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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 9/25/23-9/26/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #H1LD11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 9/25/23-9/28/23. Event ID# H1LD11. The following intakes were investigated NC00196606, NC00202605, NC00206373 and NC00201749. 3 of the 7 complaint allegations resulted in deficiency.	F 000		
F 600 SS=D	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 record reviews, observations, resident, and staff interviews, the facility failed to protect a	F 600	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 10/19/2023

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resident's right to be free from abuse for 1 of 3 residents investigated for abuse from resident-to-resident sexual abuse (Resident #19).

The findings included:

Resident #19 was admitted to the facility on 9/13/2022 with diagnoses to include intellectual disability and hypertension.

A care plan dated 2/21/2023 addressed Resident #19's difficulty with communication related to his intellectual disability and included interventions to allow Resident #19 time to answer questions, and anticipate his needs, as he was not always able to express what he needed or wanted.

The quarterly Minimum Data Set (MDS) assessment dated 4/7/2023 assessed Resident #19 to be severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 5 out of 15. The MDS documented Resident #19 had no behaviors.

Resident #1 was admitted to the facility on 9/26/2018 with the most recent readmission date of 4/19/2023. Diagnoses for Resident #1 included bipolar disease, diabetes, and hypertension.

A quarterly MDS dated 2/26/2023 documented Resident #1 was cognitively intact with a BIMS of 15 out of 15. The MDS documented verbal behaviors occurred 1-3 days during the look-back period.
A nursing note dated 4/14/2023 at 11:35 AM documented that Resident #1 was observed with Resident #19. Resident #19 had his pants down and Resident #1 was observed with her hands in Resident #19's genital area. The immediate

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intervention separated the two residents and placed both residents on 1:1 supervision. The note documented Resident #1 was anxious, upset, and agitated, and was yelling at staff. The note documented the physician, and the family member/responsible party were notified of the incident and no new orders were received.

A nursing note dated 4/14/2023 at 11:40 AM documented that Resident #1 was tearful, and she refused a skin check by the nurse. The note documented the family member for Resident #1 returned the call and he reported Resident #1 "liked men and liked to be sexual, and she could get upset when she cannot." The note documented Resident #1 told the nurse, "Why are you trying to take my boyfriend away?"

A nursing progress note dated 4/14/2023 at 11:43 AM documented Resident #19 had experienced a sexual assault, and a head-to-toe assessment was completed.

A facility reported incident dated 4/14/2023 at 11:45 AM documented an incident where Resident #1 was observed fondling Resident #19 inappropriately. The report documented the police department had been notified of the incident on 4/14/2023 at 12:49 PM.

A nursing progress note dated 4/14/2023 at 11:45 AM documented Resident #19 had been observed with his pants down and with Resident #1's hands in his genital area. Immediate interventions included removing Resident #19 from the area and he was placed on 1:1 supervision. The note documented that Resident #19 was pleasant and cooperative and his physical assessment was within normal limits.

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The note documented that Resident #19's family/responsible party was notified of the occurrence and that Resident #19 was placed on 1:1 supervision. The note documented the physician was notified of the occurrence, and no new orders were received.

A nursing note dated 4/14/2023 at 1:58 PM further documented Resident #1's refusal to permit a skin assessment, but she finally consented to allow an assessment of her neck, breasts, chest, and abdomen. No issues were identified.

A nursing note dated 4/14/2023 at 3:57 PM documented Resident #1 continued to experience anxiety and was tearful and upset about not being able to talk to Resident #19. The note documented Resident #1 did not have an effective response to the scheduled antianxiety medication administered at 1:00 PM.

A care plan dated 4/14/2023 addressed Resident #1 having inappropriate sexual behavior, with interventions included to discuss her feelings and inappropriate sexual behaviors with more appropriate options, observe for changes in mental status and reinforce unacceptability of inappropriate behaviors with other residents.

A nursing note dated 4/15/2023 documented Resident #19 had no signs or symptoms of distress noted.

A nursing note dated 4/16/2023 documented that Resident #19 had no signs or symptoms of distress.

A psychiatry initial consultation dated 4/18/2023

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documented Resident #19 was evaluated with another staff member present for inappropriate sexual behaviors. The note documented Resident #19 was alert to name, and pleasant. Resident #19 was able to answer yes/no questions. The note documented Resident #19 had no behaviors since the incident and there was no need to adjust or change medications.

The facility 5-day investigative report dated 4/19/2023 documented on 4/14/2023 Resident #19 was found with his pants lowered and Resident #1 was observed removing her hands from his genital area. The report documented the police were notified of the incident, and Resident #19's responsible party was notified of the incident, and she did not want to press charges against Resident #1, but she did not want Resident #19 and Resident #1 to be around each other. Resident #19's responsible party was supportive of Resident #19 being moved to a facility that provided care for intellectually disabled adults. The report documented that an interview was conducted with Resident #19, and he reported he pulled down his pants because Resident #1 asked him. The report documented 100% staff education was provided on the abuse policy and 1:1 supervision was provided to both residents and would continue until either resident was placed (in another facility). A Quality Assessment Performance Improvement plan was developed and implemented.

An interdisciplinary team meeting (IDT) note dated 4/21/2023 documented the team met to discuss the incident between Resident #19 and Resident #1. The note documented Resident #19 was on 1:1 supervision during the time Resident #1 was in the building and the plans included

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seeking placement for Resident #19 in an adult care home for intellectually disabled adults.

A psychiatry progress note dated 4/18/2023 documented an evaluation of Resident #1 and when she was interviewed, she stated, "I understand why they separated us, but I don't agree." The progress note documented Resident #1 was stable on her current medications and no changes would be made to her medications.

A psychiatry progress note dated 5/16/2023 documented that no behaviors were reported for Resident #19, and he no longer required 1:1 care.

Resident #19 was observed on 9/25/2023 at 3:17 PM. Resident #19 was in the dining room attending an activity. Resident #1 was in the dining room at the same time. Multiple staff members were noted supervising the activity and the residents.

An observation of Resident #19 was conducted on 9/26/2023 in the activity room. Resident #19 was sitting at a table coloring pictures. Resident #1 was across the room. The activity director and the assistant activity director were supervising the residents. The Activity Director was interviewed at the time of the observation, and she reported the two residents were never to be left alone and were always supervised. The Activity Director reported she always had another staff member assist with activities to provide the supervision that was needed.

Resident #19 was observed on 9/27/2023 in the dining room for an activity. Two staff members were noted to be attendance supervising the residents. Resident #19 was sitting close to the

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TV watching a movie and Resident #1 was noted to be seated far behind Resident #19.

Resident #19 was observed on 9/28/2023 eating lunch alone at a table in the dining room. Resident #1 was not in the dining room. Several staff members were noted to be assisting residents with the lunch meal.

A phone call was made to Resident #19's family member on 9/25/2023 at 3:15 PM and the family member did not return the phone call.

