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	345322	A. BUILDING _____ B. WING _____	C 11/20/2023

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THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

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F 000	INITIAL COMMENTS The survey team entered the facility on 10/24/23 to conduct an unannounced complaint investigation. The survey team was onsite 10/24/23 and 10/25/23. Additional information was obtained offsite through 11/20/23. Therefore, the exit date was 11/20/23. Event ID# 89IX11. The following intakes were investigated: NC00208746, NC00208750, NC00210069, NC00208336, and NC00207413. Intakes NC00208746 and NC00208750 resulted in Immediate Jeopardy. 4 of the 6 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity J. Tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/17/23 and was removed on 11/10/23. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		12/15/23

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

Electronically Signed | 12/15/2023

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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, family, staff, Physician Assistant, Guardian, Pastor, Psychiatric Nurse Practitioner, Psychotherapist, Law Enforcement, and Health Care Personnel Investigator interviews, the facility failed to protect a vulnerable female resident (Resident #1) from inappropriate sexual advances from an employee (Med Aide #1) for 1 of 3 residents reviewed for abuse. On 10/19/23, Resident #1 alleged Med Aide #1 had kissed her, touched her legs and breasts and exposed his penis to her which also had the high likelihood of placing other vulnerable residents at risk of abuse. Immediate Jeopardy began on 10/17/23 when Resident #1, who had moderate impairment in cognition, disclosed to her Family Member and Pastor that she was in a relationship with an employee at the facility and he had kissed her, touched her legs and breasts and exposed his penis to her. Immediate Jeopardy was removed on 11/10/23 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. The findings included:	F 600	F600: 1. The facility will continue to ensure that vulnerable female residents are protected from inappropriate sexual advances from employees. Resident #1 has had no identified negative outcome as a result of this allegation and continues to be seen routinely for psychiatric/psychological services. Current vulnerable female residents have the potential to be affected. On 11.08.23, the Social Services Director and Social Services assistant conducted interviews with all residents that have a BIMS of 13 or greater (cognitively intact) to determine if they felt safe in the facility. There were no issues identified. No residents reported inappropriate sexual advances by Med Aide #1 or any other staff member. 2. On 11.08.23, the Assistant Director of Nursing and MDS Coordinator conducted skin assessments on all of the residents that had a BIMS of less than 13 to determine if there were any signs of abuse. No issues were identified. On 11.08.23 the Regional Clinical	

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F 600	Continued From page 2 Resident #1 is a 76-year-old female who was admitted to the facility on 12/14/22 with diagnoses that included dementia without behavioral disturbance, major depressive disorder, hallucinations, and disorganized schizophrenia. Resident #1 was residing in an assisted living facility prior to her admission to the skilled nursing facility following a hospital stay. A North Carolina Letters of Appointment dated 04/22/19 revealed Resident #1 was deemed an incompetent person and granted court-appointed guardianship. The quarterly Minimum Data Set (MDS) assessment dated 09/12/23 assessed Resident #1 with moderate impairment in cognition. She was able to understand others and be understood. She required total staff assistance with bathing and supervision with set-up assistance only for all other activities of daily living. She had no behaviors such as rejection of care, physical or verbal aggression and no hallucinations or delusions during the MDS assessment period. Review of Resident #1's medical record revealed care plans, last revised 09/10/23, that addressed the following problem areas: Risk for decline in cognition and has impaired cognitive function or impaired thought processes related to dementia. Interventions included to administer medications as ordered, assist Resident #1 with decision making as needed, and observe for verbal/non-verbal indicators to determine level of understanding. Impaired communication as evidenced by psychosis with dementia, uncontrolled	F 600	Coordinator re-educated the facility Administrator and Director of Nursing on the Abuse Policy and Procedure. The education emphasized a resident's right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual. 3. 100% of facility staff were inserviced by the Administrator, Director of Nursing or Assistant Director of Nursing on the Abuse Policy and Procedure. The education emphasized a resident's right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual. This education began on 11.08.23 with no employee being allowed to work without receiving the education. All education was completed by 11.13.2023. Newly hired employees after 11.08.23 will receive mandatory in person education by the Assistant Director of Nursing during general orientation prior to the start of their first shift. The education will emphasize a resident's right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse will be reviewed as well as reporting examples from the state operations manual.	

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F 600	Continued From page 3 schizophrenia. Interventions included to encourage Resident #1 to continue stating thoughts even if having difficulty, observe for non-verbal indicators of attempts to express self, and use communication techniques to enhance interaction. Resident #1 was determined by mental health services to have a halted (dementia diagnosis primary to mental health diagnosis) Level II Preadmission Screening and Resident Review (PASRR) due to a diagnosis of dementia. Interventions included specialized services to consist of Psychiatry and Psychology. Potential for fluctuations in mood related in part to disease process, dementia, depression, anxiety, and repetitive concerns about her health. Resident #1's husband passed away in this facility which brings back memories for her as she visited him often. Interventions included to encourage Resident #1 to verbalize feelings as needed and provide ample time to express feelings. Potential to demonstrate negative and disruptive behaviors related to mental illness. Interventions included to assess Resident #1's understanding of the situation, allow time for her to express self and feeling towards the situation, and psychiatric consult as indicated. Resident #1 has a yeast rash related to insulin dependent diabetes mellitus and moisture associated skin damage to pannus (excess skin and fatty tissue that hangs down over the genitals and/or thighs), groin and vulva. Interventions included administer treatment and medication as ordered. A physician's order for Resident #1 dated 06/27/23 read, Estradiol Vaginal Cream (medication used to treat vaginal dryness, itching	F 600	4. A QA monitoring tool will be utilized to ensure ongoing compliance beginning on 11.08.23. The ADON/designee will screen residents that may be more vulnerable/more at risk for inappropriate staff to resident interactions through MDS interviews, observations by the Assistant Director of Nursing and Unit Managers, and through quarterly care conference reviews at a frequency of 5 residents 5x/week x 12 weeks. Any concerns identified through facility screening will be reported to the Director of Nursing who will complete an evaluation of the resident and document any follow-up required. Variances will be corrected at the time of observation and additional education provided when indicated. The Administrator will continue to be made aware of any instances of abuse, inappropriate behavior, or any other identified concern related to citation F600 from the audits, from the Direct of Nursing. The Administrator will audit at minimum monthly the completion of the audits stated at the above frequency Observation results will be reported to the Administrator (from the Director of Nursing) weekly for the next 3 months beginning on 11.15.23 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 4 months during	

