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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation survey was conducted from 04/22/24 through 04/23/24. Event ID# GZEM11. The following intakes were investigated NC00211470 and NC00215399. One (1) of 2 allegations resulted in a deficiency. | F 000 | | |
| F 600 SS=G | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and resident and staff interviews, the facility failed to protect resident's right to be free from abuse for 1 of 3 residents reviewed for abuse, when Nurse Aide (NA) #1 struck Resident #1 in the shoulder two times with an open hand during incontinence care, resulting in Resident #1 crying.<br><br>The findings included:<br><br>Resident #1 admitted to the facility on 12/05/23 with diagnoses that included hemiplegia and | F 600 | Past noncompliance: no plan of correction required. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/07/2024

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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hemiparesis following a stroke and dementia with mood disturbance.

Review of Resident #1's quarterly Minimum Data Set assessment dated 12/05/23 revealed her to be cognitively impaired without delirium, rejection of care, or instances of wandering. Resident #1 was coded as having physical and verbal behaviors directed towards others and other behaviors not directed towards others as occurring 1-3 days during the lookback period. Resident #1 was coded as frequently incontinent of bowel and bladder and was dependent on others for toilet hygiene and personal hygiene. She needed extensive assistance with rolling to the left and right.

Review of Resident #1's care plan, last updated on 11/01/23, revealed the following care area: "Level 2 Preadmission Screening and Resident Review with behaviors" which included [Resident #1] has a history of yelling, hitting, slapping, spitting, grabbing, and uses bad language towards staff in her native language.

Review of facility provided reportable incidents 12/29/23 revealed a documented incident of alleged abuse directed towards Resident #1 by Nurse Aide (NA) #1. The initial 24-hour report indicated that another nurse aide (NA #2) was assisting NA #1 with providing incontinence care to Resident #1 when Resident #1 became aggressive towards the staff which resulted in NA #1 striking Resident #1 in the left should twice. Per the facility's investigation, NA #1 was immediately suspended pending the investigation. There were written statements from NA #1 and NA #2.

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Review of NA #2's written statement revealed the following: "Today around 4:00 PM I asked [NA #1] to help me change [Resident #1] in bed. Due to her being sick and deciding not to get up. We proceeded to gather the materials that were needed for her to be changed, after doing so we both went to a side of her bed so we could roll her back and forth. [NA #1] began to grab the padding under [Resident #1], on my side. [Resident #1] smacked her hand, and [NA #1] smacked her hand back and yelled "you hit me first". [Resident #1] yelled back and began to sob. I told [NA #1] "You can't do that, that isn't right". She replied, "I can't stand this type of behavior, she is entitled". I said "nothing". As I am cleaning [Resident #1], because she is rolled now, [Resident #1] begins to cry louder and yell. [NA #1] starts to yell at [Resident #1] telling her to "stop" and "be quiet". [Resident #1] gets upset and tries to spit on her [NA #1]. [NA #1] says to her "you want to spit?" [Resident #1] tries to spit again and NA #1 "smacks" her face. I said, "[NA #1], you cannot do that, that is not right". She begins to tell me how nice of a person she is and how she has had to deal with a lot so [she] can't tolerate this kind of behavior from [Resident #1]. At this point [Resident #1] is bawling her eyes out, holding my arm. I tell her "It's ok senora". Then I left the room after cleaning up to figure out how and who to tell."

An interview with NA #2 via telephone on 04/22/24 at 5:18 PM revealed she remembered that incident with Resident #1 and NA #1. She reported she had asked NA #1 to go and assist her in providing incontinence care to Resident #1. She reported they entered the room, notified Resident #1 of their intention to provide incontinence care with NA #1 on the left side of

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the bed and herself on the right side of the bed. NA #2 reported as NA #1 began to turn Resident #1 on her side, Resident #1 became angry, yelling, and swatted at NA #1. She reported NA #1 then "popped" Resident #1 back on her left shoulder with an open hand and told Resident #1 to stop. NA #2 reported she told NA #1 at that time that she could not do that and to stop. NA #2 stated the care continued and Resident #1 attempted to spit on NA #1 multiple times. She stated at that point, NA #1 "popped" Resident #1 again, either on the side of her face or left shoulder. NA #2 stated she again told NA #1 that she could not do that, and NA #1 responded that she would "not deal with that kind of behavior". She stated at that point, she observed Resident #1 crying, and she told Resident #1 "it was ok". NA #2 then reported she and NA #1 left at the completion of incontinence care and she went and immediately reported it to her hall nurse (Nurse #1). NA #2 reported she believed NA #1 was sent home almost immediately after she reported the interaction. NA #2 indicated Resident #1 was not physically injured but reported Resident #1 was emotionally upset following the interaction. NA #2 did not clarify why she did not stop the care when Resident #1 became aggressive or why the care was not stopped after the first time NA #1 struck Resident #1.

