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	345441	A. BUILDING _____ B. WING _____	C 09/13/2023

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 09/07/23 through 09/13/23. Event ID #T2D411. The following intakes were investigated: NC00206675, NC00206673, NC00206003, NC00205439, NC00205322, NC00205151 and NC00204956. Intakes NC00206675 and NC00206673 resulted immediate jeopardy. 7 of the 13 allegations resulted in deficiencies. Past noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity of (J). CFR 483.12 at tag F607 at a scope and severity of (J). The tags F600 and F607 constitued Substandard Quality of Care. 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	F 600		

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

Electronically Signed | 10/04/2023

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F 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to protect a resident's right to be free from abuse for 1 of 1 resident (Resident #1). Resident # 1 reported she started to cry, was scared, was upset the aide was hurting her. The findings included: Resident #1 was originally admitted to the facility on 01/20/17 with diagnoses which included muscle weakness, hypertension, lack of coordination, and renal failure. Diagnoses further revealed Resident #1 had a fracture to the right tibia dated 06/30/23 with orders to wear a brace. Review of quarterly Minimum Data Set (MDS) dated 08/18/23 revealed Resident #1 was cognitively intact and required two plus assist with transfers. The MDS further revealed Resident #1 was not coded for behaviors. Resident #1's care plan revised on 05/05/23 revealed Resident #1 had limited physical mobility due to weakness. The goal was for Resident #1 to remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date. Interventions included to provide gentle range of motion as tolerated with daily care, provide supportive care and assistance with mobility as needed, and requires mechanical lift with two staff assist for transfers.	F 600	Past noncompliance: no plan of correction required.	

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Resident #1's care plan revised on 07/09/23 revealed Resident #1 required the use of an immobilizer to lower right extremity. The goal was for Resident #1 to be free of pain or discomfort through the next review. Interventions included providing verbal prompts.

Review of the facility initial allegation report dated 08/25/23 revealed on 08/25/23 at 5:50 PM Resident #1 stated to the MDS Coordinator NA #1 hit her on the right side of the temple. The report further revealed a skin assessment was completed by the MDS Coordinator and there was no evidence of abuse.

Review of the investigation completed by the Administrator on 08/31/23 related to Resident #1's incidents revealed the following:

-NA #1's written statement dated 08/25/23 revealed NA #1 and NA #2 went into Resident #1's room to provide care and Resident #1 started to fuss and state she was going somewhere else. NA #1 further revealed while she and NA #2 were lifting her into bed and Resident #1 tried to sit up and the resident stated" leave me alone and get out". NA #1 indicated she told Resident #1 she needed to check her brief and Resident #1 stated "no, I do not want you in here". NA #1 revealed she just wanted to make sure Resident #1 was not wet and started to remove Resident #1's brace on her right leg. Resident #1 started to slap at NA #1, and NA #1 indicated she grabbed Resident #1's right hand and placed it on her chest to keep her from hitting her. The statement revealed NA #1 was taking off Resident #1's right leg brace and Resident #1 balled up her fist and hit NA #1 multiple times. NA #1 stated she got Resident

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#1's right leg brace and pants off and told Resident #1 that she had to do her job and care for her. The statement indicated Resident #1 stated "to get out and not come back" and NA #1 indicated she would not return after getting Resident #1 properly positioned into bed. The statement further revealed NA #1 left the room and reported to Nurse #1 Resident #1's aggressive behaviors. The statement indicated later Resident #1's call light was on and NA #1 returned to Resident #1's room and the resident was upset and asked NA #1 to leave again.

-NA #2's written statement dated 08/25/23 revealed she witnessed NA #1 put Resident #1 in the bed and Resident #1 stated NA #1 was hurting her. NA #2 further revealed in the statement NA #1 continued to do care and Resident #1 started to swing at her and NA #1 hit Resident #1's right hand and right leg which was in a brace. The statement indicated Resident #1 wanted NA #1 to get out of the room and NA #1 stated she wasn't going anywhere. NA #2 said both NA #1 and Resident #1 were cussing at each other.

-Nurse #1's written statement dated 08/25/23 revealed during late evening medication pass Resident #1 wanted to make sure that NA #1 wasn't her NA. The statement further revealed Nurse #1 asked the resident what had happened, and Resident #1 revealed NA #1 moved her right bad leg after Resident #1 had told her not to move it a certain way. Resident #1 indicated NA #1 told her that she was her caregiver, and she would do whatever needed to be done and proceeded to move her right leg. Resident #1 indicated to Nurse #1 that she had hit NA #1. The statement further revealed Nurse #1 spoke to NA

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#1 and NA #1 reported she did not hit the resident and NA #1 moved her hand close to Resident #1's body after being hit by the resident.

-Statement written by the MDS Coordinator dated 08/25/23 revealed at 5:50 PM NA #1 revealed Resident #1 had struck at the NA several times. The statement further revealed the MDS Coordinator went, and interviewed Resident #1 and the resident stated, "the NA was moving me and hit my broken leg and told NA #1 that it hurts and don't touch it and to leave me alone." Resident #1 stated NA #1 indicated she was the resident's caregiver, and she was going to help her. The statement further revealed Resident #1 admitted to hitting NA #1 after NA #1 hit her on the temple. The MDS Coordinator notified the Administrator at 5:54 PM and left a voice mail and also contacted the Director of Nursing (DON) and Social Worker (SW).

A phone interview with NA #1 on 09/07/23 at 10:20 AM revealed on 08/25/23 NA #1 entered Resident #1's room with NA #2 around 1:30 PM after the resident had returned from dialysis. NA #1 indicated Resident #1 told her she was tired and wanted to be put into bed. NA #1 further revealed they used a mechanical lift and assisted Resident #1 into bed. While assisting Resident #1 into bed NA #1 stated Resident #1 was stating "I am leaving and going somewhere else." NA #1 revealed she got Resident #1 into her bed and started to remove her leg brace on her right leg to assist with care and Resident #1 stated "to get out and leave me alone". NA #1 revealed Resident #1 began to strike at her and she grabbed her right hand and held it down on her chest. NA #1 indicated Resident #1 continued to state, "leave me alone and get out". NA #1

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revealed she let go of Resident #1's right hand and the resident began to hit NA #1 with a balled fist. NA #1 indicated she grabbed Resident #1's right arm again and held it down to her chest to restrain her from hitting her. NA #1 further revealed she continued to give care by taking off her right brace and pants. NA #1 indicated Resident #1 complained about her right leg brace being removed. NA #1 indicated Resident #1 was dry and she left the room with NA #2. NA #1 indicated she reported Resident #1's behaviors of hitting to Nurse #1 and Nurse #1 indicated she would report it to upper management on Monday. NA #1 revealed she continued to work on the floor until about 5:50 PM and reported to the MDS Coordinator Resident #1 had shown aggressive behaviors towards NA #1. NA #1 indicated shortly after speaking to the MDS Coordinator she was pulled into the conference room and was suspended for further investigation and was not allowed back in the facility. NA #1 indicated Resident #1 was not normally aggressive and does not feel like she was restraining her. NA #1 stated she had been educated to walk away if a resident became aggressive or combative but felt like she needed to complete Resident #1's care before leaving the room even though the resident had asked her to leave.

