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	345562	A. BUILDING _____ B. WING _____	C 04/23/2024

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CLEAR CREEK NURSING & REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227

(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
E 013 SS=J	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 013		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/09/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 013	Continued From page 1 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interviews, and record review the facility failed to implement emergency procedures on 4/11/24 at approximately 9:40 P.M. when NA #3 didn't report a workplace violence situation to her nursing supervisor, Director of Nursing, Administrator, or police. For approximately one hour, NA #3 was aware a former staff was behind the facility near the back service door. During this hour, NA #3 observed former staff behind the service door at the back of the facility property waving a kitchen knife in the air, swinging a kitchen knife like "former staff was going to stab someone" and heard former staff verbalized she wanted to "kill	E 013	Past noncompliance: no plan of correction required.	

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and physical harm (NA #1)", former staff stated she wasn't leaving until she could talk to NA #1, and she observed former staff cutting NA #1's personal vehicle with a knife. NA #3 stated she spoke with NA #1 who requested the police not be contacted. NA #3 observed former staff leave the back parking lot and sent a text message to NA #1 telling her this. NA #1 left the facility through the back service door and retrieved a handgun from her vehicle. Former staff returned to the facility waving a knife at NA #1 and former staff chased NA #1 into the facility when NA #1 pulled her gun out of her coat pocket, fired two rounds, one round entered former staff's left thigh. This incidence had the high likelihood of affecting all residents, staff, and visitors in the facility and on the facility property for 1 of 1 reviewed cases of emergency preparedness.

The findings included:

Review of the emergency preparedness policy titled "Workplace Violence" dated April 2021 under the heading Prohibited Behavior read "Violence in the workplace may include but is not limited to the following list of prohibited behaviors directed at or by a team member, supervisor, or member of the public. Direct threats or physical intimidation, implications or suggestions of violence, stalking, possession of weapons of any kind on licensed premises or while engaged in activities for the company in other locations or at company-sponsored events, assault of any form, physical restraint or confinement, dangerous or threatening horseplay, loud disruptive or angry behaviors or language that is clearly not part of the typical work environment, blatant or intentional disregard of the safety or well-being of others, commission of a violent felony or

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misdemeanor on company property or the other act that a reasonable person would perceive as constituting a threat of violence." Under the heading "Reporting Acts of Threats of Violence" the policy read "A team member who is the victim of violence, or believe they have been threatened with violence, or witnesses an act or threat of violence towards anyone else shall take the follow steps. If an emergency exists and the situation is one of immediate danger, the team member shall contact the local police officials by dialing 9-1-1 and may take whatever emergency steps are available and appropriate to protect himself/herself from the immediate harm, such as leaving the area."

Review of former staff personnel file showed she had an initial hire date of 10/17/23. Former staff was terminated on 12/19/23. Former staff had a disciplinary warning notice in her file dated 12/13/23 that read "failed to comply with company's policy on workplace violence. Former staff demonstrated disorderly conduct on 12/13/23 when she and another staff member had a verbal altercation. The disciplinary notice read former staff was terminated because the company policy reflected zero tolerance for workplace violence.

A telephone interview was conducted on 4/14/24 at 11:46 A.M. with NA #3. NA #3 stated she worked with former staff at the facility until former staff was fired in December 2023. NA #3 explained when she went to her car during a break on 2/28/24, she observed former staff driving around the facility on the roadway that circled the facility. NA #3 stated this was the first day she had observed former staff at the facility since she was terminated. NA #3 stated when

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former staff observed her outside, former staff stopped her vehicle near her, and asked if NA #1 was working. NA #3 stated she told former staff, NA #1 was not at work that day and former staff left the facility. NA #3 stated she knew NA #1 was at work when former staff asked about her whereabouts because NA #1 had called that day and asked NA #3 to pick her up from a nearby establishment on her way to work because she didn't want an individual to know she was at work. NA #3 stated she picked NA #1 up from the requested establishment and took her to work for her shift. NA #3 indicated after she observed former staff driving around the facility looking for NA #1, she asked NA #1 about parking her car at the nearby establishment and NA #1 confirmed she had parked at the nearby establishment to prevent former staff from knowing she was at work. NA #3 further stated she did not ask NA #1 any addittional questions.