Review of NA #1's written statement from the day of the incident with Resident #1 read: "I was on my 2nd shift working on 400 hall. While I was working with [NA #2] helping [Resident #1] to change, she hit me multiple times and spit on my face. I witnessed several times she did it to other CNA's, but at that moment I hit her arm back. Later I realized I shouldn't, but somehow that

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| F 600 | Continued From page 4 moment I reacted. Sorry about it."<br><br>An interview with NA #1 via telephone on 04/22/24 at 12;17 PM revealed she was working on the same hall where Resident #1 resided but was not Resident #1's assigned nurse aide. She continued, stating that she and another nurse aide (NA #2) had gone into Resident #1's room to provide incontinence care. She reported she was very familiar with Resident #1 and stated she had a history of "bullying" other nurse aides and would often "punch, spit, and hit" the nurse aides that provided her care. NA #1 stated when she and NA #2 entered Resident #1's room, they explained to her what care they planned to provide and when she rolled Resident #1 onto her right side, Resident #1 began to kick her. NA #1 stated she asked Resident #1 multiple times to "please stop, don't do this" but admitted she became frustrated and ended up hitting Resident #1 with her open hand on her left shoulder. She stated Resident #1 then began to spit in her face and she reacted by "popping" Resident #1 on the left shoulder again. She stated NA #2 asked her why she was did that and she told her "you saw what she was doing; hitting, spitting, and kicking me". NA #1 reported her strikes were not hard and did not make any sounds, leave redness, bruising, or other marks on Resident #1. She reported "I never had lost my cool before that day" and stated she knew after the fact that she should not have reacted that way. NA #1 stated when she and NA #2 left the room, she knew NA #2 would have to report the incident and stated she knew she would have to report it as well. NA #1 was insistent that she only struck Resident #1 on her left shoulder and that she did not use any force. NA #1 did verify that Resident #1 did begin to cry following the interaction and stated she | F 600 | | |

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thought her striking her surprised Resident #1 and that Resident #1 probably did not believe that a nurse aide would "stand up to her behavior". NA #1 reported she did not feel as though her actions were abusive and when asked why she did not just stop the care and come back later, NA #1 reported if they would have left and come back, Resident #1 would have acted the same way and both she and NA #2 though they needed to "just get it done." NA #1 stated "I don't know why I was so frustrated that day. I worked on the dementia hall several months with no issues, I'm usually so very patient and treat the residents good." I don't think what I did was wrong, I make no apology to that resident for what I did, I'm sorry I surprised the other NA." I don't think it was abusive in nature, if they didn't lay me off, I was planning on quitting because the whole interaction was traumatizing." NA #1 reported she was approached almost immediately by the Assistant Administrator and was told she needed to go home. NA #1 stated she was suspended pending an investigation and ultimately terminated.

Multiple attempts to reach Nurse #1 by telephone on 04/22/24 and 04/23/24 were unsuccessful. Nurse #1 never returned any telephone calls.

Review of Nurse #1's written statement dated 12/29/23 revealed the following: "I was sitting in charting room when [NA #2] asked to speak to me in private. She reported what she had just seen [NA #1] had done to [Resident #1]. I immediately reported to [Assistant Administrator] who immediately spoke with [the nurse aides].