During an attempt at an interview on 9/25/2023 at 3:17 PM, Resident #19 was unable to answer interview questions, but he did answer that "yes" he felt safe.

An interview was conducted with the Business Office Manager (BOM) on 9/27/2023 at 10:18 AM. The BOM reported she had witnessed the incident between Resident #19 and Resident #1. The BOM described that she looked to her left into the front sitting room as she was leaving the conference room and saw Resident #19 standing in front of Resident #1. The BOM reported Resident #19's pants were pulled down to his upper thighs, and Resident #1 was removing her hands from his genital area. The BOM explained she did not see Resident #1 touching Resident #19, nor did she see his exposed genitals. The BOM described that Resident #1 was sitting in a wheelchair with her back to the door to the sitting room, and the BOM reported she saw that Resident #19's pants were pulled down to his upper thighs. The BOM reported she called Resident #19's name and he looked up at her and appeared startled and quickly pulled his pants up over his hips. The BOM reported

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Resident #1 turned around in her wheelchair and she "had a big grin on her face." The BOM reported she had daily contact with both Resident #19 and Resident #1 and she had not witnessed any sexual behavior from either resident prior to this incident. The BOM explained that Resident #19 had no payor source, and the facility was awaiting Medicaid approval for them to make a referral to an adult care home for intellectually disabled adults. The BOM reported no facility would accept him without a payor source and the facility was providing room and board free of charge to Resident #19.

Nursing assistant (NA) #1 was interviewed on 9/27/2023 at 1:20 PM. NA #1 reported she had not observed any sexual behaviors from Resident #1 or Resident #19, either before or after the incident. NA #1 reported she provided supervision to Resident #19. NA #1 reported Resident #19 was never left alone with Resident #1.

An interview was conducted with NA #2 on 9/27/2023 at 1:40 PM. NA #2 reported Resident #19 and Resident #1 were always supervised and were not left alone. NA #2 explained she was on medical leave when the original incident occurred. NA #2 reported she had not observed Resident #1 exhibiting sexually inappropriate behaviors prior to the incident on 4/14/2023.

The Assistant Director of Nursing (ADON) was interviewed on 9/27/2023 at 2:35 PM. The ADON reported she was working on 4/14/2023 when the incident occurred between Resident #19 and Resident #1, but she had not witnessed the incident. The ADON explained they put 1:1 supervision in place for both residents as well as 30-minute checks. The ADON reported that the

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staff make certain Resident #19 and Resident #1 are never alone together.

An attempt was made to interview Nurse #1 who was on duty when the incident occurred, but she was not available.

Resident #1 was interviewed on 9/25/2023 at 11:07 AM. Resident #1 stated, "I can tell you they won't let me have a boyfriend!" Resident #1 declined to answer further questions other than to state that the facility staff would not "leave her and (Resident #19's name) alone, at all, ever."

The Assistant Director of Nursing (ADON) was interviewed on 9/27/2023 at 2:35 PM. The ADON reported she was working on 4/14/2023 when the incident occurred between Resident #19 and Resident #1, but she had not witnessed the incident. The ADON explained they put 1:1 supervision in place for both residents as well as 30-minute checks. The ADON reported that the staff made certain Resident #19 and Resident #1 were never alone together. The ADON reported she had not observed Resident #1 exhibiting sexually inappropriate behaviors prior to the incident on 4/14/2023.

Nurse #2 was interviewed on 9/28/2023 at 11:02 AM. Nurse #2 reported she had not observed Resident #1 exhibiting sexually inappropriate behaviors prior to the incident on 4/14/2023.

The Director of Nursing (DON) was interviewed on 9/28/2023 at 1:38 PM. The DON reported that the BOM called out as she was witnessing the incident between Resident #19 and Resident #1. The DON explained that the residents were immediately separated, and both had

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assessments, the police department was notified, as well as the Department of Social Services. The DON reported the facility put both residents under 1:1 supervision to prevent any further incidents. The DON reported the psychiatrist was consulted to evaluate Resident #19 and to see Resident #1.

The facility Quality Assessment and Performance Improvement Action Plan dated 4/14/2023 was reviewed. Included in the plan was immediate actions taken by the facility of separating the residents, performing head-to-toe assessments, notification of the family/responsible parties for both residents, putting both residents on 1:1 supervision, interviewing alert and oriented residents, performing 100% skin checks on all residents, auditing all care plans for residents with like care concerns or behaviors and making adjustments as needed, and interviewing family members/responsible parties for the residents with impaired cognition. The facility put into place audits to interview 10 cognitively intact residents per week for 4 weeks, then monthly for 2 months to identify any unreported incidents of abuse. Family interviews would be conducted on 7 cognitively impaired residents for 4 weeks and monthly for 2 months to identify any unreported incidents of abuse. Education was provided to all staff on 4/14/2023 and family members.

The Quality Assessment and Performance Improvement Plan was reviewed, and each intervention had corresponding documentation to support the actions. Monitoring and audits were completed on 10 cognitively intact residents per week for 4 weeks, and then monthly for 2 months. Family interviews for 7 cognitively impaired residents were conducted for 4 weeks

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F 600	Continued From page 10 and then monthly for 2 months. Staff were interviewed and they acknowledged they had received education on 4/14/2023 regarding the residents right to be free from abuse. NA #2 reported she was on medical leave and the facility called her to provide her the education over the phone. The facility's date of compliance of 7/1/2023 was validated.	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to protect resident's bank debit cards, checks and credit cards from being accessed and used without resident permission for 3 of 3 residents reviewed for misappropriation of personal bank accounts (Resident #2,Resident #18, and Resident #14). The findings included: Resident # 2 was admitted to the facility on 06/29/23 with diagnoses that included chronic pain. Review of a quarterly Minimum Data Set (MDS) assessment dated 10/26/23 revealed Resident # 2 had no cognitive impairment.	F 602	Past noncompliance: no plan of correction required.	

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Resident #18 was admitted to the facility on 01/23/23 with diagnoses that included cerebrovascular disease.

A quarterly MDS assessment dated 07/21/23 revealed Resident #18 had no cognitive impairment.

Resident #14 was readmitted to the facility on 05/26/23 with diagnoses that included polyneuropathy and epilepsy.

A review of a quarterly MDS assessment for Resident #14 revealed she had no cognitive impairment.

A facility reported incident dated 05/02/23 at 1:00 PM documented the Director of Nurses (DON) was notified by a Police Detective from another city that during a police investigation in the early hours of 05/02/23 banking items were discovered in the possession of an agency nurse that previously worked at the facility with names of three persons (Resident #2, Resident #18, and Resident #14). The DON confirmed the three residents did reside at the facility and was provided a verbal record of the financial items found. The DON immediately reported the information to the Administrator and a report was filed with the local police department at 2:00 PM on 05/02/23. Resident #2, Resident #18, and Resident #14 were interviewed on 05/02/23 by the Administrator and Director of Nursing (DON) about missing bank or credit cards or other financial activity on their accounts that might have been fraudulently made.