An interview with NA #2 on 09/07/23 at 10:35 AM revealed on 08/25/23 after lunch she assisted NA #1 with Resident #1 getting into bed. NA #2 further revealed while lifting Resident #1 in the mechanical lift Resident #1 started to complain the lift was hurting her leg and wanted to be put down. NA #2 indicated NA #1 stated she was not putting the resident back down because the resident wanted to get back in the bed. NA #2 and NA #1 got Resident #1 into the bed and

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Resident #1 stated to NA #1 "you are hurting me, and I want you to get out of my room". NA #1 stated" I am not going anywhere because I am your caretaker". NA #2 revealed Resident #1 became more agitated and started to slap at NA #1 and NA #1 slapped Resident #1's right hand out of the way and pushed on Residents #1's right fractured leg that was in a brace. NA #2 indicated Resident #1 began to cry in pain and stated again for NA #1 to get out of her room. NA #2 revealed Resident #1 began to hit again at NA #1 and NA #1 took both hands and held them to her chest. NA #2 stated Resident #1 was very upset and continued to tell NA #1 to get out of her room. NA #2 indicated she pushed NA #1 off of Resident #1 and told NA #1 to get out of the room immediately. NA #2 indicated NA #1 stated "she wasn't going any damn where that she was caring for the resident". NA #2 stated she told her to leave again, and NA #1 left the room mad. NA #2 revealed she stayed in the room with Resident #1 to calm her down and complete care of the resident.

An interview conducted with Resident #1 on 09/07/23 at 11:50 AM revealed on 08/25/23 NA #1 and NA #2 assisted her into the bed and NA #1 was being rough and hurting her. Resident #1 further revealed she stated to NA #1 "honey, you are hurting me". Resident #1 stated NA #1 pushed on her hurt right leg and stated she was the caregiver and was going to do what she wanted. Resident #1 further revealed she started to cry and was scared so she started to slap at NA #1 to get her off and asked her to leave. Resident #1 revealed NA #1 took both her hands and held them to her chest and eventually let go. Resident #1 indicated she did not recall if she received care or not because she was so upset.

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Resident #1 indicted NA #2 did not say anything or intervene until NA #1 had left the room.

An interview conducted with the MDS Coordinator dated 09/07/23 at 12:00 PM revealed on 08/25/23 at 5:50 PM she was about to leave, and NA #1 stopped her and indicated Resident #1 was having aggressive behaviors. The MDS coordinator further revealed she went and spoke to Resident #1 and Resident #1 indicated NA #1 hit her right leg and her right temple and had hurt her. The MDS Coordinator stated Resident #1 had indicated NA #1 continued to be rough with her right leg and did not want her back in her room. The MDS coordinator revealed she contacted the Administrator and removed NA #1 off the floor immediately. It was further revealed the MDS coordinator assisted interviewing alert and oriented residents and completing skin audits with other residents who were cognitively impaired

An interview conducted with Nurse #1 on 09/07/23 at 1:45 PM revealed on 08/25/23 after dinner she was completing a medication pass and observed Resident #1 looking at her strange and seemed to be scared. Resident #1 stated to Nurse #1 she wanted to make sure she was not NA #1 because NA #1 was rough with her and didn't want NA #1 to take care of her. Nurse #1 further revealed nobody had reported to her the incident or Resident #1's behaviors. Nurse #1 revealed the MDS Coordinator came to the resident's room right after she had spoken to Resident #1.

An interview conducted with the Administrator on 09/07/23 at 4:30 PM revealed on 08/25/23 the MDS Coordinator called her about 6:30 PM and

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revealed Resident #1 reported NA #1 had hit her. The Administrator further revealed she instructed the MDS Coordinator to pull NA #1 off the floor immediately and came to the facility to complete an investigation. The Administrator revealed she received statements from all staff involved and interviewed Resident #1. The Administrator further revealed Resident #1 stated NA #1 had hurt her while putting her into the bed and had hit her right hand and leg. The Administrator indicated adult protective services, law enforcement, the state, and family were notified immediately. The Administrator indicated she completed a thorough investigation and completed in services, interviews with alert and oriented residents, skin audits with other residents, and started audits of care. The Administrator revealed nursing staff had been educated to walk away if a resident was being combative or aggressive. The Administrator further revealed NA #1 and NA #2 should have walked away from Resident #1 when she asked, and NA #2 should have reported immediately to upper management concerns of abuse.

The Administrator was notified of immediate jeopardy on 09/08/23 at 9:00 AM.

The corrective action plan for noncompliance dated 08/30/23 was as follows:
On 8/25/2023 at approximately 5:50pm CNA (Certified Nursing Assistant) #1 informed Nurse #1 (MDS Nurse) that Resident #1 had hit her. Nurse #1 at approximately 5:50PM immediately notified NHA (Nursing Home Administrator) and interviewed Resident #1, who stated that she did indeed hit CNA #1 because she (CNA #1) had hurt her leg and had hit her on her hand and her leg with an open hand. The incident occurred

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between 2:30pm-3:00pm.

On 8/25/2023 at around 6:25pm the Administrator interviewed Resident #1: Resident #1 indicated that CNA #1 and CNA #2 were transferring resident to bed, via mechanical lift and CNA #1 bumped Resident #1 foot on the foot board, which caused pain to her leg. Resident #1 stated she told CNA #1 to get out, but CNA #1 continued to take care of her, so Resident #1 hit CNA #1. Resident #1 indicated when she hit CNA #1, CNA #1 in turn hit Resident #1 on her left side of waist and left leg. Resident #1 denied any injury or pain at that time.

On 8/25/2023, between 6:45-7:00pm, CNA #2 was interviewed by the Administrator. Administrator asked CNA #2 why she did not immediately report the abuse to Administrator. CNA #2 stated that she did not report right away because she was pulled away to help with another resident. After assisting other residents, CNA #2 stated she forgot to go back and report to the charge nurse. Upon interview with Administrator CNA #2 was re-educated to immediately report abuse to the facility Abuse Coordinator, the Administrator.

On 8/25/2023, Nurse #1 removed CNA #1 from resident care area and placed her in the conference room between 6:00pm-6:05pm as soon as Administrator was made aware.

On 8/25/2023, at approximately 6:00PM alleged perpetrator CNA #1 and witness CNA #2 were suspended pending an investigation.

On 8/25/2023, staff working on the skilled unit were interviewed regarding abuse allegation, if

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they were aware of any abuse, neglect or exploitation of residents, or if they were aware of any concerns in this regard in the building at this time. Staff working on this unit (100 Hall) provided written statements regarding this allegation and day. All staff were educated regarding abuse allegation, if they were aware of any abuse, neglect or exploitation of residents, or if they were aware of any concerns.

On 8/25/2023, APS and local Police Department were notified.

On 8/25/2023, Investigation was initiated and NCDHHS was notified via fax by Administrator at approximately 6:30PM.
Administrator immediately reported to NCDHHS after interviewing CNA #1 and CNA #2.

On 8/25/2023, Administrator notified resident's daughter.

B. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed:
On 8/28/2023, skin assessments were completed on all non-interviewable residents on resident #1 ' s unit (100 Hall). No other residents were identified.

On 8/28/2023, interviews were completed on all residents cognitively intact on Resident #1's unit (100 Hall). No other residents were identified.

On 8/28/2023, interviews were completed on residents cognitively intact on 100 Hall. No other residents were identified. Social Services Director completed interviews with alert and oriented residents with a BIMS (brief interview for mental

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status) of 12-15 which reflected residents to be cognitively intact. No one reported any abuse allegations. Residents on the skilled unit with a BIMS greater than 12 received education from the Social Services Director regarding abuse, neglect and exploitation and to report this to the Administrator immediately. Questions that were asked are as follow:

1. Do you feel afraid, or humiliated at any time here at the facility?
2. Has anyone said mean things to you?
3. Has anyone hit you or handled you roughly?
4. Has anyone made you feel uncomfortable or touched you inappropriately?
5. Have you seen or heard of any residents being treated like the above mentioned?

C. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future?