An interview with the Administrator on 04/22/24 at 2:18 PM, who was serving as the Assistant

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| F 600 | Continued From page 6 Administrator the day of the incident revealed she was approached by Nurse #1 who informed her that NA #2 had alleged that NA #1 had struck Resident #1 twice during incontinence care. The Administrator stated she went and spoke with NA #2 who recounted the incident to her. The Administrator stated she then immediately went to NA #1 and informed her of the allegations and sent her home. The Administrator stated she believed less than 10 minutes passed between her being notified and NA #1 being sent home. She stated she assigned a unit manager to escort NA #1 from the building to ensure she had no other interactions with other residents. The Administrator stated she then notified the Director of Nursing and began a full investigation into the allegations. She reported her investigation determined that due to the statements that alluded Resident #1 was tearful following the interaction, she ended up substantiating the allegation and subsequently terminated the employment of NA #1. She stated immediately after the incident, Nurse #1 completed skin checks of Resident #1 and all other cognitively impaired residents, while cognitively intact residents were interviewed with no concerns noted. She also reported assigning abuse, neglect, and exploitation training to all her staff that had to be completed before their next shift, along with training regarding employee burnout. The Administrator stated when she went to interview Resident #1 shortly after being informed of the incident, she was observed to be in her room, resting comfortably and did not appear to be upset. She stated when she questioned Resident #1, Resident #1 could only respond with yes/no answers but reported someone had been mean to her but was unable to tell her where she was hit. The Administrator stated Resident #1 did | F 600 | | |

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not appear tearful or fearful during questioning. She also stated a skin check was performed with no injury, redness, or swelling being observed. The Administrator stated with the statement of Resident #1 being emotional after the incident, they reached out to Resident #1's psych provider who stated they did not currently have a provider they could send to the facility to speak with Resident #1 so she reached out to the medical director who followed up a day or two later. The Administrator reported at the time of the investigation, NA #1 only ever reported to them that she struck Resident # 1 once and that she felt that NA #2 had intervened when she told NA #1 she should not be striking the resident. The Administrator reported that all staff were trained on abuse policies and procedures at the time of hire and then on an annual basis. The Administrator also reported the facility had placed the incident in their quality assurance program which included audits of staff interactions and on-going, current monitoring.

An interview with Resident #1 was completed on 04/23/24 at 2:17 PM. Resident #1 was in her room, dressed, and sitting in her wheelchair. A facility provided translator was used as Resident #1's primary language was Spanish. Resident #1 reported that she was happy with the care she received, the staff were "very respectful" and that she felt safe at the facility. Resident #1 had no recollection of the incident with NA #1.

The facility provided the following corrective action plan:

1. Corrective action for residents found to be affected:

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| F 600 | Continued From page 8<br>A. What are we going to do for the resident affected?<br>Immediate skin check, physical assessment for injuries performed by nurse #1. Abuse Allegation was reported to the resident's family (RR), Administrator, DON, Provider, the Admin Office, Adult Protective Services, and the local police department. Accused NA was immediately suspended pending investigation results. Accused NA was advised to not return to the facility or the facility's property until further notice. NA was terminated once the investigation was completed. 2-hour abuse reporting to state completed on 12/29/23. Resident was assessed by the provider on 01/02/24 and new order for medication to decrease behaviors received however RR refused to allow the new medication. Alleged Abuse Incident report was completed by hall nurse on 12/29/23. Administrator observed four different employee interactions on 12/29/23 with residents to ensure that staff interactions were appropriate. Reviewed resident's care plan and added intervention for staff to leave and reapproach resident when she is combative with care on 12/29/23.<br><br>B. Who is going to do it?<br>Hall nurse performed assessment on resident and completed the incident report for alleged abuse on 12/29/23. Nurse notified Administrator and Administrator completed 2-hour abuse reporting form and sent in on 12/29/23. Nursing Supervisor notified provider on call on 12/29/23. Administrator notified resident's family(RR) and DON on 12/29/23. Hall nurse completed incident report on 12/29/23. Administrator met immediately with accused NA and suspended her immediately on 12/29/23. DON and Administrator met with NA #1 and terminated her employment | F 600 | | |

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once the allegation was substantiated on 12/30/23. Administrator and DON reviewed resident's care plan and added appropriate interventions.

C. How will the corrective action be communicated to staff?
N/A. None Needed. The NA involved was suspended immediately and then terminated. NA intervened and then reported immediately to supervisor. She received same education and training as all staff.

D. Is action clearly documented and care planned?
Documented in statements and in with the NA involved. Resident #1's care plan was reviewed and appropriate new interventions added on 12/29/23.