An interview was conducted with Resident #2 on

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09/25/23 at 10:55 AM. Resident #2 revealed the Administrator and DON informed her the facility received a police report that revealed random numbered bank checks with Resident #2's name on them had been discovered in the possession of an unknown person that may have worked at the facility in the past. Resident #2 went through her checkbook with the DON and discovered that some random unused bank checks were missing. The Administrator notified the bank for Resident #2 to report possible fraudulent activity on her account and to ensure the bank would continue to monitor the account. Resident #2 revealed that later that day a police officer came to talk to her and asked her if she recognized a lady in a photograph. Resident #2 revealed she told him she was not sure but thought the lady looked like a nurse that had taken care of her before and the police officer reported he believed they might have a video showing the lady trying to use one of the checks, but she was not able to do so. Resident #2 revealed no money was missing from her account and she was glad the facility informed her and did a good job investigating what happened because the nurse never came back again. Resident #2 revealed she was provided a lock box for her closet for her valuable items, and she kept the key on her person at all times. Resident #2 revealed she was safe at the facility and liked living there. Resident #2 revealed she had never given anyone permission to access her private bank account.

Resident #18 was interviewed on 09/25/23 at 11:23 AM. Resident #18 revealed he managed his own banking and checked his account balance almost daily. Resident #18 revealed a few days before 05/02/23, he noticed some unknown activity in his bank account but was not

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missing his debit card. He reported the activity to his bank , cancelled his debit card and ordered a new debit card. Resident #18 revealed there were maybe 3 or 4 charges that he did not make that totaled about $97.00 from a local grocery store and department store. Resident #18 revealed he never reported it to the facility because it was not their concern and he handled it. On 05/02/23 Resident #18 explained the DON and Administrator informed him that a police report was received by the facility, and it included store receipts with his name and bank account information on them. Resident #18 explained he had already identified the activity and informed the facility the steps he had already taken. The Administrator reimbursed him $100.00, and he was given a lockbox and key to keep his valuable items in. Resident #18 revealed that also on 05/02/23 a police officer came to his room to discuss the bank account activity information with him and was shown a photo of a young lady that he told the officer he did not recognize. Resident #18 explained that he felt safe and was appreciative of the facility and police involvement and investigations Resident #18 revealed he was private with his bank information and never shared it with anyone or gave permission to others to use his bank information.

Resident #14 was interviewed on 09/25/23 at 11:47 AM. Resident # 14 revealed her banking was done by her mother who was in possession of her checks and debit card. Resident #14 revealed she had a cash app card that had no money on it that she kept it in her wallet in her purse which she always carried and at night she covered her purse with the bed linens near her feet. Resident #14 revealed that she did not know the cash app card was missing until the DON

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came and asked her if she was missing a debit card or checks because a bank card was reportedly found in the possession of an agency nurse that had previously worked at the facility. Resident #14 revealed she opened her purse and wallet and did not find the cash app card. The DON assisted Resident #14 to search her room and they were not able to locate the cash app card. The Administrator and DON spoke to the mother of Resident #14 and confirmed the mother was in possession of the bank debit card of Resident #14 and the cash card had no funds available on it and she would contact the bank for Resident #14 and inform them of the ongoing investigation and have them monitor the bank account for fraudulent activity. Resident #14 revealed on the same day she was given a key and a lockbox from the facility to store her purse and other valuable items. Resident #14 revealed she felt safe at the facility, the facility had been informative and handled the situation very well which was calming to her and her mother both. Resident #14 denied giving anyone permission to access her bank account or the cash app card.

The facility 5-day investigation report dated 05/05/23 documented on 05/02/23 through 5/4/23. On 05/02/23 Resident #2, Resident #18, and Resident #14 were interviewed by the Administrator and Director of Nursing (DON) about missing bank, credit cards or other financial information that might have indicated fraudulent activity. The DON and Administrator interviewed 100% of cognitively intact residents and 100% of cognitively impaired residents family/RPs from 05/02/23 through 05/05/23 and educated them to monitor bank accounts, debit cards and credit card accounts for fraudulent activity, the facility offered to assist if needed making the calls or

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inquiries to these entities. Lockboxes with keys were offered to all residents and family/RPs by the facility and education was provided to report any suspicious or unusual behaviors observed to the Administrator, DON, or Social Worker immediately. The facility received no negative findings or concerns. 100 % of staff was re-educated on the abuse policy, types of abuse and reporting of abuse and any suspicious behaviors observed. A Quality Assessment Performance Improvement plan was implemented.

On 09/27/23 at 12:52 PM an interview with the DON was conducted and she presented documents for review that included the facility timecard of the nurse involved with a recorded last date and time the agency nurse worked at the facility a from 7:00 PM on 4/22/23 until 7:00 AM on 4/23/23. Other documents reviewed included a police report from the Police Department dated 05/02/23, a copy of the North Carolina Board of Nursing nurse license verification and a copy of abuse training received from the agency of hire signed and dated by the nurse on 9/14/22. The DON revealed that when the Detective spoke to her on 05/02/23 she immediately informed the Administrator, contacted the local police department, the physician, Adult Protective Services , the North Carolina Board of Nursing (NCBON) and the agency that employed the nurse. The DON reported she and the Administrator interviewed Resident #2, Resident #18, and Resident #14 and all 3 residents denied giving their bank debit card, cash cards or checks to anyone for use. The DON and Administrator interviewed 100% of alert and oriented residents and 100% of families/RPs of cognitively impaired residents No

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negative outcomes were reported. All residents, families/ RPs were offered a secured lockbox to store valuable items and banking documents in.

A phone interview conducted with the Police Department Detective on 09/27/23 at 1:36 PM revealed a person identified as a traveling nurse was found to be in possession of bank checks, bank debit cards and credit information that belonged to other people. The person of interest reported she had been given the items from residents with permission to use the items to make purchases requested by the residents. The Detective contacted the DON and she confirmed Resident #2, Resident #18, and Resident #14 resided at the facility and she would notify the Administrator, residents, and local police department immediately and begin a full facility investigation. The Detective confirmed he received calls from the agency that employed the nurse and a North Carolina Board of Nursing investigator for detailed information of the police investigation.

The Clinical Compliance Nurse Consultant of the agency that employed the nurse was interviewed via phone on 9/27/23 at 2:24 PM and revealed a report was received from the facility on 05/02/23 about the alleged incident involving a nurse employed by the agency. The DON requested a copy of the nurse license verification and most recent abuse training dated and signed by the nurse in question on 09/14/22. The Clinical Compliance Nurse Consultant revealed the DON informed the agency that the nurse was never to return to the facility, or any facility owned by the same corporation. The DON provided the contact information of the Detective and local police and after speaking to the Detective and conducting an

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investigation the agency mailed a termination of employment to the agency nurse effective 05/12/23.