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F 600	Continued From page 4 and burning) 0.1 milligram/gram inserted vaginally at bedtime every Tuesday and Friday for OAB (overactive bladder). A Physician Assistant (PA) progress note dated 10/19/23 revealed in part, "Resident #1 was seen at the request of staff due to alleged abuse by a man at the facility. Resident #1 reports that a man her kissed her on the lips. She denies any inappropriate touching, sexual activity, or physical or emotional harm. She states that it was nice. She reported to the Director of Nursing (DON) that it was a staff member." During a telephone interview on 10/26/23 at 2:54 PM, the PA revealed she was asked to evaluate Resident #1 due to alleged abuse. The PA stated Resident #1 didn't really want to discuss specifics with her other than what she had documented in the progress note. The PA recalled Resident #1 stated she didn't understand why people wanted to keep talking to her about it. The PA explained she asked Resident #1 general questions such as did he hurt you, touch your vagina, make you upset or feel uncomfortable and Resident #1 replied no to all the questions. The PA stated Resident #1 did not display any emotional harm and seemed more distressed about having to talk about the incident. The PA revealed Resident #1 could be a fairly reliable historian, she had a decent idea of what her medications were as well as knew the names of familiar staff members and providers. The PA stated Resident #1 had never mentioned anything to her in the past about a boyfriend or concerns with a staff member and felt it was possible Resident #1's recollection of events was reliable. An observation and interview was conducted with	F 600	the November through January regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified. 5. Date of Compliance: 12/15/2023	

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Resident #1 on 10/24/23 at 3:27 PM. Resident #1 was sitting in her wheelchair in her room, dressed nicely and well-groomed with her hair neatly styled and a flower tucked behind her ear. She displayed no signs of distress. Resident #1 asked if this visit was related to "that guy" and then stated this would be the 6th person she had spoken to about him. She stated her Guardian had also asked her about her boyfriend and was the one who figured out who it was but she was not really sure how. Resident #1 revealed that she and Med Aide #1 were in a relationship and had been for about the past two weeks. Resident #1 explained at first he only touched her ankles and legs as he used his hands to tuck the covers around her to make her comfortable when he tucked her into bed. She couldn't remember the date but stated one evening when he came into her room, she asked him if he could smell her cologne and he did, then he put his face up close to hers and asked her to smell his cologne and give him a kiss on the cheek and she did. She stated their relationship progressed gradually, he started with touching her legs going up to her waist, giving her soft kisses and rubbing her breasts above her clothing. Then one evening, she stated Med Aide #1 exposed his penis to her. She recalled him asking her how long it had been since she had seen one of these (referring to a penis) and she told Med Aide #1 it had been a while as the last time was her husband and it had shriveled. Resident #1 stated she looked at it, told him "boy you have some humdinger there don't you", he put his penis back into his pants and left the room. She recalled it all happened very quickly and he only exposed his penis to her that one time. Resident #1 stated when Med Aide #1 touched her and gave her soft, gentle kisses it was "really quite nice." She indicated Med Aide

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#1 was the one who had pursued her, telling her he had noticed her the first time he had seen her. Resident #1 explained she didn't seek out the relationship with Med Aide #1 but she didn't discourage it either as she was a woman after all and at the time his attention made her feel good about herself, it did not feel inappropriate and was consensual. Resident #1 revealed Med Aide #1 had told her not to tell anyone because he would get into trouble, he was afraid of losing his job and they needed to keep it between themselves. She couldn't recall the exact date but did confirm she told Nurse Aide (NA) #1 about her boyfriend and later, Med Aide #1 had come into her room stating he heard she had a boyfriend, she told him yeah you and he told her he wasn't her boyfriend, he had a girlfriend who wouldn't be happy to hear her say that and she just told him ok then. Resident #1 stated she never told NA #1 who her boyfriend was but thought NA #1 must have put 2 and 2 together. Resident #1 restated over the past two weeks anytime Med Aide #1 worked, he came to her room kissing and touching her as he tucked her into bed. Resident #1 stated a lot of people have asked her about this, including her Guardian and Pastor, and while it didn't seem inappropriate to her at the time, now that she looked back on it she realized it could have been elder abuse but it didn't feel like abuse to her.

During telephone interviews on 10/24/23 at 11:54 AM and 10/25/23 at 9:23 PM, NA #1 revealed she worked on 10/17/23 7:00 PM to 7:00 AM and was assigned to provide care to Resident #1. NA #1 stated it was around 9:30 PM on 10/17/23 when she had a conversation with Resident #1 in her room and Resident #1 disclosed she had a boyfriend. NA #1 recalled Resident #1 seemed

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excited as she talked about her boyfriend, almost "giddy, like a teenager." She stated Resident #1 told her that her boyfriend tucked her in at night, kissed her softly, and touched her feet, legs and breasts. NA #1 stated when Resident #1 mentioned her boyfriend had touched her breasts, she told Resident #1 no one should be touching her that way and tried to get Resident #1 to tell who her boyfriend was but she wouldn't say. NA #1 explained during the same conversation, Resident #1 also talked about a family member and guy who were coming to visit her and she just assumed Resident #1 was referring to a family friend as her boyfriend. NA #1 stated she felt Resident #1 was credible with what she was telling her as Resident #1 was alert and oriented and showed no distress when talking about her boyfriend. NA #1 added Resident #1 never made it seem as if the person she was referring to as her boyfriend was someone who worked at the facility. NA #1 recalled about 30 minutes after she had left Resident #1's room, Med Aide #1 approached her out in the hall, he was very disturbed and stated he wouldn't go back into Resident #1's room alone. When she asked him why, Med Aide #1 told her Resident #1 was saying he was her boyfriend and Med Aide #1 asked her if she would go with him if he had to go back into Resident #1's room. NA #1 stated Med Aide #1 never asked her to go back into the room with him the remainder of the shift.