2. How will corrective action be accomplished for those residents having the potential to be affected?

A. How will we identify other residents at risk?
All residents in the facility have the potential to be at risk.

B. After identifying at risk residents, what are we going to do for them?
The hall nurse performed skin assessments on all residents that accused NA cared for on this day that were unable to be interviewed on 12/29/23. No further injuries noted. The Administrator interviewed residents and asked if they felt safe and if they had any concerns of any staff member being mean to them or rough with them. All other residents stated they felt safe and no one had been mean or rough with them. LSC

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Employee Interaction Audit Form for Substantiated Abuse Allegation was started immediately. That audit will be completed by Central Nurse Manager who will observe 4 different employees' interactions with residents 3 times per week for 4 weeks to ensure that staff interactions are appropriate. Staff education started immediately regarding Abuse, Intervening and Caregiver burnout. Education completed 12/29/23 for all staff in facility and all staff will be educated prior to working their next shift. Two extra Relias courses were assigned by the Staff Development Coordinator for the month of January related to Abuse and Caregiver burnout.

C. Are we taking credit for interventions in the chart and on the care plan?
N/A. Nothing new required to be added to care plans for residents at risk.

3. What measures will be put into place to ensure that the deficient practice will not occur?

A. What system(s) will we adapt/change/implement to keep the problem from reoccurring?
Abuse Investigating and Reporting education materials from Lutheran Services University that includes information on caregiver burnout along with a wallet card with signs and symptoms of staff burnout added to facility orientation and will remain part of orientation moving forward. Abuse Reporting has always been included in orientation however more focus on caregiver burnout will be added effective 12/30/23. Staff education completed on LSC Policy of Abuse Investigation and Reporting for Senior Services as well as Lutheran Services University education related to

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caregiver burnout and staff intervening, staff will be educated prior to their next working shift. Staff Development Coordinator assigned Relias courses on Abuse Reporting and on Caregiver burnout to all staff for the month of January.

B. How will we educate/communicate any system changes to the staff?

" Printed Staff Education on LSC Policy of Abuse Investigation and Reporting for Senior Services and Lutheran Services University information on caregiver burnout as well as the two new Relias courses assigned to January agenda.
" Provided Staff Education on WHATSAPP messaging system to nursing department, and on PCC Bulletin Board to all departments on importance of recognizing caregiver burnout and importance of "walking away" when frustrated, importance of reporting potential abuse immediately to supervisor, and being familiar with LSC Policy on Abuse Investigation and Reporting which includes intervening.
" Added additional education materials to facility orientation related to caregiver burnout, how to recognize and importance of reporting to supervisor when caregiver burnout is suspected. Wallet card will also be provided to all new employees during facility orientation that contains symptoms of staff burnout.

4. How does the facility plan to monitor its performance to make sure that solutions are sustained?
A. Are we evaluating actual staff practices? Yes. Administrator initiated and completed 4 audits 12/29/2023. Central Nurse Manager will observe 4 different employees' interactions with

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residents 3 times per week for 4 weeks to ensure that staff interactions are appropriate starting 12/29/23.

B. Are we performing regular audits to ensure the corrective action/system/change is being implemented and are working?
Yes. Observation of employee's interactions with residents has been started and will continue monthly x3 beginning immediately and continuing February and March 2024, and then quarterly for Q2,Q3, and Q4 in 2024. These observations will end 12/31/2024.

C. Are we sharing audit results in the monthly QAPI meetings?
Yes. All POCs are shared in QAPI. The next QAPI meeting is scheduled for February 1, 2024.

Compliance date: January 3, 2024

The facility's corrective action plan was validated on 04/23/24. Review of facility provided monitoring tools revealed the facility had completed a 24 hour and 5 working day report upon notification of the incident and completion of their investigation. The investigation revealed written statements from all parties involved, a termination notification for NA #1, education with sign-in sheets for all staff in the facility, skin checks and interviews with alert and oriented residents, and finally monitoring tools for ongoing monitoring to ensure the issue was resolved. The completion of the self-imposed corrective action plan was verified on-site through staff interviews and record review. The compliance date of 01/03/24 was validated.