The Clinical Compliance Nurse Consultant of the agency that employed the nurse was interviewed on 9/27/23 at 2:24 PM and revealed a report was received from the facility on 05/02/23 about the alleged incident involving a nurse employed by the agency. The DON requested a copy of the nurse license verification and most recent abuse training dated and signed by the nurse in question on 09/14/22. The Clinical Compliance Nurse Consultant revealed the DON informed the agency that the nurse was never to return to the facility, or any facility owned by the same corporation. The DON provided the contact information of the Detective and local police to the agency and after speaking to the detective and conducting an independent investigation the agency mailed a termination of employment to the nurse at the agency effective 05/12/23.

The Administrator was interviewed on 09/28/23 at 1:12 PM and revealed that the facility took immediate action when the report from the Detective was received on 05/02/23.The proper reports were made to all entities required, an investigation began, interviews and audits of 100% of all cognitively intact residents and 100% of cognitively impaired residents family/RPs was initiated on 05/02/23 through 05/05/23. The QAPI (Quality Assurance and Performance Improvement) committee met, and a Performance Improvement Plan (PIP) was put into place immediately.

The facility Quality Assessment and Performance Improvement Plan initiated 05/02/23 by the QAPI

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committee team was reviewed. The plan included immediate actions that began 05/02/23 and included actions taken by the facility of interviewing 100% of alert and oriented residents and notification of 100% of family/ RPs of cognitively impaired residents. Residents and RPs were offered and provided with secured lockboxes to store valuable items and bank information, the facility offered assistance to notify resident's banks and creditors to ensure accounts were being monitored for fraudulent activity. The facility put into place audits to interview 3 cognitively intact residents weekly for 12 week and 2 cognitively impaired resident's family/RPs weekly for 12 weeks to inquire if any fraudulent activity of their personal bank or credit card accounts was identified. Education was provided to all staff, residents, family/RPs from 05/02/23 through 05/05/23 related to abuse, neglect, exploitation and immediately reporting of abuse, or suspicious behaviors. New staff would receive training during orientation.

The Quality Assessment and Performance Improvement Plan was reviewed, each intervention had corresponding documentation to support the actions. Monitoring and audit tools were completed weekly for 3 cognitively intact residents and 2 cognitively impaired residents for 12 weeks. Residents were interviewed and revealed they felt safe at the facility and had no reports of identified fraudulent bank or credit card concerns. The DON and Administrator conducted education of all staff from 05/02/23 through 05/04/23 related to the abuse policy, reporting of abuse and suspicious behaviors. Staff were interviewed and revealed they received education about abuse, types of abuse, reporting abuse and suspicious behaviors immediately to

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F 602	Continued From page 19 the DON or Administrator. Staff reported they were not able to work until the education was received. Residents interviewed felt safe at the facility and had no fraudulent activity identified by their banks or credit card companies. The facility's date of compliance of 07/20/23 was validated.	F 602		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) assessments for 7 of 14 residents reviewed for MDS accuracy. Resident #14 was not coded for Level II Preadmission Screening and Resident Review (PASRR) and inaccurately coded for daily restraint use. Residents #8, #5, #9, #13, #1 and Resident #6 were also inaccurately coded for daily restraint use. Findings included: 1a.Resident #14 was readmitted to the facility on 5/18/23 with diagnoses that included epilepsy. Review of a comprehensive MDS assessment dated 5/25/23 revealed Resident #14 had no cognitive impairment and was noted as not coded for PASRR Level II at section A 1500 for Level II PASRR screening and Resident #14 was not coded at section A 1510 for Level II PASRR conditions as required by the RAI manual (Resident Assessment Instrument).	F 641	Tag F641-483.20 Accuracy of Assessments: Tag F641 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction, prepared and/or executed solely because it is required by the provisions of federal and state law. This plan of correction is the facilities allegation of compliance: As stated in Tag F641: 483.20 the facility failed to accurately code the Minimum Data Set (MDS) assessments for 7 of 14 residents reviewed for MDS accuracy. Resident #14 was not coded for Level II Preadmission Screening and Resident Review (PASRR) and inaccurately coded for daily restraint use. Residents #8, #5, #9, #13, #1 and Resident #6 were also inaccurately coded for daily restraint.	10/19/23

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F 641	Continued From page 20 A review of a PASRR Level II history detail report from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services revealed Resident #14 had been determined to require a Level II PASSR since 12/18/21. A letter dated 5/31/22 from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services to the facility revealed Resident #14 had been determined to require a Level II PASRR. A phone interview conducted with the MDS Nurse on 09/26/23 at 1:21 PM revealed she never saw Level II PASRR documents in Resident #14's medical record and did not know Resident #14 had been determined to be a PASRR Level II. The MDS Nurse revealed she believed the Social Worker coded the section related PASRR Level II on the comprehensive MDS assessments. The Social Worker was interviewed on 9/27/23 at 10:31 AM. The SW revealed she was not responsible to complete any part of Section A on any MDS assessment and she believed the MDS Nurse reviewed the medical record and coded section A based on Level II PASRR status located in the medical record. The Regional Clinical Reimbursement Specialist was interviewed on 9/27/23 at 2:06 PM and revealed the PASRR status of Resident #14 should have been coded on the comprehensive MDS assessment by the MDS Nurse and the	F 641	1. To identify residents that have the potential to be affected the Director of Nursing/ designee immediately reviewed all resident PASSAR's to ensure they were coded properly on the Minimum Data Set. Negative findings were corrected. To identify residents that have the potential to be affected the Director of Nursing/designee immediately reviewed all residents with bed rails to ensure proper use of bed rails was coded correctly on the Minimum Data Set. Negative findings were corrected. 2. To prevent this from happening again, on 10/16/23, the Regional Clinical Reimbursement Specialist completed education with the temporary Minimum Data Set Coordinator on accuracy of assessments, specifically related to PASSAR and bed rails. Maintenance Director completed 100% Audit of Beds with rails and recorded type. Designee completed 100% staff education to ensure rails are positioned appropriately to assist with bed mobility and promote independence completed on 10/02/23. On 10/06/23 the Administrator completed education with the Social Worker on accuracy of assessments, specifically related to PASSAR coding. Minimum Data Set Coordinator will be educated upon return from Leave of Absence. 3. To monitor and to maintain ongoing compliance the Regional Clinical Reimbursement Specialist/Designee will audit all submitted Minimum Data Set weekly for 4 weeks, then audit 4 Minimum	

