STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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
F 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite on 7/23/24 with additional information received remotely on 7/24/24. The survey team returned to the facility on 7/25/24 and 7/26/24. Additional information was received remotely on 7/29/24, onsite on 7/30/24, and remotely on 7/31/24. Therefore, the exit date was 7/31/24. Event ID #ECIB11 The following intakes were investigated: NC00219750, NC00219659, NC00219930, and NC00219984. Intakes NC00219750 and NC00219930 resulted in immediate jeopardy. 5 of the 6 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F600 at a scope and severity (J) CFR 483.25 at tag F607 at a scope and severity (K) CFR 483.25 at tag F684 at a scope and severity (J) The tags F600, F607, and F684 constituted Substandard Quality of Care. Immediate Jeopardy for F600 and F607 began on 3/31/24 and was removed on 7/30/24. Immediate Jeopardy for F684 began on 7/13/24 and was removed on 7/27/24. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		8/14/24

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

Electronically Signed | 08/14/2024

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F 600	Continued From page 1 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to protect Resident #3's right to be free from abuse. In March of 2024 Confidential Staff #1 witnessed Nurse #3 slap Resident #3 across the face during care after Resident #3 spit on Nurse #3 twice. In July of 2024 during a weekly skin check Nurse Aide #2 and Nurse Aide #3 witnessed Nurse #3 rip a dressing off Resident #3's forearm resulting in a skin tear reopening and bleeding. Resident #3 repeatedly yelled "you're hurting me." Resident #3 then spit on Nurse #3 twice and in response, Nurse #3 raised her hand "like she was going to slap" Resident #3 when Nurse Aide #2 intervened and Nurse #3 lowered her hand and proceeded to change the dressing. Resident #3 did not have the cognitive capacity to express a psychosocial outcome. A reasonable person expects to be free from abuse in their home. There is a high likelihood that abuse from a caregiver would cause serious psychosocial harm to include feelings such as fear, intimidation, withdrawal, agitation, and	F 600	This Plan of Correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the facility or community as to the accuracy of the surveyors findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the facilitys or communitys policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The facility / community submits this Plan of Correction with the intention	

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F 600	Continued From page 2 severe anxiety. This deficient practice affected 1 of 3 residents reviewed for abuse (Resident #3). Immediate Jeopardy began on 3/31/24 when the facility failed to protect Resident #3's right to be free from abuse. Immediate Jeopardy was removed on 7/30/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: Resident #3 was admitted into the facility on 04/22/22 with non-Alzheimer's dementia. Resident #3's comprehensive care plan had a focus problem of resistance to care related to anxiety initiated on 11/6/2023 with the following interventions: educate the resident/family/caregivers of the possible outcomes of not complying with care, encourage as much participation/interaction by the resident as possible during care activities, give a clear explanation of all care activities prior to and as they occur during each contact, if the resident resists with activities of daily living, reassure resident, leave and return in 5-10 minutes and try again, praise when behaviors are appropriate, provide consistency in care to promote comfort with activities of daily living, including timing of the activities of daily living, caregivers and routine as much as possible. Resident #3's significant change Minimum Data Set dated 2/19/24 indicated her cognition was	F 600	that it be inadmissible by any third party in any civil or criminal action against the facility / community or any employee, agent, officer, director, attorney, or shareholder of the facility / community or affiliated entities. F600: The facility failed protect Resident #3□s right to be free from abuse perpetrated. In March of 2024, specific date unknown, Confidential Staff #1 witnessed Nurse #3 slap Resident #3 across the face during care after Resident #3 spit on Nurse #3 twice. In July of 2024 during a weekly skin check nurse aide #2 and nurse aide #3 witnessed Nurse #3 rip a dressing off of Resident #3□s forearm resulting in a skin tear reopening and bleeding. Resident #3 yelled repeatedly you□re hurting me. Resident #3 then spit on Nurse #3 twice and in response, Nurse #3 raised her hand like she was going to slap Resident #3 when nurse aide #2 intervened and Nurse #3 lowered her hand and proceeded to change the dressing. Resident #3 did not have the cognitive capacity to express a psychosocial outcome. 1.Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Upon notification of the alleged abuse to Resident #3 on 07/26/2024 the facility Administrator submitted a 2-hour report for abuse. The Administrator also	

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F 600	Continued From page 3	F 600		

severely impaired and she had no behaviors or rejection of care.