F 607 SS=D Develop/Implement Abuse/Neglect Policies F 607

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| F 607 | Continued From page 13<br>CFR(s): 483.12(b)(1)-(5)(ii)(iii)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br><br>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.<br><br>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.<br><br>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.<br><br>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, staff and resident interviews the facility failed to protect a resident from further abuse when Nurse Aide #2 witnessed NA #1 striking Resident #1 when she became combative during care and did not immediately report the incident to her supervisors | F 607 | Past noncompliance: no plan of correction required. | |

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which resulted in NA #1 striking Resident #1 a second time, resulting in Resident #1 crying for 1 of 3 residents reviewed for abuse.

The findings included:

A review of the facility's policy titled "Abuse Investigation and Reporting for Senior Services" last revised on 01/26/23 revealed: Retaliation by staff, regardless of whether harm was intended, is also considered abuse. The policy also stated "physical abuse is defined as hitting, slapping, pinching, kicking, etcetera. It also includes controlling behavior through corporal punishment, which is used as a means to correct or control behavior through such actions as pinching, spanking, slapping hands, or hitting with an object." The facility's policy stated its policy included identifying, correcting, and intervening in abusive situations.

Review of facility provided reportable incidents 12/29/23 revealed a documented incident of alleged abuse directed towards Resident #1 by Nurse Aide (NA) #1. The initial 24-hour report indicated that another nurse aide (NA #2) was assisting NA #1 with providing incontinence care to Resident #1 when Resident #1 became aggressive towards the staff which resulted in NA #1 striking Resident #1 in the left should twice. Per the facility's investigation, NA #1 was immediately suspended pending the investigation. There were written statements from NA #1 and NA #2.

Review of NA #2's written statement revealed the following: "Today around 4:00PM I asked [NA #1] to help me change [Resident #1] in bed. Due to her being sick and deciding not to get up. We

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proceeded to gather the materials that were needed for her to be changed, after doing so we both went to a side of her bed so we could roll her back and forth. [NA #1] began to grab the padding under [Resident #1], on my side. [Resident #1] smacked her hand, and [NA #1] smacked her hand back and yelled "you hit me first". [Resident #1] yelled back and began to sob. I told [NA #1] "You can't do that, that isn't right". She replied, "I can't stand this type of behavior, she is entitled". I said "nothing". As I am cleaning [Resident #1], because she is rolled now, [Resident #1] begins to cry louder and yell. [NA #1] starts to yell at [Resident #1] telling her to "stop" and "be quiet". [Resident #1] gets upset and tries to spit on her [NA #1]. [NA #1] says to her "you want to spit?" [Resident #1] tries to spit again and NA #1 "smacks" her face. I said, "[NA #1], you cannot do that, that is not right". She begins to tell me how nice of a person she is and how she has had to deal with a lot so [she] can't tolerate this kind of behavior from [Resident #1]. At this point [Resident #1] is bawling her eyes out, holding my arm. I tell her "It's ok senora". Then I left the room after cleaning up to figure out how and who to tell."

An interview with NA #2 via telephone on 04/22/24 at 5:18 PM revealed she remembered that incident with Resident #1 and NA #1. She reported she had asked NA #1 to go and assist her in providing incontinence care to Resident #1. She reported they entered the room, notified Resident #1 of their intention to provide incontinence care with NA #1 on the left side of the bed and herself on the right side of the bed. NA #2 reported as NA #1 began to turn Resident #1 on her side, Resident #1 became angry, yelling, and swatted at NA #1. She reported NA

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#1 then "popped" Resident #1 back on her left shoulder with an open hand and told Resident #1 to stop. NA #2 reported she told NA #1 at that time that she could not do that and to stop. NA #2 stated the care continued and Resident #1 attempted to spit on NA #1 multiple times. She stated at that point, NA #1 "popped" Resident #1 again, either on the side of her face or left shoulder. NA #2 stated she again told NA #1 that she could not do that, and NA #1 responded that she would "not deal with that kind of behavior". She stated at that point, she observed Resident #1 crying, and she told Resident #1 "it was ok". NA #2 then reported she and NA #1 left at the completion of incontinence care and she went and immediately reported it to her hall nurse (Nurse #1). NA #2 reported she believed NA #1 was sent home almost immediately after she reported the interaction. NA #2 indicated Resident #1 was not physically injured but reported Resident #1 was emotionally upset following the interaction. NA #2 did not clarify why she did not stop the care when Resident #1 became aggressive or why the care was not stopped after the first time NA #1 struck Resident #1.