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F 641	Continued From page 21 missed coding was likely an oversite by the MDS Nurse. 1.b. .Resident #14 was readmitted to the facility on 5/18/23 with diagnoses that included epilepsy, muscle weakness and right above the knee amputation. Review of a comprehensive MDS assessment dated 5/25/23 and the quarterly MDS assessment dated 8/30/23 revealed Resident #14 had no cognitive impairment and was coded at section P 0100. Physical Restraints. Section P 0100. A was coded that Resident #14 required bed rails daily. An observation of Resident #14's bed conducted on 09/25/23 at 12:50 PM revealed there were no bed rails on Resident #14's bed. A phone interview conducted with the MDS Nurse on 09/26/23 at 1:21 PM revealed she had been instructed by the Director of Nurses (DON) to code all bed rails as restraints. The MDS Nurse revealed she was not aware that Resident #14 did not have bed rails on her bed and likely coded the bed rails on both MDS assessments in error. The DON was interviewed on 9/26/23 at 3:23 PM. The DON revealed the facility had no restraints and bed rails were used to enable residents with mobility. The DON revealed she never instructed the MDS Nurse to code any bed rails as restraints on the MDS assessments and could not explain why restraints had been coded. 2.Resident #8 was admitted to the facility on 9/1/23 with diagnoses that included anxiety and dementia.	F 641	Data Set's per month for 2 months to ensure proper coding of PASSAR and Bed Rails. Audits will be reported to the administrator weekly for 4 weeks, then per month for 2 months. 4. The Administrator will report the results of the monitoring to the QPAI committee for review and recommendation for a Minimum of three months.	

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A review of an annual MDS assessment dated 8/22/23 revealed Resident #8 had short term and long-term memory deficits. Resident #8 was coded at section P 0100. Physical Restraints. Section P 0100 A was coded that Resident #8 required bed rails daily.

An observation conducted on 9/25/23 at 9:56 AM of Resident #8's bed revealed one grab bar in place to the left side of her bed.

A phone interview conducted with the MDS Nurse on 09/26/23 at 1:21 PM revealed she had been instructed by the Director of Nurses (DON) to code all bed rails as restraints. The MDS Nurse revealed she was not aware that Resident #8 did not have bed rails on her bed and likely coded the bed rails on both MDS assessments in error.

The DON was interviewed on 9/26/23 at 3:23 PM. The DON revealed the facility had no restraints and bed rails were used to enable residents with mobility. The DON revealed she never instructed the MDS Nurse to code any bed rails as restraints on the MDS assessments and could not explain why restraints had been coded.

3.Resident #5 was admitted to the facility on 4/28/22 with diagnoses that included anxiety.

A review of a quarterly MDS assessment dated 8/11/23 revealed Resident #5 had no cognitive impairment and was coded at section P 0100. Physical Restraints. Section P 0100. A was coded that Resident #5 required bed rails daily.

An observation of Resident #5 conducted on 9/25/23 at 10:29 AM revealed she had a quarter side rail in place on one side of her bed.

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A phone interview conducted with the MDS Nurse on 09/26/23 at 1:21 PM revealed she had been instructed by the Director of Nurses (DON) to code all bed rails as restraints. The MDS Nurse revealed she was not aware that Resident #14 did not have bed rails on her bed and likely coded the bed rails on both MDS assessments in error.

The DON was interviewed on 9/26/23 at 3:23 PM. The DON revealed the facility had no restraints and bed rails were used to enable residents with mobility. The DON revealed she never instructed the MDS Nurse to code any bed rails as restraints on the MDS assessments and could not explain why restraints had been coded.

Based on staff and resident interviews, observation, and record review, the facility failed to accurately code the quarterly Minimum Data Set in the area of restraints (Resident #s 9, and 13) and failed to accurately code the comprehensive Minimum Data Set in the area of restraints (Resident #s).

Findings included:

4. Resident #9 was admitted to the facility on 9/17/14 with the diagnosis of stroke.

A review of Resident #9's quarterly Minimum Data Set (MDS) dated 6/14/23 revealed the resident required assistance to transfer out of the bed and Section P A100 Restraint was coded 2 with bed rail used daily.
The corresponding care plan dated 6/14/23 documented Resident #9 had a quarter side rail

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for bed mobility as an enabler for self-movement in her bed.

On 9/26/23 at 2:30 pm the MDS Coordinator was interviewed. She stated that Resident #9's quarterly MDS dated 6/14/23 Section P A100 Restraint was coded for bed side rail as a restraint. She further stated that the Director of Nursing (DON) informed her to code the side rails as a restraint.

On 9/26/23 at 3:50 pm the DON was interviewed. The DON stated there were no restraints in the facility. The quarter side rails on the resident beds were for mobility only, they were not a restraint. The MDS Coordinator coded all residents with quarter side rails for their last MDS assessment in Section P as restraints in error. The quarter side rails were evaluated for each resident individually and used as an enabler for bed mobility. The DON further stated the staff used an informed consent form for side rail use. The resident or resident representative would be educated on the safe use and potential hazards and sign for consent of side rail use. None of the quarter side rails restrained a resident that can get out of bed to not be able to get out of bed. The DON further stated she was aware of the difference between a restraint and an enabler.

5. Resident #13 was admitted to the facility on 3/12/19 with the diagnosis of degeneration of the nervous system.

The 8/29/23 quarterly Minimum Data Set (MDS) for Resident #13 documented the resident required assistance to transfer out of the bed and Section P A100 Restraint was coded 2 with bed rail used daily.

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The corresponding care plan dated 8/29/23 documented Resident #13 had a quarter side rail for bed mobility as an enabler for self-movement in her bed.

On 9/26/23 at 2:30 pm the MDS Coordinator was interviewed. She stated that Resident #13's quarterly MDS dated 6/14/23 Section P A100 Restraint was coded for bed side rail as a restraint. She further stated that the Director of Nursing (DON) informed her to code the side rails as a restraint.

Interview of the DON 9/26/23 at 3:50 pm. The DON stated that there were no restraints in the facility. The quarter side rails were for mobility only, they were not a restraint. The resident would be evaluated for side rail use and then the resident or resident representative were educated and signed an informed consent form for use of bed rails. The care plan was for quarter side rails used as an enabler for mobility. None of the rails restrained a resident that can get out of bed to not be able to get out of bed. The DON stated and explained she was aware of the difference between a restraint and an enabler. The MDS was incorrectly coded as side rails were used as a restraint. There was a miscommunication with the MDS Coordinator. The DON further stated that the MDS coded and care plan do not match, one as a restrain and one as an enabler.

6. Resident #1 was readmitted to the facility on 4/19/2023 with diagnoses to include diabetes and hypertension.

The quarterly Minimum Data Set (MDS) assessment dated 6/30/2023 documented Resident #1 was cognitively intact, and she

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required extensive assistance for bed mobility and to transfer out of the bed. The MDS documented that bed rails were used daily as a restraint.

Resident #1 was observed on 9/25/2023 at 11:07 AM. Resident #1 was in bed with both upper side rails in the up position. Resident #1 reported she used the side rails to assist her to move back and forth in the bed and it gave her something to hold on to when she transferred out of the bed. Resident #1 reported she required someone to stand by and supervise when she transferred in or out of the bed.