During telephone interviews on 10/24/23 at 1:47 PM, 10/24/23 at 3:43 PM, and 10/26/23 at 12:35 PM, Med Aide #1 revealed he worked on 10/17/23 during the hours of 7:00 PM to 7:00 AM and was assigned to provide care to Resident #1. Med Aide #1 stated he had only been working at

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the facility since the first week of October 2023 and other than giving Resident #1 her medications, he only had physical contact with her on a few occasions. He could not recall the exact date but stated it had to be the first week he started when he was first assigned to Resident #1's hall and she was scheduled to receive vaginal cream treatment. He stated he really didn't feel comfortable administering the treatment but did it anyway and afterwards, he talked with Nurse #1 and told him that he would not administer her vaginal cream treatment again because he didn't feel comfortable and Nurse #1 told him that he would take care of it. Med Aide #1 recalled on 10/15/23 as he walked past Resident #1's room he noticed she was lying in bed with the head of the bed up and her head, arms and shoulders were leaning off the side of the bed. He was afraid she was about to fall so he went into the room, turned on the lights and told her he was going to reposition her back into bed. He lowered the head of the bed, raised the bed to his waist level, pulled on the bed pad to reposition her back into the middle, covered her up with the blanket with her arms out and elbows on the fold of the blanket and then tucked the covers in along her sides the same way he did with all the residents and left the room. On the evening of 10/17/23, Med Aide #1 stated he was again assigned to Resident #1's hall and while he was doing his medication pass and got close to Resident #1's room, he heard NA #1 and Resident #1 laughing loudly. When NA #1 came out of the room he asked NA #1 what that was all about and she told him that Resident #1 was telling her about her boyfriend. He stated he didn't think much else about it and continued on with his medication pass. Approximately 30 minutes later when he went into Resident #1's

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room, she sat up in bed and said there's my boyfriend. He stated he immediately told Resident #1 he was not her boyfriend and he had a girlfriend who would be very upset to hear her refer to him that way. He stated Resident #1 told him ok, he gave Resident #1 her medications and then left the room. When he left the room, he saw NA #1 out in the hall, told her that Resident #1 was calling him her boyfriend and asked her if he did have to go back into the room would she go with him because he didn't feel comfortable going back into her room alone. He recalled NA #1 stated Resident #1 had told her about her boyfriend earlier but didn't say who it was and she couldn't believe Resident #1 was calling him her boyfriend. Med Aide #1 stated he never went back into Resident #1's room the remainder of the shift and when the Director of Nursing (DON) arrived at the facility the next morning, he told her what had happened and she instructed him not to go back into Resident #1's room alone. Med Aide #1 denied ever kissing, touching Resident #1's breasts inappropriately or exposing his penis to her and was not sure why she would allege that he did.

During a telephone interview on 10/25/23 at 4:54 PM, Nurse #1 revealed he worked at the facility 7:00 PM to 7:00 AM on Friday, Saturdays and Sundays. Nurse #1 did not recall Med Aide #1 mentioning any incident or concerns with Resident #1 until Med Aide #1 called him at home the day after he was suspended. Nurse #1 stated the only time he recalled Med Aide #1 mentioning anything to him about Resident #1 was one night (he could not recall the date) Med Aide #1 approached him as he was working on a medication cart and asked him if he wanted to administer Resident #1's vaginal cream

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treatment. He stated he told Med Aide #1 no and also told Med Aide #1 he didn't need to administer the treatment either as they had female nurses who could administer Resident #1's vaginal treatment.

During a telephone interview on 10/24/23 at 10:51 AM, Resident #1's Pastor revealed she visited Resident #1 at the facility at least monthly or more often whenever Resident #1 needed her. The Pastor recalled she received a call from Resident #1 on 10/17/23 at approximately 9:13 PM and Resident #1 had told her about her boyfriend who worked at the facility. The Pastor stated Resident #1 told her how her boyfriend tucked her in at night, rubbed her on the legs and all the way up to her waist, touched her breasts and kissed her softly but would not tell her the name of the individual. Resident #1 then told the Pastor she didn't know if it was wrong or not and the Pastor stated she told Resident #1 it was inappropriate for him to be doing that to her. The Pastor stated the very next morning (10/18/23), she called in a report to the Department of Social Services. The Pastor stated when she visited with Resident #1 this past Saturday (10/21/23) Resident #1 had told her that she now knew it was wrong and she didn't want him doing that to her anymore. The Pastor stated Resident #1 had never made an allegation like this about another individual and felt she was telling the truth about what happened.

During a telephone interview on 10/26/23 at 1:18 PM, Resident #1's Family Member revealed Resident #1 had called her on 10/17/23 around 10:00 PM to tell her about her boyfriend. The Family Member stated Resident #1 told her how a guy who worked at the facility had complemented

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her, tucked her in at night, kissed her on the forehead and made her feel special. The Family Member stated Resident #1 told her their relationship started out as gradual flirting with him leaning in close for her to smell his cologne, telling her to give him a kiss, which she did, and later progressed to touching which Resident #1 described as him touching her legs as he went up the blanket, touching her breasts and giving her a kiss on the forehead. Then one night Resident #1 stated he pulled down his pants and exposed his penis to her. The Family Member stated Resident #1 would not tell her his name just that it was a man who had worked on the weekend. The Family Member stated Resident #1 told her on one occasion she was joking around that he was her boyfriend and he told her they needed to keep that between them. The Family Member stated she told Resident #1 what he was doing to her was inappropriate and asked Resident #1 if she had thought about the possibility he was doing the same thing to other residents as well who couldn't tell anyone what was going on and Resident #1 stated she hadn't thought about it before. The Family Member explained she was not listed as a facility contact for Resident #1 and she reached out to another Family Member to make sure it was ok for her to call the facility and when she got permission, she contacted the DON on 10/19/23 to report what Resident #1 had told her.

During a telephone interview on 10/24/23 at 4:52 PM, Resident #1's Guardian revealed Resident #1 had a past history of psychotic episodes but she was stable and not had any episodes in several years. Resident #1's Guardian recalled on 10/19/23 she received a call from the DON to inform her Resident #1's Family Member had

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called to report alleged abuse to Resident #1. The Guardian stated when she arrived later that same day (10/19/23) for a scheduled care plan meeting, the DON told her the Family Member had reported Resident #1 told them an employee at the facility had touched her legs and breasts, kissed her and exposed his penis to her. She stated the DON also reported Resident #1 would not state the actual name of the employee but did tell them the letter of his first name. She added the DON told her the names of the only two male employees that had first names starting with the letter Resident #1 revealed. The Guardian stated when she spoke with Resident #1, at first Resident #1 was very guarded about who the staff member was because she was worried he would lose his job. The Guardian stated Resident #1 told her that she had liked the attention she received from the employee and that he had touched her legs and breasts, kissed her and exposed his penis to her. The Guardian stated Resident #1 would not give a lot of details about the employee exposing his penis to her other than it only happened one time over a weekend and was really quick. The Guardian stated she explained to Resident #1 that an employee of the facility was a caregiver and when he made those types of advances to her, it crossed the line and Resident #1 restated she had liked the attention. She further explained to Resident #1 that it was inappropriate for an employee to pursue a relationship with a resident of the facility and felt Resident #1 had understood what she was saying. The Guardian stated she then asked Resident #1 if the employee was Med Aide #1 and recalled as soon as she mentioned his name, Resident #1's whole demeanor changed and Resident #1 stated how did you know? The Guardian stated she felt Resident #1 was a

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reliable historian and explained she visited with Resident #1 at least monthly and Resident #1 had never made this type of allegation or comments about anyone prior to this. The Guardian stated after her conversation with Resident #1, she stopped by the DON's office to let her know Resident #1 had confirmed the employee was Med Aide #1 and the DON had assured her that he would no longer be working at the facility.