On 8/25/2023, Director of Nursing/Designee started verbal education, to include Dietary, Housekeeping, Therapy, Maintenance, Licensed Nurses, Certified Nursing Assistants, all non-licensed administration personnel, including agency staff on the following: reporting Abuse, Neglect and Exploitation. The facility will not tolerate abuse, neglect, and mistreatment, exploitation of residents and misappropriation of resident's property by anyone. The abuse policy includes the following: Protection of the Resident and Reporting. The abuse policy was included in staff re-education. Facility lesson plan that was delivered included Stopping when a Resident Says Stop, and Protecting Residents from Abuse. Staff were not allowed to work until education was received, which was provided by Charge Nurse and Director of Nursing. Education was directed

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to each individual department and whom they should report to including during off hours. All staff report up to their supervisor and if their supervisor is not available, report to Charge Nurse. Charge Nurse will contact the Abuse Coordinator. The Abuse Coordinator is the Administrator, contact numbers are posted throughout the facility. This education was completed on 8/28/2023.

On 8/28/2023, this education was added to the facility orientation program for all new hires. This includes any new agency staff. This education will be presented during orientation by the Director of Nursing/Designee. The NHA/Designee will track education 5 times weekly to ensure new staff, including agency staff do not work before receiving education.

D. Indicate how facility plans to monitor its performance to make sure that solution was achieved and sustained:
To monitor and maintain ongoing compliance starting on 8/28/2023 ,when the HR Director was notified, Human Resource Director/Designee will randomly interview 3 employees weekly x 12 weeks to ensure understanding of abuse/neglect/timely reporting/what to do if they witness or hear abuse, which includes ensuring the safety of residents, protection of residents, stopping the abuse, reporting immediately to NHA/supervisor.

The Administrator/Designee starting 8/28/2023, will be responsible to report results of all audits to the QAPI (Quality Assurance Performance Improvement) committee for review and revision monthly x 3 months or longer if deemed so by QAPI committee.

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F 600	Continued From page 13 Alleged Date of Compliance 8/30/23 Validation of the past non-compliance immediate jeopardy corrective action plan was conducted in the facility on 09/13/23. Interviews with alert and oriented residents were reviewed with no concerns noted. Skin assessments of cognitively impaired residents were reviewed with no concerns noted. The education plan conducted along with staff signature sheets to verify completion and understanding of the education were reviewed with no concerns. The education plan included the different types of abuse. The abuse education was verified to be included in the new hire orientation for staff and was included in the orientation for agency staff utilized at the facility. Audits of care were reviewed with no concerns. The staff interviewed were able to verbalize the educational points of recognizing abuse. The corrective action plan was validated for past non-compliance effective 08/30/23.	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	F 607		

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F 607	Continued From page 14 paragraph §483.95, §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 record review, and resident and staff interviews, the facility failed to follow their abuse policy for protection and reporting. Nurse Aide (NA) #2 failed to protect the resident from further abuse and immediately report abuse to the Administrator. This deficient practice affected one of one resident reviewed for abuse (Resident #1). The findings included: A review of the facility policy and procedure titled "North Carolina Resident Abuse", with a revised date of 10/03/22 read in part "facility staff must immediately report all such allegations to the Administrator/ Abuse Coordinator. The Administrator/ Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the	F 607	Past noncompliance: no plan of correction required.	

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procedures in this policy." In the section "Protect the Resident," the policy read in part, "If the resident is injured as a result of the alleged or suspected incident, the facility should take immediate action to treat the resident. A.) staff should report all incidents immediately to their direct supervisor."

Resident #1 was originally admitted to the facility on 01/20/17 with diagnoses which included muscle weakness, hypertension, lack of coordination, and renal failure.

Diagnoses further revealed Resident #1 had a fracture to the right tibia dated 06/30/23 with orders to wear a brace.

The quarterly Minimum Data Set (MDS) dated 08/18/23 revealed Resident #1 was cognitively intact.

Review of the facility initial allegation report dated 08/25/23 revealed on 08/25/23 at 5:50 PM Resident #1 stated to the MDS Coordinator NA #1 hit her on the right side of the temple.

An interview conducted with Resident #1 on 09/07/23 at 11:50 AM revealed on 08/25/23 NA #1 and NA #2 assisted her into the bed and NA #1 was being rough and hurting her. Resident #1 further revealed she stated to NA #1 "honey, you are hurting me". Resident #1 stated NA #1 pushed on her hurt right leg and stated she was the caregiver and was going to do what she wanted. Resident #1 further revealed she started to cry and was scared so she started to slap NA #1 to get her off and asked her to leave. Resident #1 revealed NA #1 took both her hands and held them to her chest and eventually let go. Resident

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#1 indicated she did not recall if she received care or not because she was so upset. Resident #1 indicted NA #2 did not say anything or intervene until NA #1 had left the room.

A phone interview with NA #1 on 09/07/23 at 10:20 AM revealed on 08/25/23 NA #1 entered Resident #1's room with NA #2 around 1:30 PM after the resident had returned from dialysis. NA #1 indicated Resident #1 indicated she was tired and wanted to be put into bed. NA #1 further revealed they used a mechanical lift and assisted Resident #1 into bed. NA #1 revealed she got Resident #1 into her bed and started to remove her leg brace on her right leg to assist with care and Resident #1 stated "to get out and leave me alone." NA #1 revealed Resident #1 began to strike at her and she grabbed her right hand and held it down on her chest. NA #1 indicated Resident #1 continued to state, "leave me alone and get out." NA #1 revealed she let go of Resident #1's right hand and the resident began to hit NA #1 with a balled fist. NA #1 indicated she grabbed Resident #1's right arm again and held it down to her chest to restrain her from hitting her. NA #1 further revealed she continued to care for the resident by taking off her right brace and pants. NA #1 indicated Resident #1 complained about her right leg brace being removed. NA #1 indicated Resident #1 was dry and left the room with NA #2. NA #1 indicated she reported Resident #1's behaviors of hitting to Nurse #1 and Nurse #1 indicated she would report it to upper management on Monday. NA #1 revealed she continued to work on the floor until about 5:50 PM and reported to the MDS Coordinator Resident #1 had shown aggressive behaviors towards NA #1. NA #1 indicated she felt like an upper management staff should be advised of Resident

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#1's aggressive behaviors. NA #1 indicated shortly after speaking to the MDS Coordinator she was pulled into the conference room and was suspended for further investigation and was not allowed back in the facility. NA #1 indicated Resident #1 was not normally aggressive and does not feel like she was restraining her. NA #1 stated she had been educated to walk away if a resident became aggressive or combative but felt like she needed to complete Resident #1's care before leaving the room even though the resident had asked her to leave.

An interview with NA #2 on 09/07/23 at 10:35 AM revealed on 08/25/23 after lunch she assisted NA #1 with Resident #1 into getting into bed. NA #2 further revealed while lifting Resident #1 in the mechanical lift Resident #1 started to complain the lift was hurting her leg and wanted to be put down. NA #2 indicated NA #1 stated she was not putting the resident back down because the resident wanted to get back in the bed. NA #2 and NA #1 got Resident #1 into the bed and Resident #1 stated to NA #1, "you are hurting me, and I want you to get out of my room,." NA #1 stated, "I am not going anywhere because I am your caretaker." NA #2 revealed Resident #1 became more agitated and started to slap NA #1 and NA #1 slapped Resident #1's right hand out of the way and pushed on Residents #1's right fractured tibia that was in a brace. NA #2 indicated Resident #1 began to cry in pain and stated again for NA #1 to get out of her room. NA #2 revealed Resident #1 began to hit again at NA #1 and NA #1 took both hands and held them to her chest. NA #2 stated Resident #1 was very upset and continued to tell NA #1 to get out of her room. NA #2 indicated she pushed NA #1 off Resident #1 and told NA #1 to get out of the room

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immediately. NA #2 indicated NA #1 stated "she wasn't going any damn where that she was caring for the resident." NA #2 stated she told her to leave again, and NA #1 left the room mad. NA #2 revealed she stayed in the room with Resident #1 to calm her down and to complete care of the resident. NA #2 indicated she did not report to anybody once she left the room because therapy needed her to assist with another resident. NA #2 revealed she identified that NA #1 was being abusive towards Resident #1 and NA #1 had continued to work on the floor until later in the evening around 6:00 PM. NA #2 indicated Resident #1 was rarely aggressive and regrets not intervening sooner. NA #2 stated she was educated to walk away from residents if residents are aggressive or combative and to report abuse to upper management immediately.