On 3/8/24 the focus problem initiated on 11/6/23 on the care plan was revised to indicate Resident #3 was displaying the following inappropriate behaviors: spitting at others, hitting staff, yelling at staff, being combative with staff during activities of daily living care and toileting. The inteventions included: anticipate and meet needs when possible, approach in a calm manner, assess for underlying causes of frustration/behavior such as hunger, thirst, discomfort etc., encourage to express feelings appropriately, document inappropriate behaviors, and response to the interventions, and explain all procedures before starting and allow time for adjustment to change.

a) A telephone interview was conducted with Confidential Staff #1 on 7/26/24 at 11:17 AM. She indicated she no longer worked at the facility. Confidential Staff #1 revealed that she worked frequently with Nurse #3 on the Alzheimer's Unit. She revealed that in March of 2024 Nurse #3 was assisting her (Confidential Staff #1) with incontinent care for Resident #3. She was unable to recall the exact date of the incident. After they (Nurse #3 and Confidential Staff #1) got Resident #3 back into the wheelchair after incontinence care had been provided, Nurse #3 attempted to give Resident #3 her medication and Resident #3 spit on Nurse #3. Confidential Staff #1 stated that she held Resident #3's hand to comfort her so that Resident #3 would take her medication. When Nurse #3 attempted to give her the medication a second time, Resident #3 spit on Nurse #3 again and Nurse #3 slapped her across the face. Confidential Staff #1 stated that when Nurse #3 slapped Resident #3, Resident #3 put

contacted law enforcement and Adult Protective Services (APS) on 7/26/2024. The Medical Director and Responsible Party were notified of the alleged abuse that occurred to Resident #3 in March 2024 and July 2024 by the Director of Nursing Services on 07/26/2024.
On 07/25/2024 Resident #3 was assessed by the Director of Nursing and Licensed Administrator for any signs of injury and abuse to include any bruising, redness of unknown origin or skin abnormalities indicative of abuse. The skin assessment revealed that Resident #3 has a healing skin tear noted to right upper forearm with dressing as appropriate per provider orders and documentation is consistent in the medical record. Treatment records reveal wound care was provided by provider orders by the licensed nurse. Additionally, the Director of Nursing assessed Resident #3 for any pain. Pain assessment revealed no pain.
On 07/26/2024, the Licensed Administrator, Social Services Director, and Regional Vice President of Operations interviewed all dedicated Alzheimer Care staff who typically were assigned to work the Alzheimer care unit to gather details of alleged abuse. The Licensed Administrator, Social Services Director, and Regional Vice President of Operations reeducated each staff member on the abuse policy with emphasis on having a culture against barriers to reporting. Reeducation included types of abuse, how to prevent abuse, reporting abuse immediately to

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F 600	Continued From page 4	F 600		

her hand to her cheek and started yelling "you hurt me". Confidential Staff #1 stated that she did not remember if a mark was left or not. Confidential Staff #1 stated she told Nurse #3 that she could not do that to which Nurse #3 stated she did not mean to. Confidential Staff #1 stated that prior to Nurse #3 slapping Resident #3 she had complained to the previous Administrator about other instances regarding Nurse #3 that concerned Confidential Staff #1. She explained that Nurse #3 yelled at the residents, didn't take her time with them, and was rough. She indicated that nothing was ever done which was why she quit. Confidential Staff #1 stated that she did not want to say her name because she was afraid that if the facility knew that she had called or talked to the state surveyor she would never get another job in long term care.

There was no documentation of the incident in March 2024 referenced by Confidential Staff #1.

An interview was conducted on 7/26/24 at 10:16 AM with Nurse #3 and she stated that the incident referenced by Confidential Staff #1 in March of 2024 never occurred.

Resident #3's quarterly Minimum Data Set dated 5/7/24 indicated she was severely cognitively impaired and had no behaviors or rejection of care.

b) A telephone interview was conducted with Nurse Aide #2 on 7/25/24 at 2:57 PM. Nurse Aide #2 reported she worked with Nurse #3 frequently on the Alzheimer's unit. She indicated that Nurse #3 yelled at the residents when they did not listen to her or follow directions and was rough with the residents during treatments. Nurse Aide #2

Licensed Administrator without fear of retaliatory or punitive measures. Nurse #3 was suspended on 07/25/2024 out of an abundance of precaution by the Licensed Administrator.

2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
All residents have the potential to be affected by the alleged deficient practice.
On 07/25/2024 the Licensed Administrator identified residents that were potentially impacted by this practice by having the assigned nurse complete head to toe skin assessments on all current residents on the memory unit to identify any bruising, redness of unknown origin or skin abnormalities indicative of abuse. The skin assessments revealed no documented signs of abuse. Pain assessments were completed at the time of the head to toes assessments by the assigned nurse with no identified residents expressing pain and no observed signs and symptoms of pain.