During a telephone interview on 10/25/23 at 1:39 PM, the Psych Nurse Practitioner (NP) revealed he was unaware Resident #1 had alleged Med Aide #1 touched her inappropriately, kissed her and exposed his penis to her. The Psych NP stated he did not feel that Resident #1 was a reliable historian due to her dementia, cognitive impairment and inconsistencies she had told him in the past. The Psych NP explained sometimes residents with cognitive impairment had the tendency to misconstrue intentions, such as when being bathed they think they are being massaged or something else, and it was one thing for someone to misconstrue being touched but if someone had exposed themselves to someone else then that was something entirely different. The Psych NP stated he didn't want to discount what Resident #1 was saying happened and restated in his opinion, due to her dementia and cognitive impairment, he did not feel she was a reliable historian.

During a telephone interview on 10/27/23 at 11:48 AM, the Psychotherapist revealed she visited Resident #1 weekly or at the very least, a few times a month. The Psychotherapist recalled she last visited Resident #1 on 10/16/23 and she did not mention anything about having a boyfriend. She explained Resident #1's husband passed

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away and the focus of their visits centered on dealing with her grief. She explained Resident #1 could be repetitious with her statements at times or rather blunt when saying things and they had discussed ways for her to appropriately express her concerns/comments. When asked if she felt Resident #1 was a reliable historian, the Psychotherapist stated Resident #1 was consistent with her recollections visit to visit and could recall pretty strong specifics such as conversations she had with family members. She explained Resident #1 liked attention from others, such as when people commented on her external appearance, and had the tendency to be dramatic with her expressions in an attention seeking way. The Psychotherapist stated Resident #1 had not mentioned to her that someone at the facility had touched her legs, thighs and breasts as he was tucking her in and kissed her but felt it was possible she misconstrued the intent to make it seem like the encounter was more than it actually was. She could not explain how Resident #1 could have misconstrued him exposing his penis to her and stated she didn't want to imply that Resident #1 was not truthful or was making up the accusation but rather just dramatic with how she expressed herself as a way to get attention.

During a telephone interview on 11/08/23 at 9:48 AM, the Adult Protective Services (APS) Social Worker (SW) revealed when she spoke with Resident #1 on 10/19/23, Resident #1 would not tell her who the employee was or what had happened to her. The APS SW stated when she read the specifics of what was reported to them, Resident #1 did not deny the allegation. She stated Resident #1 did not mention anything about the employee exposing his penis to her or provide any details about what happened and

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only stated he told her not to tell anyone and she didn't want to get him into trouble.

Review of the police report dated 10/19/23 revealed the Sheriff's Department received a report of an incident labeled "11D-F-Sexual Battery" with the description of "unwanted touching." The report included a narrative from the responding Law Enforcement Officer that read in part, "On 10/19/23 at 10:43 AM, spoke with the DON, a supervisor at the facility, who reported a person from APS came to speak with Resident #1 and during the conversation, Resident #1 made the comment her boyfriend touched her and gave her unwanted soft kisses. Resident #1 would not say who her boyfriend was and if he was a resident or a staff member. She also would not say where he touched her or kissed her. The DON did state that Resident #1 had not been diagnosed with anything but does have some cognitive issues." Additional information added to the narrative by the responding Law Enforcement Officer read in part, "on 10/19/23 at 5:02 PM, spoke with the DON on the phone and she stated she had interviewed Resident #1. Resident #1 told the DON the suspect was Med Aide #1 who was an employee of the facility. The DON stated Resident #1 would not tell her but told some of her family members that he touched her nipples and also exposed his penis to Resident #1. The DON stated Resident #1 kept the same story to all the family members and the facility had suspended Med Aide #1 pending the investigation."

During a telephone interview on 10/27/23 at 10:21 AM, the responding Law Enforcement Officer revealed he was dispatched to the facility on 10/19/23 to obtain the initial report. He stated he

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when he spoke with the DON he was initially told an APS worker had come to the facility to talk with Resident #1 who reported her boyfriend had touched her ankles, inner thighs and kissed her on the mouth and nose but Resident #1 did not want to say who her boyfriend was. About 4 ½ hours after he took the initial report, he received a call from the DON to let him know that Resident #1 had revealed to family members the accused was Med Aide #1, an employee of the facility, and had also reported Med Aide #1 had touched her breasts and exposed his penis to her. The Law Enforcement Officer explained he added the additional information to his report, left it open for review and was not sure if a Detective had been assigned yet to investigate further.

Additional review of the police report dated 10/19/23 revealed the Law Enforcement Detective assigned to investigate the case interviewed Resident #1 on 11/03/23 and included the following narrative that read in part, "Resident #1 stated one of the employees, Med Aide #1, was assigned to her for approximately 2 weeks. She stated during that time he was friendly with her and took some liberties. She stated he would request that she kiss him on the cheek when he was attending to her and then he would kiss her on the forehead. Resident #1 stated one night he exposed his penis to her and then proceeded to touch her on her ankles, knees, and her breasts over her clothes. She stated he also kissed her on the lips. While retelling this story she mentioned multiple times that she liked it and that she was a consenting adult during these encounters. The DON stated she had interviewed Med Aide #1 about these allegations and he denied all the allegations. The DON stated Med Aide #1 was terminated for false

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documentation unrelated to the allegations. No charges will be filed in this incident and this case is closed, cleared by other means."