An interview conducted with the MDS Coordinator dated 09/07/23 at 12:00 PM revealed on 08/25/23 at 5:50 PM she was about to leave, and NA #1 stopped her and indicated Resident #1 was having aggressive behaviors. The MDS coordinator further revealed she went and spoke to Resident #1 and Resident #1 indicated NA #1 hit her right leg and temple and had hurt her. The MDS Coordinator stated Resident #1 had indicated NA #1 continued to be rough with her right leg and did not want her back in her room. The MDS coordinator revealed she contacted the Administrator and removed NA #1 off the floor immediately.

An interview conducted with Nurse #1 on 09/07/23 at 1:45 PM revealed on 08/25/23 after dinner she was completing a medication pass and observed Resident #1 looking at her strange and seemed to be scared. Resident #1 stated to

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Nurse #1 she wanted to make sure she was not NA #1 because NA #1 was rough with her and she didn't want NA #1 to take care of her. Nurse #1 further revealed nobody had reported to her the incident or Resident #1's behaviors. Nurse #1 revealed the MDS Coordinator came to the resident's room right after she had spoken to Resident #1.

An interview conducted with the Administrator on 09/07/23 at 4:30 PM revealed on 08/25/23 the MDS Coordinator called her about 6:30 PM and revealed Resident #1 reported NA #1 had hit her. The Administrator further revealed she instructed the MDS Coordinator to pull NA #1 off the floor immediately and came to the facility to complete an investigation. The Administrator revealed she received statements from all staff involved and interviewed Resident #1. The Administrator further revealed Resident #1 stated NA #1 had hurt her while putting her into the bed and had hit her right hand and leg. The Administrator indicated adult protective services, law enforcement, the state, and family were notified immediately. The Administrator indicated she completed a thorough investigation and completed in services, interviews with alert and oriented residents, skin audits with other residents, and started audits of care. The Administrator revealed nursing staff had been educated to walk away if a resident is being combative or aggressive. The Administrator further revealed NA #1 and NA #2 should have walked away from Resident #1 when she asked, and NA #2 should have reported immediately to upper management the concerns of abuse.

The Administrator was notified of immediate jeopardy on 09/08/23 at 9:00 AM.

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The facility submitted the following corrective action plan:

A. How corrective action will be accomplished for resident(s) found to have been affected:

On 8/25/2023 at approximately 5:50pm CNA (Certified Nursing Assistant) #1 informed the Nurse #1 (MDS Nurse) that Resident #1 had hit her. Nurse #1 immediately at approximately 5:50PM notified NHA (Nursing Home Administrator) and interviewed Resident #1, who stated that she did indeed hit CNA #1 because she (CNA #1) had hurt her leg and had hit her on her hand and her leg with an open hand. The incident occurred between 2:30pm-3:00pm.

On 8/25/2023 at around 6:25pm the Administrator interviewed Resident #1: Resident #1 indicated that CNA #1 and CNA #2 were transferring resident to bed, via mechanical lift and CNA #1 bumped Resident #1 foot on the foot board, which caused pain to her leg. Resident #1 stated she told CNA #1 to get out, but CNA #1 continued to take care of her, so Resident #1 hit CNA #1. Resident # 1 indicated when she hit CNA #1, CNA #1 in turn hit Resident #1 on her left side of waist and left leg. Resident #1 denied any injury or pain at that time.

On 8/25/2023, between 6:45-7:00pm, CNA #2 was interviewed by the Administrator. Administrator asked CNA #2 why she did not immediately report the abuse to Administrator. CNA #2 stated that she did not report right away because she was pulled away to help with another resident. After assisting other resident, CNA #2 stated she forgot to go back and report to

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charge nurse. Upon interview with Administrator CNA #2 was re-educated to immediately report abuse to the facility Abuse Coordinator, the Administrator.

On 8/25/2023, Nurse #1 removed CNA #1 from resident care area and placed her in the conference room between 6:00pm-6:05pm as soon as Administrator was made aware.

On 8/25/2023, at approximately 6:00PM alleged perpetrator CNA #1 and witness CNA #2 were suspended pending an investigation.

On 8/25/2023, staff working on the skilled unit were interviewed regarding abuse allegation, if they were aware of any abuse, neglect or exploitation of residents, or if they were aware of any concerns in this regard in the building at this time. Staff working on this unit (100 Hall) provided written statements regarding this allegation and day. All staff were educated regarding abuse allegation, if they were aware of any abuse, neglect or exploitation of residents, or if they were aware of any concerns.

On 8/25/2023, APS and the local Police Department were notified.

On 8/25/2023, Investigation was initiated and NCDHHS was notified via fax by Administrator at approximately 6:30PM.

Administrator immediately reported to NCDHHS after interviewing CNA #1 and CNA #2.

On 8/25/2023, Administrator notified resident's daughter.

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B. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed:
On 8/28/2023, skin assessments were completed on all non-interviewable residents on resident #1 ' s unit (100 Hall). No other residents were identified.

On 8/28/2023, interviews were completed on all residents cognitively intact on resident #1 ' s unit (100 Hall). No other residents were identified.

On 8/28/2023, interviews were completed on residents cognitively intact on 100 Hall. No other residents were identified. Social Services Director completed interviews with alert and oriented residents with a BIMS (brief interview for mental status) of 12-15 which reflected residents to be cognitively intact. No one reported any abuse allegations. Residents on the skilled unit with a BIMS greater than 12 received education from the Social Services Director regarding abuse, neglect and exploitation and to report this to the Administrator immediately. Questions that were asked are as follow:

1. Do you feel afraid, or humiliated at any time here at the facility?
2. Has anyone said mean things to you?
3. Has anyone hit you or handled you roughly?
4. Has anyone made you feel uncomfortable or touched you inappropriately?
5. Have you seen or heard of any residents being treated like the above mentioned?

C. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future?

On 8/25/2023, Director of Nursing/designee

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started verbal education, to include Dietary, Housekeeping, Therapy, Maintenance, Licensed Nurses, Certified Nursing Assistants, all non-licensed administration personnel, including agency staff on the following; reporting Abuse, Neglect and Exploitation. The facility will not tolerate abuse, neglect, and mistreatment, exploitation of residents and misappropriation of resident ' s property by anyone. The abuse policy includes the following: Protection of the Resident and Reporting. The abuse policy was included in staff re-education. Facility lesson plan that was delivered included Stopping when a Resident Says Stop, and Protecting Residents from Abuse. Staff were not allowed to work until education was received, which was provided by Charge nurse and Director of Nursing. Education was directed to each individual department and whom they should report to including during off hours. All staff report up to their supervisor and if their supervisor is not available, report to charge nurse. Charge Nurse will contact the Abuse Coordinator. The Abuse Coordinator is the Administrator, contact numbers are posted throughout the facility. This education was complete on 8/28/2023.

On 8/28/2023, this education was added to the facility orientation program for all new hires. This includes any new agency staff. This education will be presented during orientation by the Director of Nursing/designee. The NHA/designee will track education 5 times weekly to ensure new staff, including agency staff do not work before receiving education.