Review of NA #1's written statement from the day of the incident with Resident #1 read: "I was on my 2nd shift working on 400 hall. While I was working with [NA #2] helping [Resident #1] to change, she hit me multiple times and spit on my face. I witnessed several times she did it to other CNA's, but at that moment I hit her arm back. Later I realized I shouldn't, but somehow that moment I reacted. Sorry about it."

An interview with NA #1 via telephone on 04/22/24 at 12;17 PM revealed she was working

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| F 607 | Continued From page 17 on the same hall where Resident #1 resided but was not Resident #1's assigned nurse aide. She continued, stating that she and another nurse aide (NA #2) had gone into Resident #1's room to provide incontinence care. She reported she was very familiar with Resident #1 and stated she had a history of "bullying" other nurse aides and would often "punch, spit, and hit" the nurse aides that provided her care. NA #1 stated when she and NA #2 entered Resident #1's room, they explained to her what care they planned to provide and when she rolled Resident #1 onto her right side, Resident #1 began to kick her. NA #1 stated she asked Resident #1 multiple times to "please stop, don't do this" but admitted she became frustrated and ended up hitting Resident #1 with her open hand on her left shoulder. She stated Resident #1 then began to spit in her face and she reacted by "popping" Resident #1 on the left shoulder again. She stated NA #2 asked her why she was doing that and she told her "you saw what she was doing; hitting, spitting, and kicking me". NA #1 reported her strikes were not hard and did not make any sounds, leave redness, bruising, or other marks on Resident #1. She reported "I never had lost my cool before that day" and stated she knew after the fact that she should not have reacted that way. NA #1 stated when she and NA #2 left the room, she knew NA #2 would have to report the incident and stated she knew she would have to report it as well. NA #1 was insistent that she only struck Resident #1 on her left shoulder and that she did not use any force. NA #1 did verify that Resident #1 did begin to cry following the interaction and stated she thought her striking her surprised Resident #1 and that Resident #1 probably did not believe that a nurse aide would "stand up to her behavior". NA #1 reported she did not feel as though her | F 607 | | |

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actions were abusive and when asked why she did not just stop the care and come back later, NA #1 reported if they would have left and come back, Resident #1 would have acted the same way and both she and NA #2 though they needed to "just get it done." NA #1 stated "I don't know why I was so frustrated that day. She stated I worked on the dementia hall several months with no issues, I'm usually so very patient and treat the residents good." I don't think what I did was wrong, I make no apology to that resident for what I did, I'm sorry I surprised the other NA." I don't think it was abusive in nature, If they didn't lay me off, I was planning on quitting because the whole interaction was traumatizing." NA #1 reported she was approached almost immediately by the Assistant Administrator and was told she needed to go home. NA #1 stated she was suspended pending an investigation and ultimately terminated.

Multiple attempts to reach Nurse #1 by telephone on 04/22/24 and 04/23/24 were unsuccessful. Nurse #1 never returned any telephone calls.

Review of Nurse #1's written statement dated 12/29/23 revealed the following: "I was sitting in charting room when [NA #2] asked to speak to me in private. She reported what she had just seen [NA #1] had done to [Resident #1]. I immediately reported to [Assistant Administrator] who immediately spoke with [the nurse aides].

An interview with the Director of Nursing at the time of the incident on 04/22/24 at 4:11 PM revealed she felt that the facility's policies and procedures were followed at the time and that NA #2 intervened when she told NA #1 to stop. She indicated that NA #1 should have removed herself

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from the situation when she became frustrated. The Director of Nursing reported ibn response to the incident, the facility educated all staff on the policies and procedures for abuse prohibition that included intervention.

