| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345296 | A. BUILDING _____ B. WING _____ | C 10/25/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MARGATE HEALTH AND REHAB CENTER | 540 WAUGH STREET JEFFERSON, NC 28640 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced complaint investigation survey was conducted on 10/25/23. See Event ID #JOPZ11. The following intakes were investigated: NC00207270 and NC00208824. 6 of the 6 allegations did not result in a deficiency. | F 000 | | |
| F 604 SS=G | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for | F 604 | | 11/3/23 |

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

Electronically Signed | 11/16/2023

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| F 604 | Continued From page 1<br>restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident, staff, family, and Medical Director interviews the facility failed to protect Resident #1 from being physically restrained by Nurse Aide (NA) #1. NA #1 grabbed Resident #1's left forearm and held it when the resident became combative during incontinent care and Resident #1 was trying to hit NA #1 and NA #2. Resident #1 received a large purple bruise on her left forearm. This deficient practice affected 1 of 3 residents reviewed for dignity.<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on 09/10/16 with diagnoses that included dementia, delirium, anxiety, and chronic atrial fibrillation (irregular heart rhythm).<br><br>Review of a physician order dated 04/14/23 read Apixaban (also known as Eliquis) (blood thinner) 2.5 milligrams (mg) by mouth twice a day for atrial fibrillation.<br><br>Review of a quarterly Minimum Data Set (MDS) assessment dated 07/14/23 revealed that Resident #1 was moderately cognitively impaired and required extensive assistance with toileting and personal hygiene. The MDS further revealed that Resident #1 refused care 1 to 3 days during the assessment reference period and also received 7 days of an anticoagulant (blood thinner).<br><br>A care plan revised on 07/28/23 read in part, Resident #1 was at risk for adverse | F 604 | 100% in-service was completed with staff and information was provided on proper care and managing of patients with combative behaviors that includes never holding/restraining/restricting resident movement if becoming combative and returning patient to safe/dignified position and exiting or reassuring until patient has calmed down<br>We validated Resident concerns and her right to not be held. We reviewed our plan of action with her and explained that staff would not be allowed to restrain her and should she become combative, they are to leave her in a safe and dignified position until she calms down.<br>Direct care staff were instructed and interviewed to identify other residents with new, not previously known, combative behaviors<br>100% staff were educated on never holding/restraining/restricting resident movement if they become combative and newly hired staff are educated during orientation prior to working on hall(s)<br>100% of residents on affected hall were interviewed and skin checks were completed and no concerns were noted or found.<br>100% staff were educated on never holding/restraining/restricting resident movement if they become combative and newly hired staff are educated during orientation prior to working on hall(s)<br>Weekly monitoring of 24-hour nursing report will be completed to further identify | |

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| F 604 | Continued From page 2<br>effects/unusual bleeding related to anticoagulation use (Eliquis). The goal read, Resident #1 will not experience any signs or symptoms of adverse effects through next review. The intervention included observe for bleeding, hematuria, excessive bruising, tarry stools, bleeding gums, nose bleeds and notify the Medical Director (MD) for further intervention if indicated.<br><br>An additional care plan revised on 07/28/23 read in part, Resident #1 will at times refuse care such as meals, therapy, and medications. Resident #1 can become combative with some care, for example she will punch staff in stomach because she did not want to get out of bed. The goal read, Resident #1 will have decreased episodes of refusing care by 3 or fewer incidents per week over the next 90 days. The interventions included: provide a warm, non-threatening environment.<br><br>An observation and interview were conducted with Resident #1 on 10/25/23 at 10:51 AM. Resident #1 was sitting up in her wheelchair peddling a stationary bike. She was smiling and stated she "was getting her exercise in for the day." During the interview Resident #1 stated "there was a colored lady who got a hold of my arm and squeezed it so tight, and I told her to let go she was hurting me, and she would not" and the area turned black. Resident #1 pulled up her left shirt sleeve to show the area that had "turned black" there was no bruising, redness, or black color noted at the time. Resident #1 stated that this happened around a month and a half ago and she had reported the incident to the facility Social Worker (SW). Resident #1 stated she was unsure if the employee still worked at the facility or not "because there are so many people in and | F 604 | if any new combative behaviors are reported<br>Interviews of a 10% of all residents weekly x4, monthly x2 and quarterly x 4<br>Any incidents will be reviewed in QAPI meeting monthly | |

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| F 604 | Continued From page 3 | F 604 | | |

out of her room" and she could not keep up with who was who.