D. Indicate how facility plans to monitor its performance to make sure that solution are achieved and sustained:

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To monitor and maintain ongoing compliance starting on 8/28/2023, when the HR Director was notified, Human Resource Director/designee will randomly interview 3 employees weekly x 12 weeks to ensure understanding of abuse/neglect/timely reporting/what to do if they witness or hear abuse, which includes ensuring the safety of residents, protection of residents, stopping the abuse, reporting immediately to NHA/supervisor.

The Administrator/designee starting 8/28/2023, will be responsible to report results of all audits to the QAPI (Quality Assurance Performance Improvement) committee for review and revision monthly x 3 months or longer if deemed so by QAPI committee.

Alleged Date of Compliance 8/29/23

Validation of the past non-compliance immediate jeopardy plan of correction was conducted in the facility on 09/13/23. The facility's current Abuse Policy and Procedure was reviewed along with facility reported incidents in the last thirty (30) days to ensure timely reporting with no concerns noted. The education plan was reviewed along with staff signature sheets to verify completion and understanding of the education with no concerns. Interviews with staff across all departments and disciplines were conducted and staff were able to verbalize the steps they should take if they witness or suspect any type of abuse. The staff were able to verbalize they must first stop the abuse and stay with the resident providing protection from the abuse and then immediately report the abuse to the Administrator or on weekends to the Manager on Duty or Charge Nurse. The staff understood and were

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F 607	Continued From page 25 able to verbalize the perpetrator was to be placed on one-on-one supervision immediately for the protection of other residents. The education plan was verified to be part of the orientation program for all newly hired staff. The Administrator was able to verbalize her reporting requirements and time frames after becoming aware of any witnessed or suspected abuse in the facility. The plan of correction was validated for past non-compliance effective 08/29/23.	F 607		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, family member, visitor, and staff interviews, the facility failed to lower a resident's bed before leaving the resident alone after care for 1 of 3 residents reviewed for falls. Resident #3's bed was left in the high position and the resident rolled off the air mattress onto the floor and sustained a laceration to her right forehead measuring 3 centimeters (cm) by 1 millimeter (mm) that required 6 sutures to repair and an acute right comminuted (a bone that is broken in at least 2 places), non-displaced (broken bone that retains proper alignment) femoral neck fracture that was conservatively managed (no surgical intervention).	F 689	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. F689 Free From Accidents and Hazards It is the practice of this facility to maintain a safe and healthy environment for our residents. Gastonia Health and Rehab takes the care and services of our	10/4/23

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F 689	Continued From page 26 The findings included: Resident #3 was admitted to the facility on 04/25/23 and readmitted on 06/20/23 with diagnoses that included dementia, malnutrition, and aphasia. Review of Resident #3's significant change Minimum Data Set (MDS) assessment dated 07/18/23 revealed she was severely impaired cognitive skills for daily decision making and short-term and long-term memory problems. The MDS also revealed Resident #3 required extensive total assistance with all activities of daily living and impairment on both sides of her upper and lower extremities. Resident #3 had no falls since prior assessment dated 05/27/23. Review of Resident #3's care plan dated 07/30/23 revealed a focus area for the resident being at risk for falls characterized by a history of falls, injury and or multiple risk factors related to bladder and bowel incontinence, dementia, and impaired cognition. The interventions included educate resident/family regarding preventative fall interventions and safety devices as appropriate, implement preventative fall interventions and devices, maintain call bell within reach and educate resident to use call bell, maintain resident's needed items within reach, PT/OT/SLP to screen and treat as necessary per physician order and (effective 8/8/23) when resident is in bed and not receiving care, bed in low position. Review of the unwitnessed fall report written by Nurse #3 and Nurse #4 dated 08/07/23 revealed Resident #3 was found lying on the floor on her right side on the left side of the bed. The resident	F 689	residents very seriously. We strive to provide an environment that is free of accidents and hazards for our residents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 was repositioned in her bed during time of review. On 9/7/2023, a skin assessment and pain assessment were completed for Resident #1. Education was provided to CNAs and licensed nurses on the skilled unit regarding frequent rounding for turning/repositioning and monitoring of residents. On 9/7/2023 fall mats were added to left and right sides of Resident #1□s bed and Kardex and care plan were updated with immediate interventions. On 9/19/2023, bolsters were added to alternating pressure mattress of Resident #1□s bed. Resident #1□s Kardex and care plan were updated on 9/19/2023 to reflect updated fall interventions and devices. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: To identify like residents that have the potential to be affected by this deficient practice:	

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F 689	Continued From page 27 was unable to give a description as to how she had fallen out of bed. She was noted to have a gash in her forehead and a cool compress was applied to the gash. Vital signs were obtained and the physician and family were notified of the fall. An order was received to send the resident out to the hospital for evaluation and treatment. The predisposing factors included confusion (the resident was oriented to person only), gait imbalance and impaired memory. A head-to-toe assessment revealed pain at a level of 3 out of 10 for which the resident refused pain medication, respirations even and unlabored, apical pulse was 107 with regular rhythm and pedal pulses were present on the right and left. Review of witness statements attached to the facility's fall report revealed the fall was unwitnessed and the resident was seen on the floor by Visitor #1 who was there to see her family member. Visitor #1 immediately alerted Nurse #3 that the resident was on the floor and the nurse went in the room and assessed the resident and assisted in getting her back to bed via mechanical lift. The resident was sent out to the hospital via Emergency Medical Services (EMS). Review of an Intradisciplinary Department Team note revealed they had discussed Resident #3's fall on 08/07/23 and the intervention put into place was for her bed to be in low position when the resident was in bed. Review of the hospital records dated 08/07/23 revealed Resident #3 presented to the emergency department of the local hospital in stable condition with a 3 centimeter (cm) by 1 millimeter (mm) diagonal laceration to the right forehead which required 6 sutures. X-ray of her	F 689	On 9/7/2023, the ADON reviewed all residents on alternating pressure reducing mattress settings to ensure settings were accurate. On 9/22/2023 the Interdisciplinary Team reviewed all residents with falls in the last 30 days to ensure appropriate interventions were in place and accurately reflected on the Kardex and Care Plan. On 9/25/2023 the DON/designee completed a 100% audit of all current resident□s Kardex and care plans to ensure appropriate fall interventions are accurately reflected on the Kardex and Care Plans. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: To prevent this from happening again the DON/designee educated CNAs, and licensed staff, including agency staff, on frequent rounding on residents that require assist and residents on alternating pressure reducing mattresses to ensure proper air mattress settings, proper bed positioning to include bed in lowest position, and facility fall management program. Education also included accessing, reviewing and using Kardex/Care Plans to review bed mobility, positioning and interventions. This education was completed on 10/3/2023.	

