corporate Nurse Manager, the Director of Nursing, the Corporate Reimbursement Manager and the Administrator educated all staff. This will be completed by 3/19/2023. Education included: " A review of the Abuse Policy; " Prevention and Reporting of Abuse, Neglect, Misappropriation of resident property, and exploitation; injuries of unknown origin; " Signs and Symptoms of Abuse, including suspicious bruises, scratches, lacerations, cuts and swelling; " How/When & to Whom to report suspected cases of abuse, neglect, misappropriation of resident property and exploitation, injuries of unknown origin &	

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F 610	Continued From page 13 1/21/2023 and no one had asked her if Resident #3 had any bruises or injuries before she went out to the hospital on 1/23/2023. A progress note written by Nurse #1 dated 1/22/2023 at 6:46 am stated Resident #3 was observed to have a red area below her right eye with facial swelling. The note further stated the Nurse Practitioner was notified and the oncoming shift would notify the emergency contact. On 3/6/2023 at 1:30 pm Nurse #1 was interviewed and stated she worked the 11:00 pm to 7:00 am shift on 1/21/2023 and stated Nurse Aide #1 made her aware Resident #3 had an area under her right eye that looked like an insect bite. She stated she went to check on Resident #3 and she had a red area under her right eye, and it was slightly swollen. Nurse #1 stated she did not call the Director of Nursing (DON) but documented what she observed and put the information in an incident report the DON would see when she came to work. Nurse #1 stated the Director of Nursing (DON) did talk to her about Resident #3 on 1/23/2023 when the bruising was identified to Resident #3's face. Nurse #1 stated the DON asked her what her face looked like and what she thought caused it but did not ask her specific questions about how she acted that night or if she was out of bed or wandering that night. A signed statement by Nurse #2, which was included in the facility's investigation file, stated she worked 1/22/2023 on the 7:00 am to 3:00 pm shift. The signed statement indicated Nurse Aide #1 reported to Nurse #2 it looked like Resident #3 had bug bites under her eyes. Nurse #2 indicated she noticed discoloration under both eyes and the discoloration could have come from Resident #3	F 610	reasonable suspicion of crimes; " Abuse Reporting Tool, which includes a step-by-step algorithm on investigating and reporting injuries of unknown origin. " Investigations include: interviews regarding any allegations of abuse or injuries with all alert and oriented residents (either on a particular staff assignment or facility wide, as appropriate); skin assessments on those residents who are unable to be interviewed to assess for signs of abuse or other injuries of unknown origin (either on a particular unit or facility wide, as appropriate); " Keeping resident safe during investigation Abuse Policy and Abuse Reporting Tool have been posted in break rooms, medication rooms and nursing stations to assist staff in identifying/reporting abuse allegations and injuries of unknown origin. This education was provided to ensure residents are kept free from abuse and neglect, and to ensure allegations or suspicions of abuse and neglect are thoroughly investigated and documented with appropriate and timely reporting. Monitoring: The Corporate Nurse Manager will review all investigations of injuries of unknown origin and allegations of abuse to ensure a complete and thorough investigation is conducted. The audits will be done weekly x 12 weeks and will be shared with the Administrator and Director of Nursing. The Administrator will continue to review all investigations of injuries of unknown	

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F 610	Continued From page 14 lying on her face because she had just woken up. During an interview with Nurse #2 she stated she worked the 7:00 am to 3:00 pm shift on 1/22/2023 and Nurse Aide #1 told her during the beginning of the shift that Resident #3 had discoloration under her eyes, and she went to check on her. Nurse #2 stated Resident #3 had a little redness under both eyes, but they were not swollen. Nurse #2 also stated Resident #3 had been lying on the side of her face and she thought that caused the redness and did not suspect she was abused. On 3/7/2023 at 9:42 am an interview was conducted with Nurse Aide #1, and she stated she worked on 1/22/2023 on the 7:00 am to 3:00 pm shift and Resident #3 was assigned to her. Nurse Aide #1 stated she reported to Nurse #3 that Resident #3 was red and slightly swollen under her right eye, but it did not look like a bruise. Nurse Aide #1 stated she did not care for Resident #3 on Monday, 1/23/2023, but was surprised when she worked Monday evening and Resident #3 had two black eyes. An interview was conducted with Nurse #3 on 3/8/2023 at 1:53 pm and she stated she worked from 7:00 am until 11:00 pm on 1/21/2023 and 1/22/2023. Nurse #3 stated Resident #3's right eye was swollen and red on Sunday, but it was not bruised. She stated she did not remember what time it was when she found the redness under Resident #3's eye. Nurse #3 stated it looked like Resident #3 had rubbed her eye and caused the swelling and redness. Nurse #3 stated Resident #3 wandered and went into other resident's rooms and would pick up other resident's belongings. Nurse #3 stated none of	F 610	origin and allegations of abuse to ensure timely reporting. The results of these audits will determine the need for further monitoring. QAPI All audits will be brought to Quality Assurance and Performance Improvement (QAPI) Committee meeting monthly x 3 months by the Administrator for review and further recommendations to ensure compliance with the plan of correction. COMPLIANCE DATE: 3/20/2023	