The Director of Social Services was interviewed on 10/25/23 at 11:08 AM who stated that she was unaware of any incident of bruising and Resident #1 had not reported anything to her. The Director of Social Services stated that she may have spoken to the Social Services Assistant, as she was the assigned SW for Resident #1.

The Social Service Assistant was interviewed on 10/25/23 at 11:18 AM who stated that Resident #1 had not reported any incident of staff grabbing her arm or of any incident that resulted in a bruise to her arm.

Resident #1's family member was interviewed via phone on 10/25/23 at 11:26 AM who stated that at this point the bruise to Resident #1's left forearm was gone. She stated that she was on the phone with Resident #1 on 09/13/23 sometime in the afternoon when the staff came in to provide care to Resident #1. She stated that Resident #1 laid the phone down but did not disconnect the call, the family member stated she heard Resident #1 say "oh my God stop it that hurts" and then the phone went dead. The family member was unaware of the staff names who were providing care but stated that there was more than one staff member in the room at the time as she could hear two different voices. The Family member stated that she visited the following day (09/14/23) and took a picture of the bruise that was present on Resident #1's left forearm.

Review of a picture that Resident #1's family provided on 10/25/23 with no date stamp noted revealed a picture of a left forearm that contained

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| F 604 | Continued From page 4 | F 604 | | |

a large dark purple bruise with some dark redness around the edges. The approximate size of the bruise was 8 centimeters by 6 centimeters. The picture did not show Resident #1's face, only her left forearm and mid-section of her upper body.

Resident #1's medical record was reviewed on 10/25/23 and revealed no documentation of the event that occurred on 09/13/23.

The facility's daily assignment sheet for 09/13/23 indicated that Nurse #1, NA #1, NA #2, and NA #3 were assigned to work the unit where Resident #1 resided on second shift. The schedule also identified the Supervisor as Supervisor #1.

Nurse #1 was interviewed via phone on 10/25/23 at 2:26 PM who confirmed that she was working on 09/13/23 and was caring for Resident #1. Nurse #1 stated at some time between 4:00 PM and 6:00 PM NA #1 and NA #2 reported that Resident #1 had become combative during incontinent care and NA #1 had grabbed her left arm to keep her from hitting them. Nurse #1 stated that she immediately went to Resident #1's room to look at her left forearm and noted the area to be "discolored". She explained the discolored area was dark purple but stated the skin was not broken. She added that Resident #1 took blood thinner every day. Nurse #1 stated that Resident #1 was not complaining of any pain but stated "that black girl grabbed my arm" and look at what she did to my arm. Nurse #1 stated that she did not complete an incident report or document the issue because that would be the responsibility of the Supervisor once she was made aware of the incident. She added that she did see Resident #1's family member and did

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| F 604 | Continued From page 5 | F 604 | | |

inform them of the incident and bruise.

NA #1 was interviewed via phone on 10/25/23 at 3:38 PM who confirmed that she was caring for Resident #1 on 09/13/23 on second shift. NA #1 stated that on 09/13/23 just after she arrived for her shift Resident #1 rang her call bell and she went to see what she needed. NA #1 stated that when she asked Resident #1 what she needed and she stated, "you left me wet all day and I need to be changed." NA #1 stated that she could tell Resident #1 was upset so she went and asked NA #2 to assist her in providing care to Resident #1. They (NA #1 and NA #2) returned to Resident #1 and explained that they had just arrived at work, and they were sorry she was wet, but they would get her cleaned up. NA #1 stated that they began changing Resident #1 and had her turned onto her right-side facing NA #1 with NA #2 on the other side of the bed. NA #1 stated that as Resident #1 was resting on her right side on the edge of the bed Resident #1 became combative and was attempting to hit them with her left arm. NA #1 explained if she had stepped back away from the bed Resident #1 could have easily fallen out of the bed so to keep from getting hit, NA #1 stated that Resident #1's left hand was balled up into a fist and she grabbed her left arm and held it down towards the bed while NA #2 completed the care. Once Resident #1 was on her back, NA #1 stated she stepped away from the bed and NA #2 finished fastening the brief. NA #1 also add that she routinely cared for Resident #1 by herself on third shift and had never had a problem with her and she was not sure why Resident #1 became combative on 09/13/23.

NA #2 was interviewed on 10/25/23 at 2:08 PM

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| F 604 | Continued From page 6 | F 604 | | |

and again at 4:09 PM who confirmed that she worked the unit where Resident #1 resided on 09/13/23 on second shift. She stated that she was assisting NA #3 in another resident's room when NA #1 came in and asked for assistance with Resident #1. NA #2 stated that she left the room and accompanied NA #1 to Resident #1's room to provide care. NA #2 stated that they had Resident #1 turned on her right-side facing NA #1 and she became combative and started trying to hit them (NA #1 and #2). NA #2 stated that to keep from getting hit NA #1 grabbed her left arm and held it down towards the bed so care could be finished.