3.Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed.
On 07/26/2024, the Director of Nursing began in-servicing all staff in all departments (including agency staff) on the abuse prohibition policy. In addition to the facility policy on abuse, the training included:
Abuse can be physical in nature, including

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F 600	Continued From page 5 explained there was an instance in July 2024, she was unable to recall the exact date, when Nurse #3 was doing treatments with herself (Nurse Aide #2) and Nurse Aide #3 present. Nurse #3 was completing a dressing change for Resident #3. Resident #3 was yelling "you're hurting me" when Nurse #3 "ripped" the bandage off Resident #3's arm causing the area to bleed. Resident #3 then spit on Nurse #3 twice, Nurse #3 then raised her hand back "like she was going to slap" Resident #3. Nurse Aide #2 told Nurse #3 she "didn't want to do that, don't do it" and Nurse #3 then lowered her hand. Nurse Aide #2 stated that she had not reported the incident because Nurse #3 never actually hit Resident #3. An interview was conducted with Nurse Aide #3 on 7/25/24 at 4:00 PM. Nurse Aide #3 stated that she worked with Nurse #3 "quite a bit" in the Alzheimer's unit. Nurse Aide #3 revealed that Nurse #3 got upset with the residents and would yell at them over the littlest of things, such as, getting too near the medication cart or not following her directions. Nurse Aide #3 recalled an instance in July 2024, unable to recall the exact date, when Nurse #3 was doing treatments with Nurse Aide #2 and herself (Nurse Aide #3) present. A dressing change was being completed on Resident #3 by Nurse #3 when the nurse "ripped off" the dressing and it started to bleed. Nurse Aide #3 stated she heard Resident #3 say "you're hurting me, you're hurting me". Nurse Aide #3 stated she looked over and saw Resident #3 spit on Nurse #3. Nurse #3 then said "Yoouuu" and raised her arm back "to hit" Resident #3 when Nurse Aide #2 said "don't do it, you don't want to do that", and Nurse #3 lowered her arm. Nurse Aide #3 stated that she had not reported the incident to anyone because Nurse #3 never	F 600	actions such as slapping, kicking, hitting, pushing, spitting, or threatening. Abuse can also occur when care is provided inappropriately; for example, if a nurse removes a bandage roughly, it may be considered abuse. All types of abuse were covered to include: verbal, sexual, physical, involuntary seclusion, mental (emotional abuse), neglect, misappropriation of property. Education included recognizing injuries of unknown origin and reporting as possible abuse. Education of signs and symptoms of abuse. Education included how to minimize the risk of abuse and the negative results of abuse. Staff awareness for Characteristics of residents which have the potential to trigger an abusive incident such as wandering into other resident rooms, known history of aggressive behavior, residents who guard their personal space, residents who resist care giving, residents with communicative disorders, residents who startle easily, or have visual or hearing problems. When responding to resident aggression, follow the approaches listed in the care plan and inform your supervisor when you identify triggers that may cause agitation. Supervisors and the interdisciplinary care plan team should discuss situations and care plan interventions to minimize agitation risk. Maintain control of your own responses and reactions, remove the cause of the behavior if known, and protect the safety of the resident and others. Implement care plan approaches as soon as the behavior starts, use good	

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F 600	Continued From page 6 actually hit Resident #3. There was no documentation of the incident in July 2024 referenced by Nurse Aide #2 and Nurse Aide #3. An interview was conducted on 7/26/24 at 10:16 AM with Nurse #3. She stated that she remembered the incident in July 2024 with Resident #3. She reported she was with Nurse Aide #2 and Nurse Aide #3 and had been scheduled to do a weekly skin check which required her to remove all of the dressings from Resident #3. She stated that Resident #3 had tolerated the dressings being removed from her lower legs but had started getting restless. Nurse #3 indicated Resident #3 spit in her face and she had thrown her hand back in surprise from being spit on. She indicated that she had not intended to hit the resident but was able to understand how it could be interpreted that she was going to slap Resident #3. Nurse #3 stated that when Resident #3 spit on her Resident #3 jerked her right arm causing the dressing on her forearm to come off and the resident hit her arm on the wheelchair causing it to bleed. Nurse #3 stated that she applied a new dressing to the right forearm and continued with skin checks for other residents. Nurse #3 stated that Resident #3's skin was very fragile and she had multiple skin tears which were mostly healed but were kept covered for protection. Nurse #3 stated that the dressings on Resident #3 normally were easy to take off but if they appeared to be stuck on an open area she would moisten the gauze before attempting to take it off. She revealed that she had not done that with the dressing to Resident #3's right forearm because the area had been closed and it was more of a protective dressing. Nurse #3	F 600	communication and listening skills, and try to understand the resident□s point of view. Report the cause of the behavior to your supervisor and inform them if care plan approaches do not work. Adjust your approach based on the resident□s response, discuss pleasant topics with residents to provide strength and support, ensure the resident's physical needs are met, and give alert residents control by offering choices in care and routines. Smile and use positive body language, as positive behavior is contagious. Nurses should enter a progress note in the resident chart about the aggression. Aggressive behavior in the elderly may occur as a result of cognitive impairment, physical health issues, medications, psychological factors, environmental factors, communication difficulties, unmet needs, personal history, or lack of autonomy. Physical aggression involves physical actions intended to harm another person, such as hitting, kicking, slapping, pushing, biting, and scratching. Verbal aggression, on the other hand, uses words to harm others emotionally or psychologically, including insults, threats, yelling, name-calling, and belittling remarks. To minimize the risk of abuse, it is important to be aware of caregiver burnout symptoms, which can include lack of energy, fatigue, sleep problems, changes in eating habits, feelings of hopelessness, anxiety, depression, headaches, stomachaches, or other physical problems. Prevent burnout by seeking assistance when needed, taking	