The Director of Rehabilitation was interviewed on 9/27/2023 at 11:00 AM. The Director of Rehabilitation reported that Resident #1 was able turn herself in bed and was able to transfer out of bed with supervision. The Director of Rehabilitation explained that Resident #1 was discharged from therapy "last month" and she improved her activity level.

A phone interview conducted with the MDS Nurse on 09/26/23 at 1:21 PM revealed she had been instructed by the Director of Nurses (DON) to code all bed rails as restraints.

The DON was interviewed on 9/26/23 at 3:23 PM. The DON revealed the facility had no restraints and bed rails were used to enable residents with mobility. The DON revealed she never instructed the MDS Nurse to code any bed rails as restraints on the MDS assessments and could not explain why restraints had been coded.

7. Resident #6 was admitted to the facility on 8/6/2012 with diagnoses to include stroke and

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F 641	Continued From page 27 traumatic brain injury. The significant change MDS dated 8/17/2023 assessed Resident #6 to be moderately cognitively impaired. The MDS documented Resident #6 required extensive assistance for bed mobility and she had transferred once or twice in the past 7 days. The MDS documented that bed rails were used daily as a restraint. Resident #6 was observed on 9/25/2023 at 3:04 PM in bed. Resident #6 was grasping the side rail and turned her body towards the door. Resident #6 was not able to answer interview questions, but she did nod yes when asked if she used the side rails to move in bed. A phone interview conducted with the MDS Nurse on 09/26/23 at 1:21 PM revealed she had been instructed by the Director of Nurses (DON) to code all bed rails as restraints. The DON was interviewed on 9/26/23 at 3:23 PM. The DON revealed the facility had no restraints and bed rails were used to enable residents with mobility. The DON revealed she never instructed the MDS Nurse to code any bed rails as restraints on the MDS assessments and could not explain why restraints had been coded.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		

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practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, observations, and staff interviews, the facility failed to assess injuries after an unwitnessed fall for 1 of 3 residents reviewed for accidents (Resident #6).

The findings included:

Resident #6 was admitted to the facility on 8/6/2012 with traumatic brain injury and stroke. The quarterly Minimum Data Set (MDS) assessment dated 6/15/2023 assessed Resident #6 to be moderately cognitively impaired and she required total assistance of 2 people for bed mobility and transfers. The MDS did not document any falls in the past 2 months.

A fall assessment dated 7/24/2023 completed by Nurse #4 documented that Resident #6 was at high risk of falling with a score of "16". The assessment noted recent falls, need for toileting assistance, the inability to balance without assistance, and medications as having causative factors to increase fall potential of Resident #6.

A nursing note written by Nurse #4 dated 7/24/2023 at 10:14 AM was marked through as being incorrect documentation. The note read, "Writer was preparing medications in the hallway during morning med pass and witnessed resident scooting self onto floor mat beside bed. Writer went to stop resident but upon entering room, resident was already on the floor mat. Resident did not hit her head. Bed was in lowest position. No injuries noted. Vitals 122/272, 76, 18, 97.6, 96% on room air. Resident stated she was trying

Past noncompliance: no plan of correction required.

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to walk. Resident Transferred into geri-chair via mechanical lift and 2 Nursing assistants. No complaints of pain noted. Resident Responsible Party (RP) called and made aware; physician made aware."

A nursing note written by Nurse #4 dated 7/24/2023 at 6:23 PM documented that resident denied pain and her skin was normal, warm, and dry.

A nursing note written by Nurse #4 dated 7/25/2023 at 6:35 PM documented that Resident #6 denied pain and her skin was warm and dry and normal.

A skin assessment completed by Nurse #4 dated 7/25/2023 documented Resident #6 had no skin issues.

A head-to-toe assessment dated 7/25/2023 completed by Nurse #4 documented Resident #6 had a witnessed fall and her skin had normal tone and was warm and dry.

A nursing note written by the Assistant Director of Nursing (ADON), dated 7/26/2023 at 9:13 PM documented that Resident #6 had a large bruise on her right shoulder that was red, purple, and yellow in color. The note documented an assessment was completed and the physician was notified, as well as the resident Responsible Party. The physician ordered x-ray for the right shoulder.

A head-to-toe assessment of Resident #6 completed by the ADON dated 7/26/2023 at 9:13 PM documented the large bruise on the right shoulder that was red, purple, and yellow in color.

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X-ray results dated 7/27/2023 documented that there was no acute fracture or dislocation of the right shoulder.

A nursing note dated 8/3/2023 at 5:10 PM documented that swelling to her right knee was noted with some yellow bruising. The condition of the knee was reported to the physician and an order was received to obtain an x-ray of the knee. The family was notified of the change in Resident #6 and the orders.

A skin assessment dated 8/3/2023 at 7:55 PM documented Resident #6 had yellow bruising to her right shoulder and right knee.

A radiology report dated 8/5/2023 was reviewed and the x-ray determined there was a "modest depression fracture" of the right middle tibial plateau (the top of the tibia [lower leg bone/shinbone] where it connected with the femur [long bone of the thigh]). The fracture was of undetermined age.

A physician progress note dated 8/7/2023 was reviewed. The note documented that Resident #6 had an unwitnessed fall from bed on 7/24/2023 and was without pain after the fall, and on 8/3/2023 nursing noticed the right knee was swollen and bruised. The note documented that an x-ray obtained on 8/5/2023 determined there was a fracture of the right tibia plateau and Resident #6 did not report pain and did not have non-verbal expressions of pain. The note documented Resident #6's family did not want treatment for the fracture and declined to send her to the hospital or for an orthopedic referral.

A Quality Assessment and Performance

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Improvement (QAPI) Action Plan dated 8/7/2023 documented that on 8/3/2023 Resident #6 was observed with a yellowing bruise and swelling to the right knee. The nursing staff notified the physician, and an x-ray of the right knee was ordered. The x-ray was ordered on 8/3/2023 but was not obtained until 8/5/2023 due to the radiology company not having enough staff to perform the x-ray on the date ordered, and the facility staff were not notified the x-ray would not be obtained until a later date. The facility was notified of the x-ray results on 8/5/2023, but staff did not notify the DON of the x-ray results. The DON became aware of x-ray results on 8/6/2023. The DON completed an injury of unknown origin report and notified the administrator, the regional director of clinical services, and the regional vice president of operations.

An attempt was made to interview Nurse #4 on 9/27/2023 at 11:56 AM and the recording stated the number was unavailable. A text message was sent. Nurse #4 did not respond to the phone call or text.

An interview was conducted with Nursing Assistant (NA) #2 on 9/27/2023 at 1:40 PM. NA #2 reported she was in the room with Resident #6 on 7/24/2023 when she fell out of bed, but NA #2's back was turned to Resident #6, and she did not see her fall. NA #2 reported Resident #6 was in bed ready to get up for the day. NA #2 was getting clothes out of the closet and when she turned around, Resident #6 was sitting on the floor beside her bed. NA #2 explained that Resident #6 had fall mats on the floor to protect her if she did fall, and the bed was low to the floor. NA #2 reported Resident #6 had not cried out or made any noise and she denied pain. NA

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#2 said she yelled for the other NA to go to get the nurse to come to the room to assess Resident #6. NA #2 reported Resident #6 did not appear to have any injuries after the fall, but "a few days later" she had a bruise on her right shoulder.