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the other residents had been aggressive with Resident #3 when she wandered into their rooms before, and they would put their light on for staff to redirect Resident #3. Nurse #3 stated she did not report to the Director of Nursing (DON) about Resident #3's eye being red and swollen and the DON did not interview her regarding Resident #3's demeanor or if she saw any injury after the bruising was identified on 1/23/2023. Nurse #3 stated she did not know the redness and swelling to Resident #3's left eye had progressed to bruising until she returned to the facility on the following weekend, when she was scheduled to work.

Nurse Aide #2 was interviewed on 3/6/2023 at 12:13 pm, while an observation was made of Resident #3, and stated she was assigned to Resident #3 on 1/23/2024 on the 7:00 am to 3:00 pm shift. Nurse Aide #2 stated she reported to Nurse #4 that Resident #3 had black and blue bruises under both her eyes and her right ear when she checked on her at the beginning of the shift on 1/23/2023. She stated she had not worked the weekend before and had not seen Resident #3 since Friday, 1/20/2023. During the interview and observation Resident #3 sat in her wheelchair in her room and did not attempt to get up and did not have any behaviors. Nurse Aide #2 stated Resident #3 did not speak English except to say hello. Resident #3 smiles when spoken to but speaks only Spanish.
During an interview with Nurse #4 on 3/7/2023 at 9:04 am he stated he worked 1/23/2023 and when his shift began at 7:00 am Nurse Aide #2 reported that Resident #3 had bruising under her eyes and ear. He stated he went to look at Resident #3's face and found that she had bruising on her eyes that were dark black and

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blue and a darker black bruise on her right ear. He stated it looked like someone had slapped her with an open hand. Nurse #4 also stated the bruising did not look new but looked like it had been there a few days. Nurse #4 indicated he had notified the Director of Nursing of the bruising around 9:00 am when she arrived at work. He stated he had called the Family Member to notify her of the bruising to Resident #3's face and ear.

On 3/7/2023 at 2:07 pm an interview was conducted with the Family Member, and she stated she saw Resident #3 on Saturday, 1/21/2023, and she did not have any injuries. She stated on Monday, 1/23/2023, she received a call from Nurse #4, and he stated Resident #3 had marks under her eyes and he thought someone had hit her face. She stated she came to the facility and when she got to Resident #3's doorway she could see that her eyes were blackened. The Family Member stated she asked Resident #3 what happened to her face and Resident #3 stated the girl threw something at me, but Resident #3 could not tell her who it was or what they had thrown. The Family Member stated she told the Director of Nursing what Resident #3 had told her.

On 3/7/2023 at 11:42 pm an interview was held with the previous Assistant Administrator, who no longer worked at the facility, and she stated it was reported to the DON by nursing that Resident #3 had bruising under her eyes and in her ear on 1/23/2023. She stated Resident #3 had redness under her eyes the day before and they thought the redness was from something else and did not suspect abuse. The Assistant Administrator stated the next day another resident reported to DON that her roommate had thrown something at

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Resident #3.

An interview was conducted with the Director of Nursing (DON) on 3/6/2023 at 3:31 pm and she stated when she came to work on Monday, 1/23/2023, she reviewed the 24-hour activity report from the weekend and saw the note that Nurse #1 wrote on 1/22/2023 and immediately went to look at Resident #3 and she had Nurse #4 with her. The DON stated there was a little redness and swelling under Resident #3's eyes and she thought Resident #3 may have been against the bed rail and caused the redness. The DON stated she spoke to Nurse #2 who was working in the facility and was assigned to Resident #3 on Sunday, 1/22/2023, and Nurse #2 indicated that Nurse Aide #1 had reported redness under Resident #3's eyes but she thought the redness and swelling was from the way she sleeps on her face. The DON stated she checked on Resident #3 again between 1:00 pm and 3:00 pm and stated the areas under her eyes had changed to a blue color and she also had a blue area in her left ear. The DON stated Resident #3 went to the hospital that evening. The DON indicated on Tuesday, 1/24/2023, she was asked to go to Resident #7's room and the Resident #7 stated that Resident #3 had wandered into her room and Resident #7's roommate, Resident #8, had thrown something and hit Resident #3. The DON stated she reported the injury of unknown origin on 1/23/2023 when Resident #3's discoloration began to be blue and reported the incident as a resident- to- resident abuse on 1/24/2023 when Resident #7 reported that Resident #8 had thrown something at Resident #3. The DON stated Resident #3 had a history of wandering and had gone into other residents' rooms before,