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F 600	Continued From page 7 stated that Resident #3 has had behaviors of hitting, kicking, and spitting in the past. During an interview conducted with the Administrator on 7/26/24 at 11:00 AM she indicated that there had been no complaints made to her regarding Nurse #3's behavior and she had no issues reported involving any of the residents in the Alzheimer's unit. She stated that all of the residents should be free of abuse and that she was aware of Resident #3's behaviors. The Administrator stated that all staff including Nurse #3 should follow the care plan for the resident when he/she had behaviors. The Administrator was notified of Immediate Jeopardy on 7/26/24 at 2:27 PM. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. The facility failed protect Resident #3's right to be free from abuse perpetrated by Nurse #3. In March of 2024, specific date unknown, Confidential Staff #1 allegedly witnessed Nurse #3 slap Resident #3 across the face during care after Resident #3 spit on her twice. In July of 2024 during a weekly skin check NA #2 and NA #3 allegedly witnessed Nurse #3 rip a dressing off of Resident #3's forearm resulting in skin being torn off and the skin tear observed to reopen and bleed. Resident #3 yelled repeatedly "you're hurting me", then spit on Nurse #3 twice. In response, Nurse #3 raised her hand "as if to	F 600	breaks to rest, attending doctor appointments, exercising, eating well, sleeping well, and exploring other stress reduction strategies. This education will be provided to new hires during the orientation process by the Director of Nursing and/or Licensed Educator. No staff shall work without this education effective 07/30/2024. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator or Designee will monitor tag F600 for Abuse Reporting weekly for 4 weeks and monthly for 3 months or until resolved. The Administrator/Director of Nursing will ensure that all shifts have been covered during the monitoring period. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Director. Date of Compliance: 07/30/2024	

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F 600	Continued From page 8	F 600		

slap her" and NA #2 intervened and told Nurse #3 not to hit the resident. Resident #3 had her skin tear reopen, allegedly causing her pain.

The facility must ensure all residents are protected from abuse.

Upon notification of the alleged abuse to Resident #3 on 07/26/2024 the facility Administrator submitted a 2-hour report for abuse. The Administrator also contacted law enforcement and Adult Protective Services (APS) on 7/26/2024. The Medical Director and Responsible Party were notified of the alleged abuse that occurred to Resident #3 in March 2024 and July 2024 by the Director of Nursing Services on 07/26/2024.

On 07/25/2024 Resident #3 was assessed by the Director of Nursing and Licensed Administrator for any signs of injury and abuse to include any bruising, redness of unknown origin or skin abnormalities indicative of abuse. The skin assessment revealed that Resident #3 has a healing skin tear noted to right upper forearm with dressing as appropriate per provider orders and documentation is consistent in the medical record. Treatment records reveal wound care was provided by provider orders by the licensed nurse. Additionally, the Director of Nursing assessed Resident #3 for any pain. Pain assessment revealed no pain.

On 07/26/2024, the Licensed Administrator, Social Services Director, and Regional Vice President of Operations interviewed all dedicated Alzheimer Care staff who typically were assigned to work the Alzheimer care unit to gather details of alleged abuse. The Licensed Administrator,

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F 600	Continued From page 9	F 600		

Social Services Director, and Regional Vice President of Operations reeducated each staff member on the abuse policy with emphasis on having a culture against barriers to reporting. Reeducation included types of abuse, how to prevent abuse, reporting abuse immediately to Licensed Administrator without fear of retaliatory or punitive measures. Nurse #3 was suspended on 07/25/2024 out of an abundance of precaution by the Licensed Administrator.