During telephone interviews on 11/03/23 at 3:22 PM and 11/06/23 at 12:57 PM, the Law Enforcement Detective revealed he spoke with Resident #1 on 11/03/23 and she had told him for the past two weeks when Med Aide #1 was assigned to her, he had touched her ankles, knees and breasts over her clothes and blanket. In addition, he stated she had told him that Med Aide #1 started out kissing her on the forehead and progressed to kissing her on the lips and on one occasion, exposed his penis to her. The Law Enforcement Detective explained even though he was unable to charge Med Aide #1 with anything, as it was her word against his, he believed Resident #1 was credible with what she reported the employee had done to her and stated she had presented as mentally sharp, coherent, had excellent hearing, understood the questions he asked and was consistent with her statements.

During a joint interview with the Administrator on 10/24/23 at 12:56 PM, the DON revealed she was informed of the allegation of potential abuse related to Resident #1 on 10/19/23 around 10:00 AM when the APS SW arrived at the facility and informed her they had received a report of exploitation involving Resident #1. The DON stated the APS SW told her Resident #1 reported she had a boyfriend who had been touching her and giving her soft kisses. Resident #1 would not tell the APS SW who her boyfriend was but did state he had stopped for now because he was scared and he had told her not to tell anyone about them. The DON revealed the Administrator was out of town at the time and she immediately

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started an investigation which included reporting the alleged abuse to the Division of Health Services Regulation and Law Enforcement. The DON also called to inform Resident #1's Guardian who stated she would speak with Resident #1 when she arrived at the facility later that day (10/19/23) for a scheduled care plan meeting. Around 11:00 AM after the APS SW left, the DON received a call from Resident #1's granddaughter reporting Resident #1 had called her the evening of 10/17/23 to tell her about her boyfriend, but would not state who it was, and revealed Resident #1 had told her the same details as reported by APS but also stated Resident #1 told her that he had exposed his penis to her. She updated the Guardian when she arrived at the facility and when the Guardian spoke with Resident #1 about the alleged abuse, Resident #1 told the Guardian the same details she had told her granddaughter and specifically named Med Aide #1. The DON stated Med Aide#1 was immediately suspended pending an investigation and when interviewed, Med Aide#1 denied the accusation. The DON stated Resident #1 does have some cognition issues at times but for the most part was alert and oriented and could be a reliable historian.

During a joint interview with the DON on 10/24/23 at 12:56 PM, the Administrator confirmed he was notified by the DON on 10/19/23 of what Resident #1 had alleged but was out of town at the time and the DON handled the investigation.

During a follow-up telephone interview on 10/27/23 at 3:22 PM, the Administrator revealed initially, Med Aide #1 was employed at a sister facility and worked PRN (as needed) at this facility starting 09/28/23 to help with staffing. The

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Administrator explained he received a call from the Administrator at the sister facility to discuss Med Aide #1 transferring permanently to this facility. He stated the sister facility's Administrator indicated there was a conflict between the DON and Med Aide #1 and the sister facility Administrator didn't feel that Med Aide #1 was being given a fair chance. The Administrator stated they agreed on having Med Aide #1 transfer to this facility on a trial basis and then decided to go through with the official transfer when there were no issues with his performance. The Administrator stated Med Aide #1 was officially transferred to their facility as a permanent employee effective 10/13/23.

During a telephone conversation on 11/06/23 at 11:41 AM, the Health Care Personnel Investigator (HCPI) revealed she was conducting an investigation into the allegation involving Med Aide #1. The HCPI stated when she spoke with Resident #1 at the facility last Thursday (11/02/23), Resident #1 revealed Med Aide #1 had given her soft kisses on the lips and when tucking her in bed, he would lift up the cover to look under and then starting at her feet, touched her legs while moving up the cover and tucking it in around her. Resident #1 further stated to the HCPI it all progressed gradually and then one evening Resident #1 recalled Med Aide #1 stated it must have been a long time since you've seen one of these (referring to a penis), exposed his penis to her and she told him it was some "humdinger." The HCPI stated Resident #1 indicated the attention was nice and did not appear upset when discussing what had happened with Med Aide #1. The HCPI stated Resident #1 was very compelling with her statements and felt Resident #1 was credible with

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what she reported.

Review of email correspondence from the North Carolina Division of Health Service Regulation, Complaint Intake and Health Care Personnel Investigations Section dated 11/06/23 at 5:09 PM revealed there had been 8 allegations made against Med Aide #1 from 3 different nursing facilities within the past year, some similar to this allegation and some not, and all had been unsubstantiated by the nursing facilities.

The Administrator was notified of Immediate Jeopardy via telephone on 11/08/23 at 12:35 PM.

The facility provided the following Credible Allegation of Immediate Jeopardy removal:

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

The jeopardous alleged deficient practice resulted when it is alleged the facility failed to protect one resident from inappropriate sexual advances from an employee when Resident #1 revealed on October 19, 2023 to an Adult Protective Services worker that she and Med Aide #1 had been in a relationship for the past 2 weeks and referred to Med Aide #1 as her boyfriend. Resident #1 stated Med Aide #1 had pursued her and recalled him telling her he had noticed her the first time he saw her. She stated at first, Med Aide #1 just touched her ankles and legs as he tucked her into bed and then their relationship gradually progressed to Med Aide #1 touching her legs and breasts, kissing her softly and on one occasion, exposing himself to her. Resident #1 stated anytime Med Aide #1 worked, he would tuck her

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in, kiss and touch her and had told her not to tell anyone. Resident #1 stated at the time, Med Aide #1's attention made her feel good about herself and didn't seem inappropriate but now looking back she felt it could have been elder abuse.

Resident #1 had a physical examination completed by the Nurse Practitioner on October 19, 2023 and the physical examination revealed "no apparent physical or emotional harm". Resident #1 was interviewed by the psychologist on October 23, 2023 with findings of "pt reporting feelings of loneliness. Therapist prompted patient to rational beliefs versus irrational beliefs". Resident #1's BIMS score is 11 indicating moderate cognitive impairment and diagnoses include Schizophrenia, Dementia, Hallucinations, and Depression.

Other alert and oriented residents in the facility were interviewed by the Director of Nursing, MDS Coordinator, Human Resources Director, Business Office Manager, and Social Worker on October 19, 2023 with no other concerns identified. Non alert and oriented residents in the facility had head to toe skin checks completed by the Director of Nursing, Assistant Director of Nursing, Unit Managers, and staff nurses on October 19, 2023 with no concerns identified.

The facility concluded the abuse investigation on October 26, 2023 with no substantiated finding of abuse based on resident and staff interviews and resident head to toe skin checks.