A telephone interview was conducted on 4/14/24 at 1:30 P.M. with the Dietary Aide #1. The Dietary Aide stated one day in April 2024, she was unable to recall the exact date, she was behind the facility near the back service door on a break, when she observed former staff pull up near the back service door and parked her vehicle. Dietary Aide #1 stated former staff approached her and began to speak pleasantly with her before the conversation turned to discuss another employee and some information that was stated during a group text. The group text conversation included Dietary Aide #1, NA #1, and former staff. Dietary Aide #1 stated she had deleted the text messages from her phone and she was unable to recall everyone included in the group text. Dietary Aide #1 stated all she could recall from the group text conversation was NA #1 "not being a good

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friend". Dietary Aide #1 indicated former staff became very upset during their conversation outside the facility, and began to verbally threaten Dietary Aide #1 with physical harm. Dietary Aide #1 reported former staff "ran up on me" and threatened to "whoop my a**". Dietary Aide #1 stated she walked towards the back service door entrance, former staff followed her, and threatened to come into the building. Dietary Aide #1 indicated when former staff walked back to her vehicle, Dietary Aide # 1 entered the code on the back service entrance door's keypad and entered the building while former staff was in her vehicle. Dietary Aide #1 explained she went into the kitchen and told the Dietary Assistant Supervisor what had happened, and Dietary Aide #1 called the police. Dietary Aide #1 stated she went back outside to take the kitchen trash to the dumpster and observed former staff was in her vehicle at the back service area and when their eyes met former staff revved her car engine while maintaining eye contact. Dietary Aide #1 stated she told former staff the police had been called and were on their way. During the interview, the Dietary Aide explained the Assistant Dietary Manager came out the back service door, but she was unable to recall exactly when the Assistant Dietary Manager arrived. Dietary Aide #1 stated former staff had left the facility property prior to police arrival. During the interview, the Dietary Manager stated she recognized former staff because she had previously worked at the facility, but stated they were not friends; they just conversed a little when she was employed at the facility. Dietary Aide #1 further stated she had not had any incidents with former staff prior to this day and she was unsure why former staff had come to the facility and confronted her.

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An interview was conducted with the Assistant Dietary Manager on 4/15/24 at 2:47 P.M. The Assistant Dietary
Manager stated he was unable to recall the exact date when Dietary Aide #1 approached him in the kitchen about an incident involving Dietary Aide #1 and former staff behind the facility's building. He stated when Dietary Aide #1 reported the incident to him, he went out the back service door to tell former staff to leave the facility property. The Assistant Dietary Manager stated Dietary Aide #1 appeared to be upset. The Assistant Dietary Manager stated when he exited the service door, he recognized former staff because she had previously worked at the facility. He told former staff she needed to go on, leave his employees alone, and let everyone get back to work. During the interview, the Assistant Dietary Manager stated former staff told him "This and that" and she appeared very upset like former staff "was there to harm my employee". The Assistant Dietary Manager stated he did not hear former staff threaten to physically harm anyone. He observed former staff drive away and he stayed outside until the police arrived on scene. The Assistant Dietary Manager stated before he had time to report the incident to the Administrator, the police and the Administrator had arrived at the back service doors. The Assistant Dietary Manager stated when the Administrator and police arrived, he left the scene and went back into the kitchen to work. He was unsure what information was reported to the Administrator and he stated he did not provide a report to the Administrator because he was not outside during the incident.

An interview was conducted on 4/14/24 at 4:01 P.M. with the Administrator. During the interview,

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the Administrator stated when police arrived at the front of the facility on 4/3/24, was when she was made aware there was an incident that involved Dietary Aide #1 occurring at the back of the facility. The Administrator explained she told the police officer how to get to the back of the building, and she walked to the back of the building to find out what had happened. The Administrator indicated Dietary Aide #1 reported there was "an issue with a non-employee", the individual was previously employed at the facility. The Administrator stated it was reported to her Dietary Aide #1 and former staff had exchanged words outside prior to the arrival of the police. She stated former staff had already left the facility property prior to her becoming aware of an incident. The Administrator stated Dietary Aide #1 reported to her she had no concerns and Dietary Aide #1 appeared okay. During the interview, the Administrator stated following the incident on 4/3/24, there was no imminent threat and no form of violence that indicated a further situation would arise.

A follow up interview was conducted on 4/16/24 at 10:00 A.M. with the Administrator and the Regional Vice President was present. During the interview, the Administrator stated Dietary Aide #1 identified former staff as someone from the community and she was unaware the individual had been a former employee at the facility or had been terminated for a verbal altercation. The Administrator stated when the police collected their report from Dietary Aide #1, she was out of earshot and the Administrator was unable to hear the information Dietary Aide #1 provided to the police. The Administrator stated the verbal altercation on 4/3/24 was about "girl gossip". She further explained she spoke with Dietary Aide #1

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who assured her she had no other concerns and Dietary Aide #1 did not feel former staff would return to the facility. The Administrator stated there was no imminent threat and no form of violence from the situation on 4/3/24 to make her think a future situation would arise.