On 07/25/2024 the Licensed Administrator identified residents that were potentially impacted by this practice by having the assigned nurse complete head to toe skin assessments on all current residents on the memory unit to identify any bruising, redness of unknown origin or skin abnormalities indicative of abuse. The skin assessments revealed no documented signs of abuse. Pain assessments were completed at the time of the head to toes assessments by the assigned nurse with no identified residents expressing pain and no observed signs and symptoms of pain.

Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed.

On 07/26/2024, the Director of Nursing began in-servicing all staff in all departments (including agency staff) on the abuse prohibition policy. In addition to the facility policy on abuse, the training included:
Abuse can be physical in nature, including actions such as slapping, kicking, hitting, pushing, spitting, or threatening. Abuse can also occur

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	345054	A. BUILDING _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

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when care is provided inappropriately; for example, if a nurse removes a bandage roughly, it may be considered abuse.

All types of abuse were covered to include: verbal, sexual, physical, involuntary seclusion, mental (emotional abuse), neglect, misappropriation of property. Education included recognizing injuries of unknown origin and reporting as possible abuse.

Education of signs and symptoms of abuse. Education included how to minimize the risk of abuse and the negative results of abuse.

Staff awareness for characteristics of residents which have the potential to trigger an abusive incident such as wandering into other resident rooms, known history of aggressive behavior, residents who guard their personal space, residents who resist care giving, residents with communicative disorders, residents who startle easily, or have visual or hearing problems.

When responding to resident aggression, follow the approaches listed in the care plan and inform your supervisor when you identify triggers that may cause agitation. Supervisors and the interdisciplinary care plan team should discuss situations and care plan interventions to minimize agitation risk. Maintain control of your own responses and reactions, remove the cause of the behavior if known, and protect the safety of the resident and others. Implement care plan approaches as soon as the behavior starts, use good communication and listening skills, and try to understand the resident's point of view. Report the cause of the behavior to your supervisor and inform them if care plan approaches do not work.

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Adjust your approach based on the resident's response, discuss pleasant topics with residents to provide strength and support, ensure the resident's physical needs are met, and give alert residents control by offering choices in care and routines. Smile and use positive body language, as positive behavior is contagious. Nurses should enter a progress note in the resident chart about the aggression.

Aggressive behavior in the elderly may occur as a result of cognitive impairment, physical health issues, medications, psychological factors, environmental factors, communication difficulties, unmet needs, personal history, or lack of autonomy. Physical aggression involves physical actions intended to harm another person, such as hitting, kicking, slapping, pushing, biting, and scratching. Verbal aggression, on the other hand, uses words to harm others emotionally or psychologically, including insults, threats, yelling, name-calling, and belittling remarks.

To minimize the risk of abuse, it is important to be aware of caregiver burnout symptoms, which can include lack of energy, fatigue, sleep problems, changes in eating habits, feelings of hopelessness, anxiety, depression, headaches, stomachaches, or other physical problems. Prevent burnout by seeking assistance when needed, taking breaks to rest, attending doctor appointments, exercising, eating well, sleeping well, and exploring other stress reduction strategies.

This education will be provided to new hires during the orientation process by the Director of Nursing and/or Licensed Educator.

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F 600	Continued From page 12 No staff shall work without this education effective 07/30/24. Alleged date of immediate jeopardy removal: 07/30/24 The credible allegation of immediate jeopardy removal was validated on 7/30/24. A review of the skin audits and pain assessments for the residents on the Alzheimer's unit was completed and no issues were found. In-service materials were reviewed to include the staff sign in sheet. Staff verified education included the abuse prohibition policy, what constituted abuse, verbal and non-verbal indicators of abuse, what caregiver burnout was and how to prevent/help it, handling challenging behaviors, how to respond to resident aggression and who to tell if the interventions worked or did not work. All staff interviewed stated that they would not be retaliated against if they reported any abuse. The immediate jeopardy removal date of 7/30/24 was verified.	F 600		
F 607 SS=K	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		8/14/24