An interview with the Administrator on 04/22/24 at 2:18 PM, who was serving as the Assistant Administrator the day of the incident revealed she was approached by Nurse #1 who informed her that NA #2 had alleged that NA #1 had struck Resident #1 twice during incontinence care. The Administrator stated she went and spoke with NA #2 who recounted the incident to her. The Administrator stated she then immediately went to NA #1 and informed her of the allegations and sent her home. The Administrator stated she believed less than 10 minutes passed between her being notified and NA #1 being sent home. She stated she assigned a unit manager to escort NA #1 from the building to ensure she had no other interactions with other residents. The Administrator stated she then notified the Director of Nursing and began a full investigation into the allegations. She reported her investigation determined that due to the statements that alluded Resident #1 was tearful following the interaction, she ended up substantiating the allegation and subsequently terminated the employment of NA #1. She stated immediately after the incident, Nurse #1 completed skin checks of Resident #1 and all other cognitively impaired residents, while cognitively intact residents were interviewed with no concerns noted. She also reported assigning abuse, neglect, and exploitation training to all her staff that had to be completed before their next shift, along with training regarding employee burnout. The Administrator stated when she went to

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interview Resident #1 shortly after being informed of the incident, she was observed to be in her room, resting comfortably and did not appear to be upset. She stated when she questioned Resident #1, Resident #1 could only respond with yes/no answers but reported someone had been mean to her but was unable to tell her where she was hit. The Administrator stated Resident #1 did not appear tearful or fearful during questioning. She also stated a skin check was performed with no injury, redness, or swelling being observed. The Administrator stated with the statement of Resident #1 being emotional after the incident, they reached out to Resident #1's psych provider who stated they did not currently have a provider they could send to the facility to speak with Resident #1 so she reached out to the medical director who followed up a day or two later. The Administrator reported at the time of the investigation, NA #1 only ever reported to them that she struck Resident # 1 once and that she felt that NA #2 had intervened when she told NA #1 she should not be striking the resident. The Administrator also reported she felt that NAThe Administrator reported that all staff were trained on abuse policies and procedures at the time of hire and then on an annual basis. The Administrator also reported the facility had placed the incident in their quality assurance program which included audits of staff interactions and on-going, current monitoring.

The facility provided the following corrective action plan:

1. Corrective action for residents found to be affected:

A. What are we going to do for the resident

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affected?
Immediate skin check, physical assessment for injuries performed by nurse #1. Abuse Allegation was reported to the resident's family (RR), Administrator, DON, Provider, the Admin Office, Adult Protective Services, and the local police department. Accused NA was immediately suspended pending investigation results. Accused NA was advised to not return to the facility or the facility's property until further notice. NA was terminated once the investigation was completed. 2-hour abuse reporting to state completed on 12/29/23. Resident was assessed by the provider on 01/02/24 and new order for medication to decrease behaviors received however RR refused to allow the new medication. Alleged Abuse Incident report was completed by hall nurse on 12/29/23. Administrator observed four different employee interactions on 12/29/23 with residents to ensure that staff interactions were appropriate. Reviewed resident's care plan and added intervention for staff to leave and reapproach resident when she is combative with care on 12/29/23.

B. Who is going to do it?
Hall nurse performed assessment on resident and completed the incident report for alleged abuse on 12/29/23. Nurse notified Administrator and Administrator completed 2-hour abuse reporting form and sent in on 12/29/23. Nursing Supervisor notified provider on call on 12/29/23. Administrator notified resident's family(RR) and DON on 12/29/23. Hall nurse completed incident report on 12/29/23. Administrator met immediately with accused NA and suspended her immediately on 12/29/23. DON and Administrator met with NA #1 and terminated her employment once the allegation was substantiated on

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12/30/23. Administrator and DON reviewed resident's care plan and added appropriate interventions.

C. How will the corrective action be communicated to staff?
The NA involved was suspended immediately and then terminated. Reporting NA intervened and then reported immediately to supervisor. She received education regarding intervening, stopping what she is doing and reporting immediately via Abuse Reporting policy education and Relias online learning education. All staff in facility educated on Abuse, intervening, stopping what you are doing, reporting immediately, and investigations on 12/29/23. All additional staff will be educated prior to their next working shift.

D. Is action clearly documented and care planned?
Documented in statements and in with the NA involved. Resident #1's care plan was reviewed and appropriate new interventions added.