Review of a police report dated 4/3/24 showed the police arrived at the facility for a disturbance call at 7:40 P.M. The report read Dietary Aide #1 and a former employee former staff had a verbal altercation over a mutual friend at the facility. The report stated the former staff left the scene prior to the police arrival; there were no weapons and no injuries.

A telephone interview was conducted on 4/14/24 at 11:46 A.M. with NA #3 who stated she was included in a group text message chain initiated by former staff on 4/11/24. NA #3 stated former staff sent a text message out in the group text about "NA #1 not being a real friend, always talking crap", and in the message, former staff said "if (NA #1) was trying to say I'm lying, I'm outside in front". NA #3 stated the text message was sent at 8:55 P.M. However, she did not see it until later in the evening because she was providing care to residents. NA #3 indicated at approximately 9:40 P.M., she was unable to recall the exact time, she was in Resident #1's room checking on the resident when she heard yelling outside the building. NA #3 stated she looked out Resident #1's window and observed former staff behind the building near the back service door, swinging and twirling what appeared to be a kitchen knife, hitting the tires on NA #1's vehicle parked at the facility, and banging on the vehicle windows. NA #3 described the knife as a smaller kitchen knife, like a steak knife, the blade was

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silver and had a black handle. NA #3 explained she knew it was a knife because of the way former staff was holding the item and swinging it like she was going to stab someone. NA #3 stated she communicated with NA #1 and told her she had observed former staff in the parking lot and asked would NA #1 go outside and talk to former staff. NA #3 indicated NA #1 replied she wasn't going to talk to former staff because former staff was going to hurt her. NA #3 indicated when she discussed calling the police with NA #1, NA #1 stated she did not want to call the police and get former staff arrested. NA #3 stated she went back to checking on her residents until about 10:20 P.M. when she realized former staff was still in the parking lot and NA #3 went outside to talk to her to try to get former staff to leave the facility premises. NA #3 stated she spoke to former staff until about 10:35 P.M. During the conversation, NA #3 stated former staff was asking her for the code to the back service door and stated she just wanted to speak with NA #1. NA #3 indicated when she would not give former staff the codes for the door, the situation escalated, and former staff threatened to "kill and physical harm (NA #1)" and former staff stated she wasn't leaving until she could talk to NA #1.NA #3 stated former staff also remarked "I'm going to kill this girl." During the conversation, NA #3 stated former staff dug her knife into the side of NA #1's car. Then the former staff, for a reason NA #3 was unsure of, got into her vehicle and drove away from the back service door and out of NA #3's line of sight. NA #3 indicated she sat outside to make sure former staff didn't return and at 10:38 P.M. she sent NA #1 a text message. NA #3 stated the text message told NA #1 former staff had left and for NA #1 to come outside to talk with NA #3 about

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the situation, where other employees wouldn't know what was going on. NA #3 indicated NA #1 came out the back service door, went to her car, retrieved her gun, and returned to the back service door where she stood with the door closed and talked to NA #3 who was leaning against her vehicle that was parked in front of the back service door. NA #3 explained NA #1 was scared for her life and went outside to get her gun to protect herself. NA #3 stated she had never known of NA #1 bringing her gun to the facility premises prior to this evening. NA #3 stated to her knowledge NA #1 had not told anyone at the facility what was going on between NA #1 and former staff and she herself had not told anyone what she had observed that night. NA #3 explained after NA #1 retrieved her gun from her car, she stood at the back door with her back to the door, speaking with NA #3 was leaning on the front of her vehicle, which was parked front of the service door. Approximately five minutes after NA #1 and NA #3 began talking, NA #3 observed former staff running towards NA #1 from the bushes in front of the hallway on the right side of the back service door, swinging a knife in her right hand. NA # 3 stated former staff must have parked her vehicle on the other side of the building where NA #3 could not see it. NA #3 yelled at NA #1 to run. NA #3 stated as she watched former staff running towards NA #1, she felt former staff was going to physically harm NA #1 if she caught up to her. NA #3 indicated NA #1 entered the code and entered the building, but her foot got stuck as she entered. This allowed former staff to reach the back service door and NA #1, who was inside the building. Former staff who was outside the building, began to tug on the door trying to get it open and NA #1 was pulling on the service door trying to get the door closed.

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Former staff was able to snatch the door open and pursued NA #1 into the back service hall of the facility. When the door was snatched open, NA #3 observed NA #1 backing down the hallway toward a second locked door at the end of the hallway. NA #1 and former staff had gone almost halfway down the hallway to the kitchen entrance, when NA #1 pulled the gun out of her coat pocket and fired two bullets. One bullet hit former staff in the left thigh. NA #3 observed former staff run out of the building and back in the direction she had come from. NA #3 stated former staff drove her vehicle up and parked the car beside NA #1's vehicle at the back service door. NA #3 stated she told NA #1 they had to close the door and get some help. NA #3 stated she was unable to recall seeing the gun after NA #1 shot former staff, and she was unsure where the gun was place. NA #3 and NA #1 went inside and told Nurse #1 former staff had been shot by NA #1 and Nurse #1 went outside to assess former staff. NA #3 stated when she returned outside, former staff stated she had called the police, and she couldn't believe NA #1 had shot her.