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F 607	Continued From page 13 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow their abuse policy when Confidential Staff #1 allowed Nurse #3 to continue providing care to residents after witnessing Nurse #3 slap Resident #3. Confidential Staff #1 did not report the abuse to the administration resulting in no protection of residents from further abuse, no investigation, and no notification to the state, adult protective services or law enforcement. A second incident of abuse occurred when Nurse Aide #2 and Nurse Aide #3 did not identify abuse when they witnessed Nurse #3 rip a dressing off Resident #3's forearm resulting in the resident experiencing pain and her skin tear reopening and bleeding. Nurse #3 then raised her hand to Resident #3 "like she was going to slap her." This resulted in the abuse not being reported to the administration, no protection of the residents from further abuse, no investigation, and no notification	F 607	This Plan of Correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the facility or community as to the accuracy of the surveyors findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the facilitys or communitys policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that	

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F 607	Continued From page 14 to the state, adult protective services or law enforcement. This deficient practice was for 1 of 3 residents reviewed for the abuse (Resident #3) and placed other residents at high likelihood of suffering serious injury or harm. Immediate Jeopardy began on 3/31/24 when Confidential Staff #1 allowed Nurse #3 to continue providing care to residents after witnessing her slap Resident #3. Immediate Jeopardy was removed on 7/30/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. The findings included: The facility's abuse policy indicated the following: Abuse could be physical, defined as hitting, slapping, rough treatment, pinching, kicking etc. It also included controlling behavior through corporal punishment which includes rough handling of a resident. In recognizing and reporting abuse when a resident verbalizes, or abuse is witnessed, the Administrator or Director of Nursing needs to be notified immediately. When physical abuse is reported a licensed nurse or physician shall immediately examine the resident and document the findings in the medical record, the police called, and the physician notified. If an employee has been accused of abuse they will be suspended until the investigation is complete. The facility must do an investigation which includes interviewing staff and residents to determine what happened. The	F 607	basis. The facility / community submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility / community or any employee, agent, officer, director, attorney, or shareholder of the facility / community or affiliated entities. F607: The facility failed to follow their abuse policy when Confidential Staff #1 allowed Nurse #3 to continue providing resident care after witnessing Nurse #3 slap Resident #3. Confidential Staff #1 did not report the abuse to the administration resulting in no protection of residents from further abuse, no investigation, and no reporting to the state, Adult Protective Services, or law enforcement. A second incident of abuse occurred when Nurse Aide #2 and Nurse Aide #3 did not identify abuse when they witnessed Nurse #3 rip a dressing off Resident #3□s forearm resulting in the resident experiencing pain and her skin tear reopening and bleeding. Nurse #3 then raised her hand to Resident #3 like she was going to slap her. This resulted in the abuse not being reported to the administration, no protection of the residents from further abuse, no investigation, and no notification to the state, adult protective services or law enforcement. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

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F 607	Continued From page 15 facility must report to the state agencies when the facility suspects abuse has occurred against a resident in the facility to the State Survey Agency using the initial allegation report and notify local law enforcement and adult protective services. Within 5 days the investigation report needs to be completed and submitted to the State Survey Agency. An undated abuse addendum indicated abuse can occur when care is provided inappropriately and if a resident states that they were hurt by a staff member this should be treated as a potential abuse case. Resident #3 was admitted into the facility on 04/22/22. a) A telephone interview was conducted with Confidential Staff #1 on 7/26/24 at 11:17 AM. She indicated she no longer worked at the facility. Confidential Staff #1 revealed that she had worked frequently with Nurse #3 on the Alzheimer's Unit. She revealed that in March of 2024 Nurse #3 was assisting her (Confidential Staff #1) with incontinent care for Resident #3. She was unable to recall the exact date of the incident. After they (Nurse #3 and Confidential Staff #1) got Resident #3 back into the wheelchair after incontinence care had been provided, Nurse #3 attempted to give Resident #3 her medication and Resident #3 spit on Nurse #3. When Nurse #3 attempted to give her the medication a second time, Resident #3 spit on Nurse #3 again and Nurse #3 slapped her across the face. Confidential Staff #1 stated that when Nurse #3 slapped Resident #3, Resident #3 put her hand to her check and started yelling "you hurt me". Confidential Staff #1 stated that she did not remember if a mark was left or not. Confidential	F 607	Upon notification of the alleged abuse to Resident #3 on 07/26/2024 by the facility Administrator submitted a 2-hour report for abuse. The Administrator also contacted law enforcement and contacted on Adult Protective Services (APS) on 07/26/2024. The Medical Director and Responsible Party were notified of the alleged abuse that occurred to Resident #3 in March 2024 and July 2024 by the Director of Nursing on 07/26/2024. On 07/26/2024, the Licensed Administrator, Social Services Director, and Regional Vice President of Operations interviewed all dedicated Alzheimer Care staff who typically were assigned to work the Alzheimer care unit to gather details of alleged abuse. The Licensed Administrator, Social Services Director, and Regional Vice President of Operations reeducated each staff member on the abuse policy with emphasis on having a culture against barriers to reporting. Reeducation included types of abuse, how to prevent abuse, reporting abuse immediately to Licensed Administrator without fear of retaliatory or punitive measures. Nurse #3 was suspended on 07/25/2024 out of an abundance of precaution by the Licensed Administrator. On 07/26/2024 the licensed nurse completed assessment of resident with no identified concerns of abuse. On 07/26/24 the Medical Director and Responsible Party were notified by the Director of Nursing of the allegation. No new orders were obtained from the Medical Director.	