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F 689	Continued From page 28 pelvis revealed an acute right femoral neck fracture and the computerized tomography (CT) scan of the pelvis revealed an acute right comminuted, non-displaced intertrochanteric fracture of the right hip. An orthopedic surgeon was consulted while the resident was in the emergency department and the surgeon and family member who was the responsible party made the decision not to treat the fracture surgically but to manage it conservatively with pain medication and follow up with orthopedics. The resident was returned on 08/08/23 to the facility with new orders for pain medication and to follow up with orthopedics in 1 to 2 weeks. A phone interview on 09/07/23 at 9:43 AM with Visitor #1 who had seen the resident on the floor revealed she came to the facility on 08/07/23 at 9:30 PM and was talking with Nurse #3 in the hallway and looked to her left and saw Resident #3 lying on the floor and stated she said to the nurse "oh my gosh you've got one down." Visitor #1 stated she noticed the bed was in a high position and the nurse immediately went into the room and yelled for assistance. Visitor #1 further stated she walked down to her family member's room and relieved NA #3 so she could assist the Nurse with Resident #3. A phone interview on 09/07/23 at 10:53 AM with NA #3 who was assigned to Resident #3 on the evening of her fall revealed she was in another resident's room providing assistance when Visitor #1 came in and relieved her and said Nurse #3 needed her in Resident #3's room. NA #3 stated she had been in Resident #3's room about 30 minutes earlier and had changed her brief and got her ready for bed. NA #3 further stated she couldn't remember what position her bed was in	F 689	This education will be added to the facility orientation program for new hires, including agency staff. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., The Director of Nursing/Designee will randomly audit 10 residents weekly x 12 weeks to validate that interventions and devices are accurate per Kardex/Care Plans. The Director of Nursing/Designee will randomly interview 3 staff nursing staff members weekly for 12 weeks on location and utilization of resident fall intervention care plan and Kardex. The Director of Nursing/Designee will randomly audit mattress settings for 3 residents weekly x 12 weeks to ensure settings are appropriate and accurate. The Director of Nursing/Designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance. By what date the systemic changes will be completed: Compliance Date: October 4, 2023.	

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when she left the room. She indicated she was not sure how the resident fell out of bed but had a sheet on her air mattress and that along with the air mattress could have attributed to her fall. NA #3 stated she was aware the resident's bed was now supposed to be in low position when in the bed and she was supposed to be positioned in the center of the bed with fall mats placed on either side of the bed. NA #3 stated all staff had been in-serviced on the resident's positioning after her fall.

A phone interview on 09/07/23 at 12:15 PM with Nurse #3 who was assigned to Resident #3 on the evening of her fall revealed when she was alerted by Visitor #1 and went into Resident #3's room she found her lying on the floor on her right side on the left side of her bed. Nurse #3 stated Resident #3 had a gash in her forehead where she had hit the floor or hit something on the way down to the floor. She further stated NA #3 and NA #6 had just been in her room to change her and get her ready for bed. Nurse #3 said she thought NA #3 and NA #6 had positioned the resident too close to the edge of her bed and felt like she either wiggled or the air mattress forced her off the bed. She indicated when she went into the room the bed was not in a low position but was in a higher position for the NAs to change her brief. Nurse #3 further indicated Resident #3 was sent out to the hospital because she had a deep gash in her forehead and they later learned she had broken her hip with the fall. Nurse #3 stated she had been in-serviced after the fall about positioning the resident in the center of the bed and putting her bed in low position when she was in bed and placing fall mats down on either side of the bed.

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Several attempts were made to contact Nurse #4 without success.

Several attempts were made to contact NA #6 without success.

An interview on 09/07/23 at 2:34 PM with the Assistant Director of Nursing (ADON) revealed she was familiar with Resident #3's fall. She stated the resident was found lying on her right side on the left side of the bed. The ADON further stated she felt like the resident had been positioned too close to the edge of the bed and either through her movement in the bed or movement of the air mattress, the resident fell out of bed. She indicated Resident #3 was able to move some in bed and able to straighten one of her legs out and wiggle in the bed. The ADON indicated the interventions put into place following Resident #3's fall were to make sure the air mattress was on the right setting, bed in low position when Resident #3 was in the bed and make sure resident is positioned in the center of the bed and fall mats placed on either side of the bed.

A phone interview on 09/07/23 at 3:00 PM with the former Director of Nursing (DON) revealed she recalled Resident #3's fall and said she came in the following day and the only conclusions she came to was the sheet on the air mattress and the Resident being positioned too far to the edge of the bed caused her fall or the air mattress settings along with the sheet on the mattress caused her to fall. The former DON stated the resident did move sometimes in the bed and either a positioning problem or problem with the air mattress settings had attributed to her fall. She further stated the resident was able to move

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some in the bed and was able to straighten out one of her legs and either by doing that or movement from the air mattress she had fallen out of the bed. The former DON explained she had completed a 4-step fall with fracture plan and had in serviced all NAs, Patient Care Assistants (PCAs) and licensed staff on positioning of the resident and her bed and had completed monitoring of residents with fall precautions in place. She stated when she left her position at the facility the monitoring was to continue with the ADON.

A phone interview on 09/07/23 with Resident #3's family member and responsible party revealed she had visited Resident #3 on Monday, 09/04/23 at 2:45 PM and she found her in the bed and the bed was in waist high position and the resident was not positioned in the center of the bed but was again positioned on the edge of the bed. The family member stated she told NA #4 who was assigned to the resident but said the bed remained in the same position during her visit. The family member stated she then went to the Administrator with her concerns of the staff not positioning the resident correctly while in bed because she was afraid of her falling out of bed again. She further stated the Administrator told her she would re-educate the staff.

A phone interview on 09/11/23 at 11:57 AM with NA #4 revealed he had been assigned to care for the resident on 09/04/23 during the 7:00 AM to 3:00 PM shift. NA #4 did not recall what position the bed was in on that day but said typically the bed was to the floor when the resident was in the bed. He stated Resident #3 leans to the left when in bed and usually ends up on the edge of the bed from leaning. NA #4 further stated he

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typically raises her bed to change her but makes sure it is lowered before leaving the room but said he could not recall the position of the bed on 09/04/23. NA #4 stated all the staff had been in serviced on positioning the resident in the middle of the bed and ensuring her bed was in low position when she was in the bed.

Observation of Resident #3 on 09/07/23 at 9:30 AM revealed resident lying on her left side on the edge of the left side of her bed with half of her pillow hanging off the bed. The resident had her eyes closed with her covers pulled up over her and her air mattress on. Her bed was noted to be in waist high position and was not in low position (close to the floor) as indicated in her care plan. There were no staff in the room at the time providing care.

An interview on 09/07/23 with NA #5 who was assigned to Resident #3 on the 7:00 AM to 3:00 PM shift revealed the only time she raised the resident's bed was when she fed the resident in her room or when changing her brief. She stated she always tried to put the resident's bed back down before leaving the room but must have forgotten to do that today after feeding her. NA #5 further stated she knew the bed was supposed to be in low position when the resident was in it and the resident positioned in the middle of her bed. She said they had been in serviced on positioning of the bed and the patient after her fall.

A phone interview on 09/11/23 at 3:57 PM with NA #2 revealed she had not been assigned to Resident #3 on 09/07/23 but had lowered the resident's bed to the floor and placed the fall mats

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on either side of her bed. She stated when she had gone into the room the bed was in waist high position and the fall mats were not at her bedside so she lowered the bed and placed the fall mats down. NA #2 stated they had been in serviced more than once regarding the resident's bed being in low position while she was in it and her being positioned in the middle of the bed with fall mats on either side of her bed. NA #2 stated the resident was able to move one of her legs and tended to lean to her left side while in bed and often wiggled over to the edge of the left side of her bed.

An interview on 09/07/23 at 4:58 PM with the Administrator revealed she had talked with Resident #3's family member after her visit on 09/04/23 and her concerns about Resident #3 still not being positioned correctly in bed. The Administrator stated that she, the DON and the ADON had met with the family member and assured her they would re-educate staff about the bed being positioned low when the resident was in bed and the resident being positioned in the center of the bed. The Administrator was made aware of the observation made earlier in the day on 09/07/23 of the resident still not being positioned in the center of the bed and the bed not being positioned in low position and she stated they would have to do more one-on-one education with the staff.