A telephone interview was conducted on 4/14/24 at 11:30 A.M. with Nurse #3 who stated on 4/11/24 at approximately 11:00 P.M., she was at the nursing station giving shift report to Nurse #4 when NA #1 abruptly entered the nursing station and stated she had to go home. Nurse #3 stated she had not heard any yelling or anything out of the ordinary prior to NA #1 entering the nursing station and she was unsure what had happened. Nurse #3 stated it was out of character for NA #1 to verbalize she was not going to complete her shift, and therefore, she questioned NA #1 about leaving early. NA #1 then stated to her she had just shot someone who had been harassing her.

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Nurse #3 indicated when she asked for more information NA #1 told her she had shot former staff and former staff was in the back parking lot of the facility. Nurse #3 indicated herself, NA #3 and Nurse #1 left the nursing station, exited the facility, through the back service door, and found former staff siting in a parked car near the near the back service door. Nurse #3 stated the driver door was open, and former staff's leg was dangling outside the door, her left pants leg was pulled down to reveal an injury on her thigh. Nurse #3 indicated Nurse #1 told her to go back into the facility and get some bandages for former staff's wound. Nurse #3 stated she had to get NA #3 to give her the codes for the back service door to reenter the facility and retrieve the supplies to bandage former staff's wound. Nurse #3 said when she returned outside with the bandages, former staff moved from her car into a chair in front of her car to allow staff to bandage her thigh. Nurse #3 observed a very deep wound about the size of "a quarter or a half dollar" on former staff's left thigh, with lots of white tissue, there was not a lot of blood, but there was a lot of clear-red drainage. During the interview, Nurse #3 stated after she gave Nurse #1 the bandages, she returned inside the facility to check on her residents. She explained she found the residents assigned to her in bed sleeping and she does not feel they witnessed the event. Nurse #3 further stated she was unaware there was any discussion between NA #1 and former staff or that former staff was in the back parking lot until after the shooting had occurred. Nurse #3 stated she was not aware former staff had a knife or that NA #3 had a gun when she reported to work on 4/11/24.

A telephone interview was conducted on 4/14/24

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at 11:37 P.M. with Nurse #1. During the interview, Nurse #1 stated NA #1, NA #3, and Nurse #3 walked up to her and told her they had a bad situation. NA #3 told her NA #1 had shot the former employee inside the facility on the service hallway, outside the kitchen entrance door. Nurse #1 stated she immediately got up and went with NA #3 and Nurse #3 to assess former staff. Nurse #1 stated when they exited the building, she saw former staff sitting in her car, with her pants down to her mid-thigh and there was a wound exposed on her left thigh. Former staff was yelling NA #1 had shot her and former staff stated she'd called the cops. Nurse #3 explained former staff moved to a chair that was outside the facility, and she sent Nurse #3 into the facility to get some material to bandage the wound until rescue personnel could evaluate the wound. Nurse #3 stated the wound was not actively bleeding and no tourniquet was required. The wound was "about 2 ½ inches long and about ½ inch wide, with the widest part maybe ¾ inch wide". Former staff continued to yell at NA #1, who had come outside, stating why wouldn't you talk to me. Nurse #1 stated NA #3 replied because you tried to stab NA #1 with a knife. Nurse #1 stated she told NA #1 to go walk away from former staff and go wait for the police to show up. NA #1 went to her car and Nurse #1 went over to NA #1's car and asked what happened. NA #1 replied former staff tried to stab her and had called her 400 times that day harassing her. Nurse #1 stated this was the first time she observed the gun, and it was lying on NA #1's front passenger seat. Nurse #1 asked NA #1 if that was the gun she had used to shoot the former staff, NA #1 replied yes and explained the gun was no longer loaded. Nurse #1 stated when the police showed up at the facility, Nurse #1

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entered the building and used the phone near the back service door to contact the Administrator. During the interview, Nurse #1 stated she was unaware there was a conflict with NA #1 and former staff until after the shooting on 4/11/24. Nurse #1 stated usually staff will let her know when a situation is rearing up and had she known was at the facility threatening staff and causing property damage, she would have called the police. She stated after the incident on 4/11/24, NA #1 showed her text messages sent from former staff that included threats of former staff coming to the building and for NA #1 to come outside. Nurse #1 stated she was not made aware by staff former staff was at the facility and she had never observed NA #1 to have a gun. Nurse #1 explained the back service hall was closed off with two locking doors and it would be hard for any individual inside the building to hear a commotion on the service hallway. Nurse #1 further stated, she checked on her assigned residents after former staff was taken away in the ambulance and everyone was sleeping.