NA #3 was interviewed on 10/25/23 at 4:40 PM who confirmed that she was working the unit where Resident #1 resided on 09/13/23 along with NA #1 and NA #2. NA #3 recalled that she and NA #2 were in a room providing care and NA #1 came in and asked for assistance in changing Resident #1. NA #3 stated that she stayed with the resident and finished the care and NA #2 accompanied NA #1 to Resident #1's room to provide care. NA #3 stated that a few minutes later NA #1 and NA #2 came out of Resident #1's room and stated that she had become combative during care and NA #1 put her hand up to stop her from hitting them and she had gotten a bruise.

The Director of Nursing (DON) was interviewed on 10/25/23 at 3:45 PM and again at 6:11 PM who stated that she vaguely recalled the event. She recalled that she spoke with NA #2 while the Administrator spoke with NA #1 about the incident. The DON stated she did not go and look at the bruise but stated she went to Resident #1's room, and she was sleeping so she did not bother

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| F 604 | Continued From page 7<br>her. The DON stated that Nurse #1 should have documented the incident and stated that they believed that Resident #1 was in an unsafe position and could have fallen out of bed if NA #1 had stepped away, so she did what she needed to finish the care.<br><br>The Administrator was interviewed on 10/25/23 at 3:45 PM and again at 5:23 PM who stated that he was notified of the incident and went to find out what had happened. He stated that he spoke with NA #1 and had her provide a written statement about what happened. She stated that Resident #1 was turned on her side and they had her brief off and were actively providing care and needed to finish the care. To keep from getting hit and to finish providing care NA #1 had to hold Resident #1's left arm.<br><br>The MD was interviewed via phone on 10/25/23 at 6:31 PM who stated that she was fairly certain she had been made aware of the bruise on Resident #1's left forearm. She stated that she would have instructed the staff just to monitor the site because Resident #1 was on Eliquis (blood thinner) and if it got worse to let her know. The MD explained that it was not uncommon for people on blood thinners to get bruises, but it certainly was something they don't like to see when the staff cause the bruising. She explained that Resident #1 was on a low renal dose of Eliquis which would place her at the same risk for bruising as someone on a higher dose of the same medication. | F 604 | | |
| F 607 SS=G | Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(5)(ii)(iii)<br><br>§483.12(b) The facility must develop and | F 607 | | 11/3/23 |

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| F 607 | Continued From page 8<br>implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br><br>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.<br><br>§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.<br><br>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.<br><br>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident, and staff interviews the facility failed to remove Nurse Aide (NA) #1 from a resident care assignment after NA #2 witnessed the NA grab Resident #1's left forearm to prevent her from hitting NA #1 and NA #2 when the resident became combative during incontinent care. In addition, the facility failed to identify, thoroughly investigate, and report the incident to the state | F 607 | 100% in-service and education was done with staff regarding facility policy on abuse and reporting any allegations and the procedures that will be followed in accordance with the policy and newly hired staff are educated during orientation prior to working on hall(s)<br>All supervising staff were in-serviced and educated on the implementation and | |

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| F 607 | Continued From page 9<br>agency, Adult Protect Services, and local Law Enforcement for 1 of 3 residents reviewed for dignity.<br><br>The findings included:<br><br>Review of the facility Abuse/Neglect/Misappropriation of Resident Property policy revised 07/2022 read in part, "All allegations of resident abuse, neglect, misappropriation of resident property, involuntary seclusion, and injuries of unknown origins will be promptly reported and thoroughly investigated, and facility must prevent further potential abuse while investigation is in progress. Any suspicion of a crime will be reported to law enforcement. Employees of the facility that have been accused of resident abuse, neglect, misappropriation of resident property or involuntary seclusion are suspended."<br><br>The policy further read, "when an incident or suspected incident of resident abuse, neglect, or misappropriation of resident property is reported the Executive Director will appoint a facility representative to investigate the incident. The investigation shall include the following: an interview with the person(s) reporting the incident, interview with any witness to the incident, an interview with the resident, a review of the residents medical record, an interview with staff members (all shifts) having contact with the resident during the period of the alleged incident, interview with the residents roommate, family, and visitors if appropriate, a review of all circumstances surrounding the incident, outcome of investigation, corrective action, and date of time person(s) notified." | F 607 | procedures of any and all allegations<br>Any and all allegations will be thoroughly investigated and reported appropriately<br>Any and all allegations will be thoroughly investigated and reported appropriately<br>Any reported allegations will be reviewed in QAPI meeting monthly<br>10% of staff will be interviewed for understanding of abuse policy weekly x4, monthly x2 and quarterly x 4 | |

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Resident #1 was admitted to the facility on 09/10/16.