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F 607	Continued From page 16 Staff #1 stated she told Nurse #3 that she could not do that to which Nurse #3 stated she did not mean to. Confidential Staff #1 stated that she knew it was abuse when Nurse #3 slapped Resident #3 and she should have reported it to the Administrator. Confidential Staff #1 stated she couldn't say why she didn't report it other than nothing had ever happened when she had complained about Nurse #3 in the past to the previous Administrator. Confidential Staff #1 explained there were other instances regarding Nurse #3 that concerned her (Confidential Staff #1). She further explained that Nurse #3 yelled at the residents and didn't take her time with them and was rough. She stated that she couldn't stop worrying about the residents with Nurse #3 still working there knowing she should have reported the abuse when it happened. She stated that she was afraid one of the other residents would be hurt and she couldn't live with that thought, which was why she reported it now. She indicated that nothing being done regarding her previous concerns that she took to administration was why she quit. Confidential Staff #1 stated that she did not want to say her name because she was afraid that if the facility knew that she had called or talked to the state surveyor she would never get another job in long term care. There was no documentation of the incident in March 2024 referenced by Confidential Staff #1. b) A telephone interview was conducted with Nurse Aide #2 on 7/25/24 at 2:57 PM. Nurse Aide #2 worked with Nurse #3 frequently after Nurse #3 had been assigned to the Alzheimer's unit. She indicated that Nurse #3 yelled at the residents when they did not listen to her or follow directions and was rough with the residents	F 607	2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 07/26/24 the Administrator audited grievances for the last 30 days and Resident Council Minutes for any concerns related to abuse. There were no grievances noted in the Resident Council Minutes that included any abuse. Upon auditing grievances, the Administrator noted one neglect allegation on 06/29/24. The reporting of the allegation followed facility policy and Department of Health and Human Services regulation on reporting allegations of neglect. The neglect allegation was made known to the Administrator by facility staff immediately and the Administrator reported the allegation to the Department of Health and Human Services within the required reporting time frame for the Initial Allegation and the 5-day Investigation Report. The Initial Allegation report contained all aspects of the required report to include identification of other residents who have suffered abuse and assessed if other residents were free from further potential harm. On 07/26/24 the Director of Nursing audited incident reports for the last 30 days for any abuse related incidents. There were no incident reports that involved abuse. During in-service education that began on 07/26/24, all staff will be interviewed by the Administrator and/or designee. Staff	

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F 607	Continued From page 17 during treatments. Nurse Aide #2 further explained there was an instance in July 2024, she was unable to recall the exact date, when Nurse #3 was doing treatments with herself (Nurse Aide #2) and Nurse Aide #3 present. Nurse #3 was completing a dressing change for Resident #3. Resident #3 was yelling "you're hurting me" when Nurse #3 "ripped" the bandage off Resident #3's arm causing the area to bleed. Nurse Aide #2 indicated that she felt it made Resident #3 mad and Resident #3 spit on Nurse #3 twice. Nurse #3 then raised her hand back "like she was going to slap" Resident #3. Nurse Aide #2 indicated she told Nurse #3 she "didn't want to do that, don't do it" and Nurse #3 then lowered her hand. Nurse Aide #2 stated that she believed if she had not said anything, Nurse #3 would have slapped Resident #3. She stated she should have reported it because Nurse #3 continued to work on the Alzheimer's unit and "who knew what happened" between Nurse #3 and the other residents when other people were not around. An interview was conducted with Nurse Aide #3 on 7/25/24 at 4:00 PM. Nurse Aide #3 stated that she worked with Nurse #3 "quite a bit" in the Alzheimer's unit. Nurse Aide #3 revealed that Nurse #3 got upset with the residents and would yell at them over the littlest of things like if they got too near the medication cart or were not following her directions. Nurse Aide #3 recalled an instance in July 2024, unable to recall the exact date, when Nurse #3 was doing treatments with Nurse Aide #2 and herself (Nurse Aide #3) present. A dressing change was being completed on Resident #3 by Nurse #3 when the nurse "ripped off" the dressing and it started to bleed. Nurse Aide #3 stated she heard Resident #3 say "you're hurting me, you're hurting me" sounding	F 607	will be asked to report any abuse or incident that they may have seen that they had not previously been reported. This will be completed on 07/29/24. If any abuse allegations are identified, the Administrator will follow facility policy and regulations to submit report of allegation to Department of Health and Human Services. There were no identified concerns. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 07/26/2024, the Director of Nursing and/or Licensed Educator began in-servicing all staff in all departments (including agency staff) on the abuse prohibition/reporting policy. In addition to the facility policy on abuse, the training included: Abuse can be physical in nature, including actions such as slapping, kicking, hitting, pushing, spitting, or threatening. Abuse can also occur when care is provided inappropriately; for example, if a nurse removes a bandage roughly, it may be considered abuse. If a resident state that they were hurt by a staff member, this should be treated as a potential abuse case. Additionally, if a resident reacts by hitting or spitting at a staff member, it must be reported to a supervisor. If the suspected abuser is your supervisor, notify the administrator or Director of Nursing immediately. All instances of abuse should be reported to	