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but she did not do it routinely. The DON indicated Resident #8 was admitted to the hospital on 1/24/2023 before Resident #7 had reported the incident and she had not been able to interview her. The DON also indicated the facility had done skin assessments on all residents in the facility and had spoken with all cognitively intact residents on 1/23/2023.

The Director of Nursing stated on 3/8/2023 at 3:14 pm that the Restorative Aide, who spoke Spanish, went to Resident #3's room with her on Monday, 1/23/2023, and asked her if she was in pain and what happened to her face.

The Restorative Aide was interviewed on 3/8/2023 at 3:20 pm and stated the Director of Nursing asked her on Monday, 1/23/2023, to ask Resident #3 if she was in pain and what happened to her face. The Restorative Aide stated Resident #3 nodded her head "no" when asked if she was in pain and spoke words that did not make sense when asked what happened to her face.

On 3/8/2023 at 6:29 pm the Administrator sent a written statement from the Director of Nursing that stated on 1/24/2023 at approximately 11:30 am she was notified by Nurse Aide #2 and Nurse Aide #4 that Resident #7 wanted to speak to her and when she spoke with Resident #7 she stated she (pointing at her roommates bed) did it, she did that to that lady and threw something at Resident #3. Resident #7 also stated that Resident #8 had hit her and hit her and hit her.

The Nurse Practitioner (NP) was interviewed on 3/7/2023 at 1:27 pm and she saw Resident #3 on 1/23/2023 between 9:00 am and 12:00 pm after

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nursing had reported she had bruising under her eyes; she did not remember the specific time. The NP stated there was a very small vertical abrasion to Resident #3's middle, upper lip, a peanut sized bruised area below each eye and a pea sized black area to her left inner ear and Resident #3 was swollen under her eyes but not in her ear. The NP stated she questioned nursing, and they did not know of any injuries. She stated it looked like Resident #3 had run into a door and hit her lip and eyes, and the injuries did not worry her that the resident had been abused. The NP stated that it would be out of character for Resident #8, the resident accused of throwing something at Resident #3, to throw anything at another resident and she had never had behaviors before.

During an interview with the Physician on 3/7/2023 at 3:18 pm she stated she saw Resident #3 on Monday, 1/23/2023, around 12:00 pm. She stated she had dark black, blue bruising under her left eye and in her left ear. She stated the bruising did not look old and it looked like it had happened recently, and she was concerned that it was abuse. The Physician stated she had questioned to see if she had a fall or if she had been hit and they did not know at that time.

A hospital History and Physical dated 1/24/2023 stated the circumstances surrounding the bruising to Resident #3's eyes was not apparent, and the facility had stated she may have walked into something as she is able to walk on her own. The hospital History and Physical further stated the hospital Physician could not rule out elder abuse however the Physician felt it was less likely given Resident #3's ability to walk unassisted.

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The Hospital Discharge Summary dated 1/27/2023 indicated the hospital Physician's suspicion was Resident #3 fell at the skilled nursing facility. The Discharge Summary further stated the hospital's Physician could not rule out elder abuse but felt that it was less likely due to Resident #3's propensity to get up and her diagnoses of dementia.

An interview was conducted with the Administrator on 3/8/2023 at 2:20 pm and he stated he was partially involved with the investigation of Resident #3's facial bruising. He stated Resident #3 ambulates and they felt she had walked into something, or she could have gotten fatigued and fallen, and they really didn't know what had happened to her on 1/23/2023 when the redness under her eyes changed to bruising. The Administrator stated Resident #3 went to the hospital at the Family Members request and the next morning anther resident reported to me that her roommate had hit that woman. The Administrator stated the resident did not name Resident #3 as the person that was hit, she just stated that woman. The Administrator stated they had not asked staff who worked prior to 1/23/2023 if they found anything in the floor that was thrown or broken or if Resident #3 was more agitated. The Administrator stated after they found the bruises they did not go back and interview the staff because they seemed to have an eyewitness.