An observation and interview were conducted with Resident #1 on 10/25/23 at 10:51 AM. Resident #1 was sitting up in her wheelchair peddling a stationary bike. She was smiling and stated she "was getting her exercise in for the day." During the interview Resident #1 stated "there was a colored lady who got a hold of my arm and squeezed it so tight, and I told her to let go she was hurting me, and she would not" and the area turned black. Resident #1 pulled up her left shirt sleeve to show the area that had "turned black" there was no bruising, redness, or black color noted at the time. Resident #1 stated that this happened around a month and a half ago and she had reported the incident to the facility Social Worker (SW). Resident #1 stated she was unsure if the employee still worked at the facility or not "because there are so many people in and out of her room" and she could not keep up with who was who.

The facility's daily assignment sheet for 09/13/23 indicated that Nurse #1, NA #1, NA #2, and NA #3 were assigned to work the unit where Resident #1 resided on second shift. The schedule also identified the Supervisor as Supervisor #1.

Nurse #1 was interviewed via phone on 10/25/23 at 2:26 PM who confirmed that she was working on 09/13/23 and was caring for Resident #1. Nurse #1 stated at some time between 4:00 PM and 6:00 PM NA #1 and NA #2 reported that Resident #1 had become combative during incontinent care and NA #1 had grabbed her left arm to keep her from hitting them. Nurse #1 stated that she immediately went to Resident #1's

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room to look at her left forearm and noted the area to be "discolored". She explained the discolored area was dark purple but stated the skin was not broken. She added that Resident #1 took blood thinner every day. Nurse #1 stated that Resident #1 was not complaining of any pain but stated "that black girl grabbed my arm" and look at what she did to my arm. Nurse #1 stated she went to Supervisor #2 and reported the incident and then it was reported to the Director of Nursing (DON) who was still in the building that day. She added that Supervisor #2 had also gone to Resident #1's room along with Nurse #1 to look at the bruise. Nurse #1 stated that she did not complete an incident report or document the issue because that would be the responsibility of the Supervisor once she was made aware of the incident. She added that she did see Resident #1's family member and did inform them of the incident and bruise. Nurse #1 stated that she instructed NA #1 to write a statement that was given to the DON or Administrator.

Supervisor #2 was interviewed via phone on 10/25/23 at 3:00 PM who stated that she did not recall the event and did not recall looking at Resident #1's left forearm with Nurse #1. Supervisor #2 stated she had looked at Resident #1's forearms before but could not recall this specific event. She added that Resident #1 could become combative with staff particularly "staff of color." Supervisor #2 stated that if a bruise was found then an online incident report would be completed, along with a narrative note, and notification to the family and MD were also required. She stated that would be the responsibility of the nurse on the hall nurse to complete those things unless they asked for help or assistance. Again, Supervisor #2 stated she

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was unaware of the incident and had not completed any of the required documentation.

NA #1 was interviewed via phone on 10/25/23 at 3:38 PM who confirmed that she was caring for Resident #1 on 09/13/23 on second shift. NA #1 stated that on 09/13/23 just after she arrived for her shift Resident #1 rang her call bell and she went to see what she needed. NA #1 stated that when she asked Resident #1 what she needed and she stated, "you left me wet all day and I need to be changed." NA #1 stated that she could tell Resident #1 was upset so she went and asked NA #2 to assist her in providing care to Resident #1. They (NA #1 and NA #2) returned to Resident #1 and explained that they had just arrived at work, and they were sorry she was wet, but they would get her cleaned up. NA #1 stated that they began changing Resident #1 and had her turned onto her right-side facing NA #1 with NA #2 on the other side of the bed. NA #1 stated that as Resident #1 was resting on her right side on the edge of the bed Resident #1 became combative and was attempting to hit us with her left arm. NA #1 explained if she had stepped back away from the bed Resident #1 could have easily fallen out of the bed so to keep from getting hit, NA #1 stated that Resident #1's left hand was balled up into a fist and she grabbed her left arm and held it down towards the bed while NA #2 completed the care. Once Resident #1 was on her back, NA #1 stated she stepped away from the bed and NA #2 finished fastening the brief. Once the care was done NA #1 stated that they (NA #1 and NA #2) went and reported the incident to Nurse #1 who reported it to Supervisor #1 and she provided a written statement to the Administrator. NA #1 stated that the Administrator and DON met with her and NA #2 and asked