During an interview on 9/27/2023 at 2:35 PM with the ADON she reported she was working on 7/24/2023 when Resident #6 fell, but she was not in the building when it happened, rather she arrived to work about 30 minutes later. The ADON explained that Nurse #4 documented that Resident #6's fall was witnessed and that she had assessed Resident #6. The ADON explained on 7/26/2023 the bruise was discovered on Resident #6's right shoulder and on 8/3/2023, a bruise on her right knee. The ADON reported that the bruise on the right knee appeared to be the same age as the right shoulder knee, and the facility felt Resident #6 obtained both bruises at the same time. The ADON reported on 8/3/2023 Resident #6's family member reported the bruise on her right knee. The ADON reported she had completed a skin assessment on Resident #6 on 7/26/2023 and she had noted the bruise on her right shoulder but had not seen the bruise on her knee.

The DON was interviewed on 9/28/2023 at 1:41 PM. The DON explained that Nurse #4 had reported she had witnessed Resident #6's fall on 7/24/2023 and Nurse #4 had reported she had completed the post-fall assessment. After the bruise on her right knee was discovered on Resident #6 on 8/3/2023 and the x-ray results on 8/5/2023 determined Resident #6 had a fracture of her right tibia, the DON initiated an investigation. The DON explained she was not

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notified of the fracture until 8/7/2023 and she initiated her investigation on that date. The DON reported she interviewed NA #2 and discovered that NA #2 was in the room with Resident #6, but she had not seen her fall. Nurse #4 reported she had been right outside of the door, but NA #2 reported she had to send another NA to find the nurse. The DON reported the administrative staff watched video playback from the date of the initial fall on 7/24/2023 and discovered that Nurse #4 was nowhere near Resident #6's room and after questioning Nurse #4, the facility had determined she had not completed the head-to-toe assessment after the fall and had falsified her documentation. The DON reported that Nurse #4 was terminated because she had not documented the fall, had not reported the fall, and had failed to complete a full assessment of Resident #6 after the fall.

The QAPI Action plan was reviewed, and the root cause was identified as staff did not follow procedures for the notification of an injury of unknown origin.

The Action Plan detailed that on 8/3/2023 the physician was notified of the bruise and orders were received for an x-ray. A head-to-toe assessment was completed on Resident #6 on 8/3/2023. The x-ray was obtained on 8/5/2023 and results were called to the facility. Staff did not notify the DON until 8/7/2023, when she discovered it took 2 days for the x-ray to be taken due to issues with staffing at the radiology agency. On 8/7/2023 a full head to toe assessment was completed on Resident #6, an interview was conducted with the family member of Resident #6's family member and the plan of care was discussed. Nurse #4 and NA #2 were

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interviewed by the DON on 8/7/2023 and statements were obtained. A pain assessment was conducted on Resident #6 on 8/7/2023. Residents who had the potential to be affected were identified and skin assessments were completed on 8/7/2023. Current staff were educated by the DON regarding notification of the DON with x-ray results that showed fractures and documentation of incident reports after falls and education was completed by 8/8/2023. The facility instructed the radiology agency to communicate staffing issues that would affect the timeliness of x-rays directly to the DON in the future. Monitoring was put in place to conduct skin assessments on 4 residents weekly for 4 weeks, then monthly for 2 months to monitor for skin assessment documentation completed appropriately. Results of the monitoring to be taken to the QAPI committee for review and revision as needed. Additionally, the DON would review all skin documentation for 5 days per week for 12 weeks to ensure any concerns or change in condition. The facility date of completion will be 11/6/2023.

The Action Plan was validated by reviewing the audits completed since 8/7/2023 and no issues were identified. Interviews were conducted with staff regarding education they received related to reporting, documentation, and procedures related to change in condition, injury of unknown origin, and falls. The ADON was interviewed on 9/27/2023 at 2:35 PM and she reported she is participating in monitoring by completing skin checks on residents and conducting audits on documentation. Nurse #6 was interviewed on 9/28/2023 at 11:02 AM and she reported she received education related to documentation of falls, reporting injuries of unknown origin and skin

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F 684	Continued From page 35 assessments. The facility's correction date of 8/31/2023 was validated.	F 684		
F 880 SS=D	Infection Prevention & Control 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	F 880		

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F 880	Continued From page 36 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 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 record reviews and staff interviews, the facility failed to protect residents and staff from COVID-19 exposure and infection after a medication aide (MA#1) reported to work with signs and symptoms of COVID-19 and worked	F 880	Past noncompliance: no plan of correction required.	

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her shift before testing positive for COVID-19. MA #1 failed to notify the facility administration of the positive test result. 11 out of 21 residents were reviewed for COVID (Resident #4, Resident #9, Resident #18, Resident #13, Resident #3, Resident #2, Resident #15, Resident #17, Resident #123, Resident #124, and Resident #19) and 6 out of 35 staff (MA #2, Nursing Assistant #3, Nursing Assistant #4, Assistant Director of Nursing, MA #3, and Maintenance Director) tested positive for COVID-19.

The findings included:

A review of the facility immunization report revealed that 84% of the census of 21 had been vaccinated for COVID-19 (3 resident refusals for the vaccine).

A review of the staff immunization report revealed the 32 out of 35 staff members had been vaccinated for COVID-19 (3 staff approved exemptions for the vaccine).

The facility Performance Improvement Plan dated 3/4/2023 identified that on 3/3/2023 MA #1 entered the facility with signs and symptoms of COVID. The root cause analysis documented MA #1 did not notify administration of her symptoms and did not wear a mask during her shift. The root cause analysis documented MA #1 tested herself for COVID approximately 4:30 AM on 3/4/2023 and she tested positive, but she did not notify the Director of Nursing (DON), Assistant Director of Nursing (ADON), or the Administrator of the positive test.

Resident #4 tested positive for COVID on 3/8/2023. Review of her medical record indicated

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Resident #4 was fully vaccinated and had a mild illness and did not require hospitalization.

Resident #9 tested positive for COVID on 3/8/2023. Review of her medical record indicated Resident #9 was fully vaccinated and had a mild illness and did not require hospitalization.

Resident #18 tested positive for COVID on 3/8/2023. Review of his medical record indicated Resident #18 was fully vaccinated and had a mild illness and did not require hospitalization.

MA #2 tested positive to COVID on 3/8/2023. MA #2 was not available for interview. The Administrator reported that no staff were severely ill with COVID, and no staff had been hospitalized.

Resident #13 tested positive for COVID on 3/11/2023. Review of her medical record indicated Resident #13 was fully vaccinated and had a mild illness and did not require hospitalization.