A telephone interview was conducted on 4/14/24 at 6:55 P.M. with Nurse #2. During the interview, Nurse #2 stated on 4/11/24 prior to her break at 10:20 P.M., she heard NA #1 on the phone talking to someone and she heard NA #1 reply "stop calling me, you're harassing me and I don't want to talk". Nurse #2 stated she did not ask NA #1 about the phone call and NA #1 did not mention the phone call to her. Nurse #2 indicated she left the facility through the front entrance door on 4/11/24 at about 10:20 P.M. to get something to eat. Nurse #2 stated she was unable to hear any shouting and she was unaware former staff was at the back of the building. She stated when she returned about 10:45 P.M., Nurse #3

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approached her in the hallway and told her NA #1 had just shot someone at the facility and asked if Nurse #2 would go with her to check on the individual who was shot. Nurse #2 stated when she exited the facility through the back service doors, former staff was observed in a chair and NA #3 and Nurse #1 were assessing her. Nurse #2 stated she went back inside the facility to check on staff and her assigned residents. Nurse #2 stated she had not observed a gun or knife at the facility on 4/11/24. During the interview, Nurse #2 stated after the incident she had read some of the text messages sent in a group message on 4/11/24 where former staff stated she was going to the facility. Nurse #2 indicated the police should have been called when former staff was observed in the parking lot with a weapon, and she explained all staff had received training about calling police for an unsafe environment prior to 4/11/24.

A telephone interview was conducted on 4/14/24 at 11:14 P.M. with Nurse #4 who stated she was at the nursing station getting shift report when NA #1 told her she was leaving. Nurse #4 stated NA #1 looked serious, and when she asked NA #1 if it was a family emergency, NA #1 started to walk away, and then looked back at Nurse #4 and replied I won't be back. Nurse #4 stated she called the Director of Nursing (DON) to make her aware NA #1 had left to ensure there were enough staff at the facility to meet resident needs with NA #1 leaving. Nurse #4 stated she saw Nurse #2 who reported to her something was going on and someone had heard a crash on the back hallway. Nurse #4 stated within minutes there was a police officer in the facility. Nurse #4 stated she called the DON back and told her the police were in the building, and the DON informed

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her she was receiving other calls with information too. During the interview, Nurse #4 stated she was unaware there were any concerns between NA #1 and former staff. She further explained she had not heard anything unusual at the facility prior to the police showing up.

A telephone interview was conducted on 4/15/24 at 11:37 AM. with NA #4 who stated she had worked at the facility on 4/11/24 during the 7:00 P.M. to 7:00 A.M. shift. During the interview, NA #4 stated before midnight on 4/11/24, she observed NA #1 walking towards the kitchen area with another teammate, whom NA #4 was unable to recall the teammates name. NA #4 indicated the teammates had not said anything to her and she had not heard any yelling at the back of the facility. NA #4 stated approximately 5-10 minutes later she heard two popping noises that sounded like a door closing; NA #4 described it like the sound of a heavy steal door closing in the building. NA #4 explained her mind was processing the first sound when she heard the second popping noise, she knew a gun had been fired in the facility. NA #4 indicated she stayed where she was and checked on her residents to ensure they were safe. NA #4 stated "some girl came through the double doors into the resident hallway and said, "I just shot someone". NA #4 stated she never left her assigned area to investigate the noise and after it was reported someone had been shot, she immediately went to close the resident doors and ensure her assigned residents were safe. NA #4 stated she did not see a gun and was unsure where NA #1 had placed the gun.

An interview was conducted on 4/15/24 at 10:33 A.M. with the Director of Nursing (DON). During

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the interview, the DON stated she received a phone call the evening of 4/11/24 from a nurse who stated NA #1 had a family emergency and was going home and the nurse was trying to figure out how to manage staffing to meet resident needs. The DON stated during the conversation with the nurse, she learned "there is someone fighting outside". The DON was then made aware the police had arrived at the facility. The DON stated she called the Administrator and told her there were police at the building. The DON received a return phone call from the Administrator for her to immediately go to the facility. The DON stated when she arrived, she checked on the residents and none of the residents had any concerns. During the interview, the DON explained after the incident on 4/11/24, she became aware the former staff was the same individual who had an encounter with Dietary Aide #1 on 4/3/24 and had also been terminated from the facility prior to her talking the role of DON. The DON indicated when staff witnessed the former staff in the parking lot, with a knife and communicating threats to staff inside, she expected staff to immediately call 911, management, the Administrator, and herself. The DON was unable to provide a reason why staff had not made a notification to someone when the former staff was first observed in the parking lot.