Med Aide #1 no longer works at the facility. His last date worked was October 17, 2023. Med Aide #1 was terminated on October 26, 2023 due to falsification of documentation related to a

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medication documentation discrepancy.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

Resident #1 has had no changes in mood, behavior, food intake or sleep patterns since the allegation was made. She remains stable in the facility at this time as evidenced by follow up Nurse Practitioner visit on October 26, 2023 and psychologist visit on October 30, 2023. Care plan was reviewed by the Director of Nursing on November 8, 2023 and direct care staff were re-educated by the Assistant Director of Nursing on November 9, 2023 on the care plan intervention for no male caregivers. Resident #1 will continue to be monitored closely by the Director of Nursing for changes in behavior or changes in activities of daily living through weekly review of the Periodic Care Observation documentation beginning on November 9, 2023. The Director of Nursing will refer Resident #1 to the physician and/or psychologist as appropriate. Resident #1 will continue to be followed by the facility psychologist weekly. The facility psychologist will meet with the Director of Nursing after each weekly visit to discuss any changes or concerns beginning on November 13, 2023. The facility psychologist was notified of the need for a weekly meeting by the Director of Nursing on November 9, 2023.

On November 8, 2023, the Social Services Director and Social Services assistant conducted interviews with all residents that have a BIMS of 13 or greater (cognitively intact) to determine if they felt safe in the facility. There were no issues

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identified. No residents reported inappropriate sexual advances by Med Aide #1 or any other staff member.

On November 8, 2023, the Assistant Director of Nursing and MDS Coordinator conducted skin assessments on all of the residents that had a BIMS of less than 13 to determine if there were any signs of abuse. No issues were identified.

On November 8, 2023 the Regional Clinical Coordinator re-educated the facility Administrator and Director of Nursing on the Abuse Policy and Procedure. The education emphasized a resident's right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual.

On November 8, 2023 the facility Administrator and Director of Nursing did in-person re-education with all staff in the facility on the Abuse Policy and Procedure. The education emphasized a resident's right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual.

All other employees were notified on November 8, 2023 by their respective Department Manager (Administrator, Director of Nursing, Housekeeping Supervisor, Dietary Manager, Therapy Director) of the need to receive mandatory in person education prior to the start of their next scheduled shift, including night shift and weekend shifts. All other employees will

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receive the same education prior to the start of their next scheduled shift by the Administrator, Director of Nursing or Assistant Director of Nursing. The Administrator will monitor the staff re-education roster to ensure that any staff that have not received the above education will receive stated education prior to working. There are no contract or agency staff working at the facility currently. Newly hired employees after November 8, 2023 will receive mandatory in person education by the Assistant Director of Nursing during general orientation prior to the start of their first shift. The Assistant Director of Nursing was notified on November 9, 2023 of this requirement.

The facility will screen residents that may be more vulnerable/more at risk for inappropriate staff to resident interactions through MDS interviews by the MDS Coordinator and Social Worker, through observations by the Assistant Director of Nursing and Unit Managers, and through quarterly care conference reviews by the MDS Coordinator and Social Worker beginning on November 8, 2023. Any concerns identified through facility screening will be reported to the Director of Nursing who will complete an evaluation of the resident and document any follow-up required. The MDS Coordinator, Social Worker, Assistant Director of Nursing, and Unit Managers were notified of this responsibility by the Director of Nursing on November 9, 2023.

The facility alleges credible allegation of immediate jeopardy removal November 10, 2023. The LNHA is responsible to implement the plan.

On 11/20/23, the facility's credible allegation for Immediate Jeopardy removal was validated by

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F 600	Continued From page 25 the following: Staff interviews revealed they had received education on the Abuse Prohibition Policy which included types of abuse, recognizing and understanding behavioral symptoms of abuse, residents' right to be free from abuse, and to immediately report any concerns of abuse to their immediate supervisor, DON, and/or Administrator. Review of the attendance sign-in sheets revealed staff education of all staff/all departments was completed on 11/10/23. Skin assessments were conducted on all cognitively impaired residents with no concerns identified and alert and oriented residents were interviewed who all reported they felt safe at the facility and had not experienced any unwanted touching or inappropriate interactions with staff or other residents.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care	F 607		12/15/23

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F 607	Continued From page 26 facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interviews, the facility failed to implement their abuse policy and procedures in the areas of screening and protection by not: 1) screening an employee prior to him transferring from a sister facility (Med Aide #1) and 2) protecting a vulnerable female resident (Resident #1) from inappropriate sexual advances from an employee (Med Aide #1) for 1 of 3 residents reviewed for abuse. Findings included: The facility policy titled "Abuse Prohibition Policy" with a revised date of 09/09/22, read in part: "Each resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse, corporal punishment, and involuntary seclusion. The facility will pre-screen employees, volunteers and residents for a history of abusive behavior with a criminal background check in states that conduct them. To assure residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor resident care and treatments on an	F 607	F607 1. The facility will continue to ensure that the abuse policy in the areas of screening and protection are implemented. Resident #1 has had no identified negative outcome as a result of this allegation and continues to be seen routinely for psychiatric/psychological services. Med Aide #1 no longer works at the facility. 2. Current vulnerable female residents have the potential to be affected. On 11.08.23, the Social Services Director and Social Services assistant conducted interviews with all residents that have a BIMS of 13 or greater (cognitively intact) to determine if they felt safe in the facility. There were no issues identified. No residents reported inappropriate sexual advances by Med Aide #1 or any other staff member.	

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F 607	Continued From page 27 on-going basis. It is the responsibility of all staff to provide a safe environment for the residents. A. Screening: 1) The facility will screen potential new employees for a history of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law (this includes attempting to obtain information from previous employers and/or current employers and checking with the appropriate licensing boards and registries and background checks per state guidelines). F. Protection: 1) If the accused is an employee of the facility, he/she will be suspended until the investigation has been completed." During an interview on 10/25/23 at 4:40 PM and a follow-up telephone interview on 10/27/23 at 3:22 PM, the Director of Nursing (DON) revealed they completed a background check whenever an employee transferred from a sister facility but they did not recheck references. She explained the employee's references would have been checked by the sister facility when the employee was initially hired. The DON recalled on the morning of 10/18/23, Med Aide #1 had reported to her that Resident #1 said he was her boyfriend and he didn't feel comfortable going back into her room. In addition, Med Aide #1 also told her a Nurse Aide had reported Resident #1 stated her boyfriend had touched her ankles and legs. The DON revealed nothing was mentioned about Resident #1 stating her boyfriend also touched her breasts and kissed her softly and if that had been mentioned, she would have started an immediate investigation. She stated she did not learn the extent of what Resident #1 had disclosed until 10/19/23 and Med Aide #1 was immediately suspended pending an investigation. During a telephone interview on 10/27/23 at 3:22	F 607	On 11.08.23, the Assistant Director of Nursing and MDS Coordinator conducted skin assessments on all of the residents that had a BIMS of less than 13 to determine if there were any signs of abuse. No issues were identified. On 11.17.2023, 100% audit of all new hires for the last year was conducted to ensure that reference checks were obtained prior to employment. No issues were identified. On 11.08.23, the Regional Clinical Coordinator re-educated the facility Administrator and Director of Nursing on the Abuse Policy and Procedure. The education emphasized a resident□s right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual. 3. 100% of facility staff were inserviced by the Administrator, Director of Nursing or Assistant Director of Nursing on the Abuse Policy and Procedure. The education emphasized a resident□s right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual. This education began on 11.08.23 with no employee being allowed to work without receiving the education. All education was completed	