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what happened and then instructed NA #1 to not go back into Resident #1's room then allowed us to go back to work on the hall. NA #1 stated that they told her there was a bruise on Resident #1's left forearm but she did not return to the room that evening to see the bruise. NA #1 also add that she routinely cared for Resident #1 by herself on third shift and had never had a problem with her and she was not sure why Resident #1 became combative on 09/13/23. She confirmed that she returned to the hall that evening to care for other residents but did not care for Resident #1 after the incident.

Supervisor #1 was interviewed on 10/25/23 at 4:48 PM and confirmed that Nurse #1 reported the incident that occurred to her on 09/13/23. When she heard about the incident she immediately went and reported it to the Administrator and DON who were both still in the building. Supervisor #1 stated she did not go to the room and look at the area, once the Administrator and DON were aware she had no other involvement in the incident. She stated once reported to the Administrator he would direct the staff of what to do next and she had received no further instructions.

NA #2 was interviewed on 10/25/23 at 2:08 PM and again at 4:09 PM who confirmed that she worked the unit where Resident #1 resided on 09/13/23 on second shift. She stated that she was assisting NA #3 in another resident's room when NA #1 came in and asked for assistance with Resident #1. NA #2 stated that she left the room and accompanied NA #1 to Resident #1's room to provide care. NA #2 stated that they had Resident #1 turned on her right-side facing NA #1 and she became combative and started trying to

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hit us (NA #1 and #2). NA #2 stated that to keep from getting hit NA #1 grabbed her left arm and held it down towards the bed so care could be finished. NA #2 stated that they had reported the incident to Nurse #1 who had reported it to Supervisor #1 and ultimately the DON was notified. Shortly after the incident DON came and talked to NA #2 about what had happened and after they had talked, she returned to the unit and finished her shift. She stated that NA #1 did not go back into Resident #1's room after the incident and she and NA #3 provided anything that Resident #1 needed.

NA #3 was interviewed on 10/25/23 at 4:40 PM who confirmed that she was working the unit where Resident #1 resided on 09/13/23 along with NA #1 and NA #2. NA #3 recalled that she and NA #2 were in a room providing care and NA #1 came in and asked for assistance in changing Resident #1. NA #3 stated that she stayed with the resident and finished the care and NA #2 accompanied NA #1 to Resident #1's room to provide care. NA #3 stated that a few minutes later NA #1 and NA #2 came out of Resident #1's room and stated that she had become combative during care and NA #1 put her hand up to stop her from hitting them and she had gotten a bruise. She added that no one from management had spoken to her about that evening but stated Supervisor #1 had "jumped all over us about how we could let this happen" to Resident #1. NA #3 confirmed that after the incident NA #1 did not go back into Resident #1's room and she and NA #2 provided any care that was needed for the remainder of the shift.

The DON was interviewed on 10/25/23 at 3:45 PM and again at 6:11 PM who stated that she

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vaguely recalled the event. She recalled that she spoke with NA #2 while the Administrator spoke with NA #1 about the incident. The DON stated looking back at the incident she felt like the facility should have reported the incident and followed Their policy for the investigation. The DON explained that when the facility opened an investigation then she would conduct interviews or whatever the Administrator needed her to do. She stated that they worked together to get the investigation completed.

The Administrator was interviewed on 10/25/23 at 3:45 PM and again at 5:23 PM who stated that he was notified of the incident and went to find out what had happened. He stated that he spoke with NA #1 and had her provide a written statement about what happened. She stated that Resident #1 was turned on her side and they had her brief off and were actively providing care and needed to finish the care. To keep from getting hit and to finish providing care NA #1 had to hold Resident #1's left arm. The Administrator stated that he instructed NA #1 to not go back into Resident #1's room and after they had spoken to the staff directly involved in the incident, they allowed NA #1 and NA #2 to return to the unit to finish their shift. He stated that looking back at the incident he should have followed his policy and done exactly what it instructed him to do. The Administrator stated that if they opened a full investigation that included protection of the whole hall but with this case, they did not open a full investigation because "we quickly identified that there was no abuse." Again, the Administrator confirmed that he had not suspended NA #1 or NA #2, he had not reported the incident to the State Agency or other regulatory agencies and did not notify law enforcement.

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