An interview was conducted with the Administrator on 4/14/24 at 4:01 P.M. who stated on 4/11/24 at approximately 11:00 P.M. she was notified by Nurse #1 and Nurse #2 there was a violent altercation at the facility. The Administrator stated she immediately responded to the scene and checked on the employees and residents to ensure everyone was safe. The Administrator stated she was made aware former

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staff had followed NA #1 into the building by yanking on the back service door when NA #1 entered. The Administrator stated she had not received any reports of the facility outside doors being broken and the code pads not properly working. The Administrator stated she expected staff to notify her immediately if there was a violent situation at work and she felt the staff had notified her when the violent situation occurred. The Administrator further stated she was unaware former staff was the same individual for the incidences on 4/3/24 and 4/11/24 until the investigation was completed following the 4/11/24 incident and that is when she became aware former staff's employment was terminated at the facility in December 2023 for a verbal altercation prior to the Administrator's arrival at the facility.

An interview was attempted with former staff and was unsuccessful.

An interview was attempted with NA #1 on 4/14/24 at 6:33 P.M. who stated she had given a report to the police department, and she was not comfortable answering any additional questions.

Measurements were taken on 4/15/24 at 11:25 A.M. with the Maintenance Director, showed there was approximately 50 feet from Resident #1's bedroom window to the back service door of the facility. The window from Resident #1's room was a straight line to the walkway at the back service door. There was approximately 18 ½ feet from the back service door to the asphalt roadway where former staff parked her vehicle. There was approximately 17 feet down the hallway from the back service entrance door to where NA #1 fired her handgun. The interior side of the back service door had a hole that measured ¾ inches vertical

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by 1 ¼ inches horizontal, by 1 ¼ inches deep. The outside of the door was a metal sheet with Styrofoam inside. The hole in the door was on the left side of the door, the side opposite the hinges and was 5 ¼ inches to the right of the edge of the door, and 22 ¼ inches from the bottom of the door. The Maintenance Director stated he presumed the hole was created by a bullet.

An interview was conducted on 4/14/24 at 3:10 P.M. with Resident #2 who was cognitively intact and resided in the room beside Resident #1, (closer to the end of the hallway near the back parking lot). Resident #2 stated sometime in the late evening last Thursday (4/11/24), she heard females shouting outside her bedroom window. She explained on a noise scale of 0-10, with 10 being the loudest, the individuals were "extra loud, an 8". During the interview, Resident #2 stated the shouting "made me feel nervous". Resident #2 explained, she normally keeps her blinds closed during the day and at night. She was unable to see anything outside of the building because her blinds were closed on 4/11/24. Resident #2 explained she was unable to make out the words being used. She was able to tell it was more than one female and they were "arguing like cats and dogs". Resident #2 indicated a short time later she knew the police had arrived because she saw their flashing blue lights in her room and heard male voices. During the interview, Resident #2 stated she felt safe the whole time because she was inside the building. Resident #2 stated she did not hear any other noise other than female individuals arguing.

An interview was conducted on 4/14/24 at 4:27 P.M. with Resident #3 who resided on the hallway to the right when standing in the back parking lot

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looking at the back service door. Resident #3 explained on Thursday, 4/11/24, she heard a lot of noise outside the facility. She stated she was able to hear female voices outside the building yelling, and then later, she was unsure how much time had passed, she heard male voices outside the building yelling. During the interview, Resident #3 stated she wasn't sure what time it happened, but it was late at night. Resident #3 stated "it was very scary" and "I thought to myself, I hope no one has a gun, if they had a gun I would have been scared". Resident #3 stated her window was closed and she did not observe anything outside the building, and she was unable to make out what the individuals yelling were saying.

Review of a police report dated 4/11/24 read the police department received a call on 4/11/24 at 10:48 P.M. about an assault with a deadly weapon with intruder. The first patrol car arrived on scene at the facility at 10:51 P.M. The report read NA #1's car had been damaged by what appeared to be a sharp object. The vehicle had multiple gouges and slashes in the paint. Former employee was initially taken to the hospital by ambulance for evaluation, and upon release from the hospital, former employee was taken into custody by the police. NA #1 was taken into police custody.

A telephone interview was conducted on 4/16/24 at 10:52 A.M. with the back service door contract vendor. During the interview, the door contract vendor stated when he arrived at the facility on 4/12/24, the back service door was closed. The vendor stated he was unable open the door by pulling on it prior to entering the code onto the keypad. The vendor explained there was some damage to the interior side of the door and the

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outer edge of the door where the bullet deflected downward when the bullet traveled through the door. The bullet caused the metal on the edge of the door to buldge out and hit the door frame as the door was closed. The vendor stated the door was able to be forced closed following the incident 4/11/24.