2. How will corrective action be accomplished for those residents having the potential to be affected?

A. How will we identify other residents at risk?
All residents in the facility have the potential to be at risk.

B. After identifying at risk residents, what are we going to do for them?
The hall nurse performed skin assessments on all residents that accused NA cared for on this day that were unable to be interviewed on 12/29/23. No further injuries noted. The Administrator interviewed residents and asked if

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they felt safe and if they had any concerns of any staff member being mean to them or rough with them. All other residents stated they felt safe and no one had been mean or rough with them. LSC Employee Interaction Audit Form for Substantiated Abuse Allegation was started immediately. That audit will be completed by Central Nurse Manager who will observe 4 different employees' interactions with residents 3 times per week for 4 weeks to ensure that staff interactions are appropriate. Staff education started immediately regarding Abuse, Intervening and Caregiver burnout. Education completed 12/29/23 for all staff in facility and all staff will be educated prior to working their next shift. Two extra Relias courses were assigned by the Staff Development Coordinator for the month of January related to Abuse and Caregiver burnout.

C. Are we taking credit for interventions in the chart and on the care plan?
The Resident's care plan was reviewed and updated to reflect additional interventions for staff.

3. What measures will be put into place to ensure that the deficient practice will not occur?

A. What system(s) will we adapt/change/implement to keep the problem from reoccurring?
Abuse Investigating and Reporting education materials from Lutheran Services University that includes information on caregiver burnout along with a wallet card with signs and symptoms of staff burnout added to facility orientation and will remain part of orientation moving forward. Abuse Reporting has always been included in orientation

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however more focus on caregiver burnout will be added effective 12/30/23. Staff education completed on LSC Policy of Abuse Investigation and Reporting; this policy includes education on intervening, stopping what you are doing, reporting immediately, for Senior Services as well as Lutheran Services University education related to caregiver burnout. Staff will be educated prior to their next working shift. Staff Development Coordinator assigned Relias courses on Abuse, intervening, stopping what you are doing, reporting immediately and on Caregiver burnout to all staff for the month of January.

B. How will we educate/communicate any system changes to the staff?

" Printed Staff Education on LSC Policy of Abuse Investigation and Reporting for Senior Services and Lutheran Services University information on caregiver burnout as well as the two new Relias courses assigned to January agenda.
" Provided Staff Education on WHATSAPP messaging system to nursing department, and on PCC Bulletin Board to all departments on importance of recognizing caregiver burnout and importance of "walking away" when frustrated, importance of reporting potential abuse immediately to supervisor, and being familiar with LSC Policy on Abuse Investigation and Reporting which includes intervening, stopping what you are doing and reporting immediately.
" Added additional education materials to facility orientation related to caregiver burnout, how to recognize and importance of reporting to supervisor when caregiver burnout is suspected. Wallet card will also be provided to all new employees during facility orientation that contains

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345152 | A. BUILDING ______ B. WING ______ | C 04/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **TRINITY VILLAGE** | **1265 21 STREET NE HICKORY, NC 28601** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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symptoms of staff burnout.

4. How does the facility plan to monitor its performance to make sure that solutions are sustained?

A. Are we evaluating actual staff practices? Yes. Administrator determined audits were needed at time of initial investigation report on 12/29/23. Audits were initiated and completed 4 audits 12/29/2023 by Administrator. Central Nurse Manager will observe 4 different employees' interactions with residents 3 times per week for 4 weeks to ensure that staff interactions are appropriate starting 12/29/23.

B. Are we performing regular audits to ensure the corrective action/system/change is being implemented and are working?
Yes. Audits were initiated on 12/29/23. Observation of employee's interactions with residents has been started and will continue monthly x3 beginning immediately and continuing February and March 2024, and then quarterly for Q2, Q3, and Q4 in 2024. These observations will end 12/31/2024.

C. Are we sharing audit results in the monthly QAPI meetings?
Yes. All POCs are shared in QAPI. The next QAPI meeting is scheduled for February 1, 2024.

Date of compliance: January 3, 2024

The facility's corrective action plan was validated on 04/23/24. Review of facility provided monitoring tools revealed the facility had completed a 24 hour and 5 working day report upon notification of the incident and completion of

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|---|---|---|---|---|
| F 607 | Continued From page 26<br>their investigation. The investigation revealed written statements from all parties involved, a termination notification for NA #1, education with sign-in sheets for all staff in the facility, skin checks and interviews with alert and oriented residents, and finally monitoring tools for ongoing monitoring to ensure the issue was resolved. The completion of the self-imposed corrective action plan was verified on-site through staff interviews and record review. The compliance date of 01/03/24 was validated. | F 607 | | |