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F 607	Continued From page 28 PM, the Administrator revealed initially, Med Aide #1 was employed at a sister facility and worked PRN (as needed) at this facility starting 09/28/23 to help with staffing. The Administrator explained he received a call from the Administrator at the sister facility to discuss Med Aide #1 transferring permanently to this facility. He stated the sister facility's Administrator indicated there was a conflict between the DON and Med Aide #1 and the sister facility Administrator didn't feel that Med Aide #1 was being given a fair chance. The Administrator stated they agreed on having Med Aide #1 transfer to this facility on a trial basis and then decided to go through with the official transfer when there were no issues with his performance. The Administrator stated Med Aide #1 was officially transferred to their facility as a permanent employee effective 10/13/23 and a background check was completed at that time. He confirmed when an employee transferred from one sister facility to another, they did not recheck the employee's references.	F 607	by 11.13.23. Newly hired employees after 11.08.23 will receive mandatory in person education by the Assistant Director of Nursing or trained designee during general orientation prior to the start of their first shift. The education will emphasize a resident□s right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse will be reviewed as well as reporting examples from the state operations manual. On 12.11.23, the Administrator and all department managers that have the ability to hire employees were inserviced by the Regional Clinical Coordinator on the abuse policy Section A screening. The education emphasized the screening process for new hires, including transfers from sister facilities, with the expectation that references from previous and current employers will be obtained prior to hire or transfer. On 12.14.2023, the Administrator conducted an audit on all the new hires from 11/06/2023 to current to ensure that all new staff had completed upon hiring the following: background checks, reference checks, and checks on the abuse registry. Abuse education during orientation was also audited by the administrator on 12.14.23 and there were no identified issues. Any identified issue will result with the employee being immediately taken off the schedule until	

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that employee has been educated by the Administrator or designee on the Abuse Polices and procedures.

4. A QA monitoring tool will be utilized to ensure ongoing compliance by the AP/Payroll Coordinator beginning on 12.16.23. The AP/Payroll Coordinator will review all potential new hire/transfer packets weekly x 12 weeks to ensure that references from previous and current employers are obtained prior to hire or transfer. Variances will be corrected at the time of review and additional education provided when indicated. All findings will be documented on the QA Monitoring Tool for F607 by the AP/Payroll Coordinator; the administrator will audit this tool at a minimum of monthly to ensure new staff are being trained on the Abuse Policies and Procedures.

Results from the QA Monitoring Tool for F607 will be reported to the Administrator weekly for the next 3 months beginning on 12.18.23 and concerns will be reported to the Quality Assurance Committee during monthly meetings. The administrator will review the QA Monitoring tool for F607 (which documents the new/transferred staff members' background check, abuse registry screening, reference checks, and abuse education) as well as proof of each of the referenced documents to ensure compliance with F607.

Continued compliance will be monitored through the facility□s Quality Assurance Program.

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F 607	Continued From page 30	F 607	Compliance will be monitored by the QA Committee for 3 months during the December through February regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified. 5. Date of Compliance: 12.15.23	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		12/15/23

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F 842	Continued From page 31 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

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F 842	Continued From page 32 Based on record review and staff interviews, the facility failed to maintain an accurate Medication Administration Record (MAR) for the administration of vaginal cream for 1 of 1 resident reviewed (Resident #1). Findings included: Resident #1 was admitted to the facility on 12/14/22. Her diagnoses included dementia without behavioral disturbance and overactive bladder. The quarterly Minimum Data Set (MDS) dated 09/12/23 assessed Resident #1 with moderate impairment in cognition. The MDS noted Resident #1 was occasionally incontinent of bladder and required partial/moderate staff assistance with toileting. Review of Resident #1's October 2023 MAR revealed a physician's order dated 06/27/23 for Estradiol Vaginal Cream (medication used to treat vaginal dryness, itching and burning) 0.1 milligram/gram inserted vaginally at bedtime every Tuesday and Friday for overactive bladder. Further review noted the order was initialed on the MAR as administered by Med Aide #1 on 10/06/23 and 10/17/23. During telephone interviews on 10/24/23 at 1:47 PM, 10/24/23 at 3:43 PM, and 10/26/23 at 12:35 PM, Med Aide #1 revealed he worked on 10/17/23 during the hours of 7:00 PM to 7:00 AM and was assigned to provide care to Resident #1. Med Aide #1 could not recall the exact date but stated it had to be the first week he started when he was first assigned to Resident #1's hall and she was scheduled to receive vaginal cream	F 842	1. The facility will continue to maintain accurate medical records for vaginal creams. Resident #1 continues to receive Estradiol vaginal cream per physicians order. No negative outcome was identified relating to these observations. 2. Current residents with orders for vaginal creams have the potential to be affected. MARs for current residents with orders for vaginal creams were reviewed on 12.11.23 to ensure that medical records for vaginal creams were accurate. No negative outcomes were identified relating to these observations. 3. 100% of licensed nurses and medication aides were inserviced by the ADON as of 12.15.23 on the facility policy on ensuring that medical records are accurately documented. Newly hired staff and agency nurses that are hired after 12.15.23 will be educated by the ADON on the facility policy on ensuring that medical records are accurately documented. The policy “Documentation Expectations” was used for the inservice beginning 12.15.23. The education primarily focused on accurate medical records documentation. The policy and the inservice also covers the following areas: a. Resident Identifiable Information (e.g., only having authorized individuals access) b. Complete, accurately documented, organized & readily accessible.	