The Administrator was notified of Immediate Jeopardy on 4/16/24 at 11:33 P.M. The facility provided an approved corrective action plan on 4/17/24 which alleged a date of compliance of 4/13/24. The corrective action plan indicated:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 4/11/24, at 9:55 pm Nursing Assistant (NA) #3 observed former staff in the back-parking lot of the facility waving a kitchen knife, yelling for NA #1 to come out of the facility, threatening to kill/physically harm NA #1, and caused damage to NA #1's personal vehicle. The situation was not reported immediately to the nursing supervisor, Director of Nursing (DON), Administrator, or police because NA #3 attempted to deescalate the situation because of their known friendship and believed that former staff had left the property because she was no longer in sight. NA #3 notified NA #1 via text that former staff was outside with a knife and yelling for her to come outside. NA #1 exited the building and retrieved a gun from her car. Former staff arrived back in sight of NA #3 and NA #1 and chased NA #1, with a knife, back into the facility forcing the back door of the service hall in a nonresident care area out of NA #1's hand. NA #1 pulled a gun out of her coat pocket and shot former staff in the left thigh.

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NA #3 stood at the hood at the front of her car and observed while the incident took place then she went to notify the nurse. NA #1 went to collect her belongings and notified the hall nurse of the incident. Former staff called law enforcement and notified them that she had gotten shot. The nurse assessed former staff and applied first aid. Law enforcement arrived on site to investigate the situation. Former staff was taken to the hospital by Emergency Medical Services (EMS). NA #1 was removed from the property by law enforcement. At 11:05 pm, the Administrator was notified of the incident by the hall nurse. At 11:55 pm, the Administrator arrived at the facility to investigate the situation and ensure the safety of residents and staff. At 12:00 am, the DON arrived at the facility and made rounds to ensure everyone was safe and accounted for. On 4/11/24, NA #3 was relieved of her shift after the incident and called out for her scheduled shift the following day.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

On 4/11/24 going into 4/12/24, the hall nurses made the decision to complete a head count to ensure the safety of all residents while waiting for direction from the law enforcement. There were no identified areas of concern.

On 4/12/24, two Directors of Nursing from sister facilities completed trauma informed assessments for all residents except five. There were no identified areas of concern. On 4/12/24, the two Directors of Nursing attempted to contact families of the five residents who were non-alert and oriented to complete trauma informed

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assessments however, they were unable to be reached. Trauma informed assessments will be completed for the five identified residents upon the families return of call. The Director of Nursing is tracking to follow up with the families.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 4/11/24 at 11:05 pm, the Administrator activated the emergency preparedness plan for an active shooter.

On 4/11/24, when the incident happened, the front door was already locked requiring a code for entry. On 4/12/24 at 9:25 am, the Maintenance Director ensured that the front door continuously remained on lock down requiring a code for entry per the direction of the Administrator.

On 4/11/24 at approximately 11:30 pm, the Maintenance Director completed an audit of all entrance and exit doors to ensure all doors were secured and functioning properly. There were no other concerns identified.

On 4/12/24, NA #1 was suspended by the Administrator.

On 4/12/24, NA #3 was relieved of her shift after the incident. The facility initiated an investigation. During the course of the investigation it was determined that NA #3 would be provided with education upon return to work.

On 4/12/24, the Assistant Vice President of Sales and Marketing collaborated with the Administrator to ensure Carefeed communication (Electronic

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	345562	A. BUILDING _____ B. WING _____	C 04/23/2024

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communication platform to send out messages) were sent to families and staff for notification of the event.
On 4/12/24, the Maintenance Director changed all door codes in the facility.

On 4/12/24, the Regional Maintenance Support changed the service door lock to ensure the door was functioning properly.

On 4/12/24, the door vendor arrived on-site to assess the service hall door and a replacement door was ordered.

On 4/12/24, Counseling Services was provided through the Employee Assistance Program for support of the staff.

On 4/12/24, Counseling Services was provided through Human Resources for support of the staff. Following the trauma-informed assessments, no concerns were identified. Therefore, counseling was not offered to residents.

On 4/12/24, the Administrator initiated discussion with legal counsel to arrange a civil no contact order regarding NA #1 and former staff to refrain them from entering the facility premises.

On 4/12/24, the Administrator implemented a staff member to be assigned to sit at the front desk to ensure no unauthorized visitors enter the facility. The name of the NA #1 and former staff with photos were placed at the front desk to alert the staff that they are not allowed on the premises and what to do if they see these individuals (call 911 and notify the Administrator immediately).