Review of a 4-step fall with fracture plan (a 4-step plan including assessment of the fall, identification of other vulnerable residents, interventions to prevent fall from happening again and monitoring for ongoing compliance) dated 08/08/23 revealed on 08/07/23 a head to toe

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assessment, pain assessment, fall assessment were all completed, the Medical Director (MD) and responsible party for the resident were notified of the fall and an order received to transfer the resident to the hospital for evaluation and treatment. Residents with the potential to be affected were identified by the Director of Nursing (DON)/Designee and all residents were reviewed to ensure the care needs were reflected accurately on the Kardex and care plans with a completion date of 08/14/23. To prevent this from happening again the DON/Designee educated Nurse Aides (NAs), Patient Care Assistants (PCAs) and licensed staff on positioning of residents in bed, managing settings on the air mattress and making sure the settings are correct on the air mattress. The staff was also shown how to find the Kardex information on the kiosk and this education will be presented to new staff in the new hire orientation. This education was completed on 08/14/23. To monitor and maintain ongoing compliance the DON/Designee completed an observation audit weekly for 4 weeks then monthly for 2 months to ensure that residents were being cared for appropriately per the plan of care and the results will be presented to the QAPI committee for review and revisions as needed. The audits attached were reviewed with no concerns except Resident #3 was not included in the audits each week and month. The compliance date for the plan was 08/14/23.

This was determined not to be past non-compliance because the resident was observed on 09/07/23 in the bed with the bed in waist high position and the resident was observed on the edge of the bed with her pillow hanging halfway off the bed instead of being positioned in the middle of the bed. During the observation

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F 689	Continued From page 35 there was no staff member in the room with Resident #3. NA #5 was assigned to Resident #3 on 09/07/23 and stated she had been educated to lower the bed after providing care and had forgotten to do so before she left the room. Review of the auditing tools for the 4-step action plan revealed Resident #3 was not consistently included in the weekly and monthly. As a result, the facility remains out of compliance for supervision to prevent accidents.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews, the facility failed to follow a	F 692	F692 Nutrition/Hydration Status Maintenance	10/4/23

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F 692	Continued From page 36 physician order for a nutritional supplement for 1 of 3 sampled residents reviewed for nutrition (Resident #2). The findings included: 1. Resident #2 was admitted to the facility on 08/18/22. A care plan dated 05/25/23 had a focus area for increased nutrition/hydration due to poor by mouth intake. The goal was for the resident to be adequately nourished within limits of her end stage illness. Interventions included providing supplements per order. An annual Minimum Data Set dated 08/17/23 revealed Resident #2 was cognitively intact. The resident was coded as receiving a therapeutic diet. Resident #2 was not coded for weight loss or weight gain. A Physician order dated 12/01/22 read, "Nutritional supplement three times a day 90 milliliters three times daily, offer non-vanilla flavor, unable to swallow vanilla". Resident #2's Medication Administration Record (MAR) dated September 2023 revealed a physician order dated 12/01/22 which read, "Nutritional supplement three times a day 90 milliliters three times daily, offer non-vanilla flavor, unable to swallow vanilla". The order was listed for 9:00 AM, 1:00 PM and 5:00 PM. On 09/07/23 Nurse #2 documented she had administered the supplement to Resident #2 at 9:00 and 1:00 PM. An observation was conducted on 09/07/23 at 11:31 AM of the 100-hall nourishment room. The	F 692	Immediate Action Nurse #1 educated on September 7, 2023 by Unit Coordinator on Nourishments/Supplements Policy and Medication Skills Administration Checklist was completed. Resident #2 hydration/supplement orders were reviewed and validated by physician without any new orders. Identification of Others All residents are at risk for the deficient practice. On September 25, 2023, The Regional Nurse Consultant completed an audit on all supplement orders to identify any residents that were not receiving supplements with medication pass per order. No other issues noted. Systemic Change To prevent this from happening again the DON/Designee educated all Licensed Nurses, including agency Licensed Staff and dietary staff on facility Nourishment/Supplement and Hydration policy to include offering supplements per MD orders, offering a variety of flavors depending on resident preferences and nutritional/diagnosis considerations. This education was completed on 10/3/2023. This education will be added to the facility orientation program for new hires, including agency staff.	

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F 692	Continued From page 37 observation revealed 3 vanilla flavored nutritional supplement drinks in the refrigerator. On 09/07/23 at 10:16 AM an interview was conducted with Resident #2. She stated she did not receive her morning nutritional supplement because Nurse #1 had not asked. The interview revealed she did not like the vanilla flavor the facility often provided and that was all the nurses had been offering to her. She stated she would like to try the chocolate or strawberry flavor. She stated staff had not asked her to try another flavor they just assumed because she did not like vanilla that she would refuse for the day. On 09/07/23 at 3:24 PM an interview was conducted with the Dietary Manager. During the interview she stated the facility had several different flavors of nutritional supplements such as strawberry, chocolate and vanilla. She stated the supplements were provided to the residents by the nurses on the hall unless specified on the dietary card. The Dietary Manager reviewed Resident #2's dietary card and stated the kitchen did not send her supplement out with the meal tray, the nurses on the hall provided it to her. On 09/07/23 at 3:45 PM an interview was conducted with Nurse #2. During the interview she stated she knew Resident #2 had orders for a Nutritional Supplement but was in a hurry and did not give it to her at 9:00 AM or 1:00 PM and the documentation on the MAR was an error. Nurse #2 stated she thought that vanilla was the only flavor in the facility anyway and Resident #2 often refused. The interview revealed Nurse #2 had not asked Resident #2 if she would like to try another flavor or if she wanted to take her supplement on 09/07/23.	F 692	Monitoring The Dietary Manager/designee will audit nourishment rooms weekly x12 weeks to ensure multiple flavors of house supplements are available per resident□s preference. The DON/Designee will audit 5 residents with supplement orders during medication pass weekly x12 weeks to ensure residents are receiving house supplements per order and resident□s preference, and medication administration record is completed accurately. The DON/Designee will review supplement orders weekly x12 weeks during resident review to validate any changes and ensure Registered Dietitian is aware. The Director of Nursing/Designee and Dietary Manager/Designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance. Compliance Date: October 4, 2023.	

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F 692	Continued From page 38	F 692		

On 09/07/23 at 4:09 PM an interview was conducted with the Registered Dietitian (RD). She stated she normally prescribed a nutritional supplement to residents that she felt needed additional calories in between meals. The interview revealed she wanted the nurses on the halls to provide the residents with the supplemental drinks she ordered to ensure the residents did not have a weight loss. The RD stated Resident #2's weight was between 97 pounds to 103 pounds, and she wanted her to maintain that weight. She stated she was unaware the resident had not been receiving the nutritional supplement as ordered.

On 09/07/23 at 5:10 PM an interview was conducted with the Administrator. She stated Nurse #2 should have given the resident the supplement as ordered or at least have asked if she wanted to take it for the day. She stated since the last survey this concern was in the plan of correction book assigned for the Assistant Director of Nursing (ADON) to ensure an audit was conducted weekly. She stated she did not know how the problem was still occurring.

On 09/07/23 at 5:30 PM an interview was conducted with the Assistant Director of Nursing (ADON). During the interview she stated she had been conducting weekly audits of nurses on the medication cart administering nutritional supplements. She stated she knew Resident #2 had not received her nutritional supplement on several days and thought the only flavor of the nutritional supplement the facility had was vanilla. The ADON stated she didn't know she could go to the kitchen and get another flavor per the resident's request.