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F 842	Continued From page 33 treatment. He stated he really didn't feel comfortable administering the treatment but did it anyway and afterwards, he talked with Nurse #1 and told him that he would not administer her vaginal cream treatment again because he didn't feel comfortable and Nurse #1 told him that he would take care of it. Med Aide #1 stated he could not remember if it was during the same conversation with Nurse #1 or on another occasion that Nurse #1 had instructed Med Aide #1 to just go ahead and sign it off as completed on Resident #1's MAR. On the evening of 10/17/23, Med Aide #1 stated he asked Nurse #2 if she would administer Resident #1's vaginal cream treatment that was due and she told him that she would. Med Aide #1 stated he personally did not administer the vaginal cream treatment to Resident #1 on 10/17/23 but did sign it off on the MAR as completed based on what he was previously instructed to do by Nurse #1. During a telephone interview on 10/25/23, Nurse #1 stated he never told Med Aide #1 that he would administer Resident #1's vaginal treatment or instructed him to sign it off on the MAR as completed. Nurse #1 stated the only time he recalled Med Aide #1 mentioning anything to him about Resident #1 was one night (he could not recall the date) Med Aide #1 approached him as he was working on a medication cart and asked him if he wanted to administer Resident #1's vaginal cream treatment. He stated he told Med Aide #1 no and also told Med Aide #1 he didn't need to administer the treatment either as they had female nurses who could administer Resident #1's vaginal treatment. During a telephone interview on 10/26/23 at 8:34 AM, Nurse #2 confirmed on the evening of	F 842	c. Exceptions to confidentiality, such as treatment, payment, & law requirements. d. Safeguarding against loss or destruction e. Retention periods f. The types of information that is included in the medical record. 4. A QA monitoring tool will be utilized to ensure ongoing compliance by the Treatment nurse/designee beginning on 12.16.23. The audit tool will include auditing for timely administration and accurate details. The Treatment nurse/designee will randomly audit MARs for 3 guests with orders for vaginal creams 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then bi-weekly x 4 weeks to ensure that documentation for vaginal creams is accurate. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Director of Nursing and Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the December through February regularly scheduled monthly meetings or until resolved and additional education/training will be provided for any issues identified.	

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F 842	Continued From page 34 10/17/23 Med Aide #1 had asked her if she would administer Resident #1's vaginal cream treatment because he didn't feel comfortable and she told him that she would. Nurse #2 explained she had every intention of administering Resident #1's vaginal cream treatment for Med Aide #1 but recalled it was a busy evening and she just forgot. During an interview on 10/25/23 at 4:40 PM, the Director of Nursing (DON) revealed nursing staff were expected to accurately document on a resident's MAR that medications or treatments were completed per the physician order only when they were the ones who actually administered the medication or treatment.	F 842	5. Date of Compliance: 12.15.23	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but	F 867		12/15/23

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not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to

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ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s)

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F 867	Continued From page 37 functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey completed on 06/22/22. This was for one repeat deficiency in the area of resident records originally cited on 06/22/22 during a recertification and complaint investigation survey and subsequently recited on 11/20/23 during the complaint investigation survey. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F842: Based on record review and staff interviews, the facility failed to maintain an accurate Medication Administration Record (MAR) for the administration of vaginal cream for 1 of 1 resident reviewed (Resident #1).	F 867	F867: 1. The facility will continue to ensure that the quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. Resident #1 continues to receive Estradiol vaginal cream per physicians order. No negative outcome was identified relating to these observations. 2. Current residents with orders for vaginal creams have the potential to be affected. MARs for current residents with orders for vaginal creams were reviewed on 12.11.23 to ensure that medical records for vaginal creams were accurate. No negative outcomes were identified relating to these observations. 3. 100% of licensed nurses and	

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F 867	Continued From page 38 During the recertification and complaint investigation survey of 06/22/22, the facility failed to maintain an accurate Treatment Administration Record (TAR) related to the placement of a left-hand splint. During an interview on 11/20/23 at 5:05 PM, the Director of Nursing (DON) revealed she was not employed at the facility in June 2022 and was not sure what processes were put into place following the recertification and complaint investigation survey related to the repeat deficiency. On 11/20/23, the Administrator was out of town and unavailable for an interview.	F 867	medication aides were inserviced by the ADON as of 12.15.23 on the facility policy on ensuring that medical records are accurately documented. Newly hired staff and agency nurses that are hired after 12.15.23 will be educated by the ADON on the facility policy on ensuring that medical records are accurately documented. The policy “Documentation Expectations” was used for the inservice beginning 12.15.23. The education primarily focused on accurate medical records. The policy and the inservice covers the following areas: a. Resident Identifiable Information (e.g., only having authorized individuals access) b. Complete, accurately documented, organized & readily accessible. c. Exceptions to confidentiality, such as treatment, payment, & law requirements. d. Safeguarding against loss or destruction e. Retention periods f. The types of information that is included in the medical record. On 12.11.23, the facility’s quality assurance committee was inserviced by the Regional Clinical Consultant on the procedures for developing and implementing appropriate plans of action to correct identified quality concerns. Education included determining the root cause of the identified concern, identifying, implementing, and monitoring the corrective action plan and recognizing when an action plan may need to be	

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revised.

On 12.11.23, the new Administrator audited the facility's last 4 surveys (including complaints and recertification surveys) to ensure that there were no persistent or patterned deficiencies related to the operating of the facility. None were identified, other than the repeat of citation F842.

4. A QA monitoring tool will be utilized to ensure ongoing compliance by the Treatment nurse/designee beginning on 12.16.23. The Treatment nurse/designee will randomly audit MARs for 3 guests with orders for vaginal creams 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then bi-weekly x 4 weeks to ensure that documentation for vaginal creams is accurate. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 12.16.23 and concerns will be reported to the Quality Assurance Committee during monthly meetings.

Beginning 12/16/2023, the Regional Quality Assurance Nurse/Regional Operator will review the facility's quality assurance action plans monthly for the next 3 months then randomly thereafter to ensure continued compliance. A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Coordinator. The tool will include

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F 867	Continued From page 40	F 867	that the facility has discussed all areas of the citations from the survey (F600, F607, F842, and F867) to ensure that the QAPI team has appropriate plans in place and discussions/recommendations regarding any deficient practices. The Regional Clinical Coordinator will attend the facility quality assurance meeting monthly x 3 months to ensure committee is developing and implementing appropriate plans of action to correct quality concerns. Variances will be corrected and/or additional education provided when indicated. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. 5. Date of Compliance: 12/15/2023	