Resident #3 tested positive for COVID on 3/11/2023. Review of her medical record indicated Resident #3 was fully vaccinated and had a mild illness and did not require hospitalization.

Nursing Assistant (NA) #3 tested positive for COVID on 3/15/2023. NA #2 was not available for interview. The Administrator reported that no staff were severely ill with COVID, and no staff had been hospitalized.

Nursing Assistant (NA) #4 tested positive for COVID on 3/15/2023. NA #2 was not available for

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	345140	A. BUILDING _____ B. WING _____	C 09/28/2023

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PIEDMONT HEALTH & REHAB CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

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interview. The Administrator reported that no staff were severely ill with COVID, and no staff had been hospitalized.

Resident #2 tested positive for COVID on 3/16/2023. Review of her medical record indicated Resident #2 was fully vaccinated and had a mild illness and did not require hospitalization.

Resident #15 tested positive for COVID on 3/15/2023. Review of his medical record indicated Resident #15 declined the COVID vaccine and had a mild illness and did not require hospitalization.

Resident #17 tested positive for COVID on 3/15/2023. Review of his medical record indicated Resident #17 was fully vaccinated and had a mild illness and did not require hospitalization.

Resident #123 tested positive for COVID on 3/17/2023. Review of his medical record indicated Resident #123 was fully vaccinated and had a mild illness and did not require hospitalization.

Resident #124 tested positive for COVID on 3/17/2023. Review of his medical record indicated Resident #124 was fully vaccinated and had a mild illness and did not require hospitalization.

Resident #19 tested positive for COVID on 3/17/2023. Review of his medical record indicated Resident #19 was fully vaccinated and had a mild illness and did not require hospitalization.

The Assistant Director of Nursing (ADON) tested positive for COVID on 3/19/2023.

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MA #3 tested positive for COVID on 3/20/2023. MA #3 was not available for interview. The Administrator reported that no staff were severely ill with COVID, and no staff had been hospitalized.

The Maintenance Director tested positive for COVID on 3/22/2023.

The Maintenance Director was interviewed on 9/28/2023 at 8:34 AM and he reported he was fully vaccinated against COVID, but he tested positive in March of 2023. The Maintenance Director explained he had very mild symptoms and recovered without incident. The Maintenance Director reported he had been provided with education related to testing after COVID exposure and the signs and symptoms of COVID to report to the administration staff.

An interview was conducted by phone with MA #1 on 9/28/2023 at 10:15 AM. MA #1 reported she came to work on 3/3/2023 with a cough and she reported she felt like she couldn't stop coughing. MA #1 explained she had COVID in the past, but it "wasn't that bad." MA #1 reported she wore a blue surgical mask during her shift, and she was fully vaccinated for COVID. MA #1 explained she felt like she had a cold, but about 4:00 AM it occurred to her that she should test for COVID. MA #1 expressed that when the test resulted positive for COVID she didn't believe that the test was right. MA #1 reported she went out to complete her medication administration to the residents and after she was finished, she retested for COVID, and the results were again positive. MA #1 explained she stayed in the medication room until the change of shift at 7:00 AM and her relief MA #2 showed up. MA #1 stated she and

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MA #2 counted narcotics and then she called MA #2 into the medication room and showed her the positive COVID tests. MA #1 reported she went home and was sick for almost 10 days. MA #1 stated she had not called the DON, ADON, or Administrator to report the positive COVID test and her symptoms because she thought MA #2 would report to the DON for her.

During an interview on 9/28/2023 at 11:02 AM, the ADON reported she had COVID in March 2023, but she was not hospitalized.

Resident #18 was interviewed on 9/29/2023 at 11:54 AM. Resident #18 reported he had COVID in 2023 but did not remember the exact dates. Resident #18 reported he had a mild illness, "It was nothing."

An interview was conducted with the DON on 9/28/2023 at 1:38 PM. The DON reported that MA #1 had not called her to report her symptoms or the positive COVID test and later in the day on 3/4/2023 the DON had been notified by MA #2 that MA #1 had gone home at 7:00 AM after testing positive for COVID. The DON explained she called MA #1 and took a statement regarding the positive COVID test, her symptoms, and the residents and staff she was in contact with on 3/3/-3/4/2023. The DON explained they initiated contact tracing and tested anyone who had worked with MA #1 and residents she provided care to during her shift. The DON reported all residents tested negative on 3/4/2023, but on 3/10/2023 MA #2 started having symptoms of COVID and tested positive. The DON reported on 3/4/2023 they initiated a plan of correction to prevent any further incidents or risk resident exposure to COVID by a staff member with signs

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and symptoms of the infection.

The facility Performance Improvement Plan dated 3/4/2023 was reviewed. The facility identified MA #1 reported for work on 3/3/2023 with signs and symptoms of COVID and did not report her symptoms to the administrative staff. MA #1 worked until 4:00 AM and then took a COVID test, which was positive. MA #1 continued to work her shift and passed medications before taking another COVID test, which was positive. MA #1 did not wear a mask during her shift, and she did not notify the DON, ADON, or the Administrator of the positive COVID test.

The facility contacted MA #1 on 3/4/2023 to obtain a list of her close contacts and testing was performed on those residents and staff on day 1, day 3, and day 5 after exposure. The facility identified that all residents had the potential to be affected by the deficient practice. The facility conducted education to 100% of the staff on the signs and symptoms of COVID, the COVID policy, and the testing requirements after exposure. The facility put a monitoring plan in place to maintain ongoing compliance that included daily audits on mask compliance, and monitoring all callouts for signs and symptoms of COVID to ensure testing for COVID was completed per the guidelines. The facility continued this monitoring 5 days per week for 12 weeks. The results of the audits were reported to the Quality Assurance Performance Improvement committee for review and recommendations during the monitoring period and the results were reviewed for 3 months.

The facility Performance Improvement Plan was validated by reviewing the education provided to

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the staff and interviews with staff to validate the education.

NA #1 was interviewed on 9/27/2023 at 1:20 PM. NA #1 reported she had received education related to COVID, mask use, testing, and signs and symptoms to report.

An interview was conducted with NA #2 on 9/27/2023 at 1:40 PM. NA #2 reported she had received education related to COVID, mask use, testing, and signs and symptoms to report.

Nurse #3 was interviewed on 9/27/2023 at 2:14 PM and she reported she was newly hired and in orientation. Nurse #3 reported she had received COVID education in orientation, including signs and symptoms to report and testing requirements.

The Maintenance Director was interviewed on 9/28/2023 at 8:34 AM. The Maintenance Director reported he had been provided with education related to testing after COVID exposure and the signs and symptoms of COVID to report to the administration staff.

The ADON was interviewed on 9/28/2023 at 11:02 AM, and she reported she provided education and monitoring of mask and personal protective equipment by the staff on all nursing units.

The facility correction date of 6/14/2023 was validated.