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F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.	F 867		10/4/23

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F 867	Continued From page 40 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the	F 867		

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F 867	Continued From page 41 facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place	F 867	F867 The Administrator has been reeducated by the Regional Director of Clinical Services concerning the policy Quality	

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F 867	Continued From page 42 following the recertification and complaint investigation surveys that occurred on 02/17/22 and 07/12/23. This failure was for two deficiencies that were originally cited in the areas of Nutrition/Hydration Status Maintenance (F692) and Infection Prevention and Control (F880) and were subsequently recited on the current complaint investigation and revisit survey of 09/13/23. The repeat deficiencies during multiple surveys of record show a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: F692: Based on observations, record review, resident, and staff interviews, the facility failed to follow a physician order for a nutritional supplement for 1 of 3 sampled residents reviewed for nutrition (Resident #2). During the recertification and complaint investigation survey conducted on 07/12/23, the facility failed to follow a physician's order for a nutritional supplement for a Hospice resident and provide the supplement in the flavor that the resident preferred and could swallow for 1 out of 1 resident. F880: Based on observations, record reviews, and staff interviews, the facility failed to follow their COVID-19 Testing Guidance within their Policy and Procedure when the staff failed to provide testing of residents and staff after a positive COVID-19 test was obtained on a symptomatic resident (Resident #5) on 09/02/23 at 1:30 AM.	F 867	Assurance and Performance Improvement (QAPI) Program. Completed on 9/28/2023 The facility will hold monthly meetings, utilizing the company□s standard QAPI format to review plans for areas identified in state surveys, mock surveys, facility audits, regional team visits, concern form reviews and any other feedback given to the facility. The committee will evaluate the effectiveness of each plan based on the monitoring feedback and decide if there needs to be a continuation, changed or resolution of the plans. This will include Infection Control and Nutrition/Hydration/Supplements. The meeting minutes will be reviewed by the Regional Vice President of Operations or Regional Director of Clinical Services monthly x3 months and will update or make changes as needed. The Administrator is responsible for this plan of correction. Compliance date is 10/4/2023	

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F 867	Continued From page 43 During the recertification and complaint investigation survey conducted on 02/17/22 the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 when staff members working on the 100-hall failed to wear eye protective gear while providing care to residents for 5 out of 10 staff members. During an interview on 09/07/23 at 4:58 PM with the Administrator, she reported her quality assurance (QA) team met monthly and included the Medical Director, department heads, administrative staff, the Nurse Practitioner, and the Regional Dietician and Pharmacist by phone. She reported they currently had Process Improvement Plans (PIPs) addressing the deficiencies of the previous complaint investigations and recertification surveys and had made significant changes but still had work to be done. She further reported they were currently working on PIPs on recruitment and retention to hire their own staff instead of relying on agency staff which would help alleviate some of the issues they were having with nursing, PIP on nutritional supplements which they would need to implement a more significant focus on going forward and infection prevention and control which would need more focused approach. She stated they had hired a new Director of Nursing that would be starting on 09/25/23 and they were sending the Assistant Director of Nursing to SPICE training in November of this year. The Administrator further stated the PIPs in place would be ongoing and monitored extensively to ensure ongoing and future compliance.	F 867		
F 880 SS=E	Infection Prevention & Control	F 880		10/4/23

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F 880	Continued From page 44 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 45 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to follow their COVID-19 Testing Guidance within their Policy and Procedure when the staff failed to provide testing of residents and staff after a positive COVID-19 test was obtained on a symptomatic resident (Resident #5) on 09/02/23 at 1:30 AM. The findings included:	F 880	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. F880-Infection Control	

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F 880	Continued From page 46 Review of the facility's "COVID Testing Guidance" under section "Testing Summary" - under the column "Testing Trigger - newly identified COVID-19 positive staff or resident in a facility that is unable to identify close contacts/Broad Based approach." Under the column "Staff/Healthcare Personnel (HCP)", the guidance read, "Test all staff, regardless of vaccination status, facility-wide or at a group level if staff are assigned to a specific location where the new case occurred (e.g., unit, floor, or other specific area(s) of the facility). If negative, test again 48 hours later, and if negative 48 hours after the second test. In general, testing should continue every 3-7 days until 14 days have passed without any new cases." Under the column "Residents," the guidance read, "Test all residents, regardless of vaccination status, facility-wide or at a group level (e.g., unit, floor, or other specific area(s) of the facility). If negative, test again 48 hours later and, if negative, 48 hours after the second test. In general, testing should continue every 3-7 days until 14 days have passed without any new cases." The Administrator stated on 09/07/23 at 8:45 AM there was one positive case of COVID-19 in the building and the resident remained on transmission-based contact precautions. She further stated Resident #5 had tested positive after exhibiting symptoms of cough and congestion and the test was completed on 09/02/23 at 1:30 AM. The Administrator indicated Resident #5's roommate - Resident #6 had been tested but her results were negative. Observation on 09/07/23 at 09:45 AM of Resident #5's room revealed signage on the door indicating Transmission Based Contact Precautions and	F 880	It is the practice of this facility to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #5 and Resident #6 were assessed on 9/7/2023 by Licensed Nurses. No issues noted related to COVID-19. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. On 9/8/2023, all residents on Hall 2 were tested for COVID-19, all test results were negative. No current residents were affected by this deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: To prevent this from happening again, the	

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F 880	Continued From page 47 instructions for personal protective equipment (PPE) to be worn inside the room. A bin was observed outside the room with all needed PPE contained in the bin. Review of the vaccine status of staff revealed 50 of the 72 staff were fully vaccinated or 69%. Review of the vaccine status of residents revealed 27 of 45 residents were fully vaccinated or 60%. During a follow up interview on 09/07/23 at 5:15 PM with the Assistant Director of Nursing (ADON) who also served as the Infection Preventionist (IP) revealed the facility had only done testing on Resident #5 and Resident #6 for COVID-19. She stated they had not done contact tracing for Resident #5 and they had not done broad based testing of residents and staff because it was her understanding from her Regional Nurse Consultant, they only tested residents and staff that were exhibiting symptoms. The ADON/IP further stated she had not tested any of the residents or staff because none were exhibiting symptoms of COVID-19. She indicated she was aware of their COVID-19 Policy and Procedure but was following instruction from her Regional Nurse Consultant. During a follow-up phone interview on 09/08/23 at 11:45 AM with the ADON/IP information was requested regarding their COVID-19 guidance and specifically their testing guidance, test results for Residents #5 and #6. The ADON/IP again stated they still had not done contact tracing or broad-based testing of the residents and staff. Several attempts were made to interview the Nurse who had tested the two residents with no	F 880	Clinical Quality Specialist educated Administrator and the ADON/IP on the COVID-19 Testing Guidance for Staff and Residents facility policy, which included contact tracing and surveillance per CDC Guidelines. This education was completed on 9/8/2023. This education will be added to the facility orientation program for any new staff in facility Senior Leadership positions. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing/designee will audit contact tracing, surveillance and facility testing weekly x 12 weeks to ensure COVID-19 facility policy per CDC Guidelines is being followed. The Regional Director of Clinical Services will audit contact tracing, surveillance and facility testing monthly x 3 months to ensure COVID-19 facility policy per CDC Guidelines is being followed. The Director of Nursing/Designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance. Compliance date is 10/4/2023	

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F 880	Continued From page 48 success. During a follow-up phone interview on 09/08/23 at 12:00 PM with the Administrator and the Clinical Quality Specialist, explained the concern regarding infection control due to staff and residents not being tested after a symptomatic resident tested positive and contact tracing was not initiated. Referred them back to their testing guidance and once reviewed, they both agreed they should have done contact tracing or broad-based testing of the residents and staff. During a phone interview on 09/11/23 at 10:58 AM with the Regional Nurse Consultant, he revealed he had not told the ADON/IP that she only had to test residents and staff who had symptoms once a COVID-19 positive result was obtained. He stated she had misunderstood initial testing with symptoms and testing after a positive test is obtained. He further stated he would talk with the ADON/IP and make sure she understood the testing guidelines outlined in their policy and procedure and they would immediately begin testing residents and staff.	F 880		