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On 4/12/24, the Administrator notified the Medical Director of the incident and action steps taken.

On 4/12/24, the Senior Vice President of Health Services notified the Nursing Home Licensure and Certification Section Chief of the event.

On 4/12/24, the Senior Administrator made the decision to post a sign at the entrance doors to the facility that no weapons are allowed on the premises and for the sign to remain posted ongoing.

An in-service was initiated on 4/12/24 by the Nurse Educator to all staff regarding the emergency preparedness procedures for active shooter and work place violence, with emphasis on 1) immediately notify your Supervisor and Administrator of an act or threat of violence in the workplace by employees or any non-employee (such as a spouse, significant other, family member, resident, visitor, or any other person) who commits or threatens violence on company property or while you are performing your duties 2) If there is believed to be an immediate threat for your safety or safety of others contact law enforcement authorities immediately by dialing 911, and 3) If you are uncertain about whether the incident is serious enough to contact the police, immediately consult with your Supervisor or another available Supervisor 4) weapons policy with emphasis on a) All employees of this company and any other person coming onto company premises are prohibited from carrying any concealed dangerous weapon of any sort, in accordance with applicable law and b) Any employee with personal safety concerns or who becomes aware of another individual in possession of a weapon on company premises,

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should immediately report to the Administrator. The In-service was completed by 4/13/24. At the conclusion of the face to face education for all employees that have worked, there were no additional reports of workplace violence. After 4/13/24, the Administrator will monitor staff completion and any staff who has not completed the in-service will complete it before working their next scheduled shift.

All newly hired staff will be educated regarding the emergency preparedness procedures for active shooter, weapons policy, and workplace violence with emphasis on 1) immediately notify your Supervisor and Administrator of an act or threat of violence in the workplace by employees or any non-employee (such as a spouse, significant other, family member, resident, visitor, or any other person) who commits or threatens violence on company property or while you are performing your duties 2) If there is believed to be an immediate threat for your safety or safety of others contact law enforcement authorities immediately by dialing 911, and 3) If you are uncertain about whether the incident is serious enough to contact the police, immediately consult with your Supervisor or another available Supervisor by the Staff Development Coordinator or Director of Nursing during orientation. The Staff Development Coordinator was notified of this responsibility by the Administrator on 4/12/24.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The decision to monitor the system for notification of workplace violence through staff knowledge and understanding by successful completion of

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quizzes was made on 4/12/24 by the Administrator and Director of Nursing and presented to the Quality Assurance (QA) Committee on 4/12/24.

The Administrator, DON, Unit Manager, Dietary Manager, Social Worker, Pay Roll, or Scheduler will conduct quizzes with 10 staff weekly x 4 weeks then monthly x 1 month to ensure staff understand what to do when an individual exhibit acts of violence on the facility premises. Any staff that does not successfully pass the quiz will be retrained. After two failed attempts, staff will be removed from the schedule and will not be allowed to take an assignment until successful completion.
The Administrator and/or DON will present the findings of the quizzes to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions and the need for additional monitoring.
Date of immediate jeopardy removal is 4/13/24.

The facility provided a corrective action plan for the incident that happened on 4/11/24. The validation process was completed on 4/22/24. Validation was completed and showed education was provided to staff. The staff received education in all departments. Trauma informed assessments were completed on all residents. The facility offered counseling to the staff on duty the night of the incident. Observed the maglock being changed by the door company and they upgraded from 600 pounds to 1200 pounds for the front door; the service door and frame were replaced with the same mag lock 1200 pounds

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E 013	Continued From page 28 installed. The unauthorized visitor notice for the NA #1 and former employee was posted at the front desk and they have staffed a receptionist to work around the clock to answer phones and man the front door. All staff are using the front door to enter the building. An Ad Hoc QAPI was conducted on 4/12/24. Audits (testing staff) has been conducted and the doors are all checked daily by the maintenance director (Monday-Friday) and the weekend supervisor on Saturday and Sunday. Door codes will be changed every 2 weeks on their payday. Alleged date of immediate jeopardy removal is 4/13/24 was validated.	E 013		
F 000	INITIAL COMMENTS A complaint survey was conducted from 04/14/24 through 04/16/24. Onsite validation of the immediate jeopardy removal plan was conducted on 4/22/24. Additional information was received on 4/23/24 remotely. Therefore, the exit date was 4/23/24 for Event ID #JV1611. The following intakes were investigated NC0000215742 and NC0000215770. Both intakes resulted in immediate jeopardy. 2 of the 2 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.73 at tag E0013 at a scope and severity J Immediate Jeopardy began on 04/11/24. Immediate Jeopardy was removed on 04/13/24.	F 000		