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like she was mad. Nurse Aide #3 stated she looked over and saw Resident #3 spit on Nurse #3. Nurse #3 then said "Yoouuu" and raised her arm and she thought Nurse #3 was going to hit Resident #3 when Nurse Aide #2 said "don't do it, you don't want to do that", and Nurse #3 lowered her arm. Nurse Aide #3 stated that she had not reported the incident to anyone because Nurse #3 never actually hit Resident #3. She reported that looking back on the incident, she should have told the Administrator. She explained that she found herself wondering if anything had ever happened to the residents when it was just Nurse #3 and a resident alone in a room and they made Nurse #3 mad.

An interview conducted with the Administrator on 7/26/24 at 11:00 AM indicated that there had been no complaints made to her regarding Nurse #3's behavior or had any issues reported involving any of the residents in the Alzheimer's unit. The Administrator stated that any form of abuse was to be reported immediately to her or the Director of Nursing and if they were not there the employee's supervisor or charge nurse. She stated the two incidents were abuse and should have been reported so the residents could be immediately protected. She also stated that residents in the Alzheimer's unit are vulnerable to abuse due to being cognitively impaired and may not be able to report the abuse themselves.

The Administrator was notified of Immediate Jeopardy on 7/26/24 at 2:27 PM.

The facility presented the following credible allegation of immediate jeopardy removal:

Identify those recipients who have suffered, or

a supervisor immediately. This means notifying them at once or as soon as the resident's safety is ensured. If you are uncomfortable reporting to your supervisor, you may report confidentially to the corporate hotline.
Staff may fear retaliation or causing trouble, while residents may fear reprisals, losing caregivers, or not being believed. All staff should feel empowered to report abuse confidentially. Retaliation against any staff member who reports potential abuse will not be tolerated. If you feel retaliated against, contact the corporate hotline. Your message will be handled confidentially. You may remain anonymous, but this could limit our ability to clarify facts and notify you of the outcome.
Immediate steps must be taken to protect the residents. These steps should include the following: taking steps to prevent further potential abuse, conducting a thorough investigation of the alleged violation, reporting the alleged violation and investigation within required time frames, and upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the medical records. The police should be called. The MD must be notified immediately.
The Administrator and/or Director of Nursing should ensure that steps are taken to prevent further abuse from occurring. These actions may include but are not limited to: notifying the police if a crime is suspected, suspending the

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F 607	Continued From page 19 are likely to suffer, a serious adverse outcome as a result of the noncompliance. The facility failed to follow their abuse policy as evidenced by: a) Confidential Staff #1 allowed Nurse #3 to continue providing resident care after witnessing her slap Resident #3. The abuse was not reported to the administration resulting in no protection of residents from further abuse, no investigation, and no reporting to the state, APS, or law enforcement. b) NA #2 and NA #3 did not identify abuse when they witnessed Nurse #3 rip a dressing off of Resident #3's forearm resulting in skin being torn off and the nurse raising her hand to the resident "as if to slap her". This resulted in the abuse not being reported to the administration, no protection of residents from further abuse, no investigation, and no reporting to the state, APS, or law enforcement. Nurse #3 worked on the memory care unit and she continued to work with other residents. This placed all residents on that unit at risk for further abuse. The facility needs to implement a system to protect all residents from abuse. Upon notification of the alleged abuse to Resident #3 on 07/26/2024 by the facility Administrator submitted a 2-hour report for abuse. The Administrator also contacted law enforcement and contacted on Adult Protective Services (APS) on 07/26/2024. The Medical Director and Responsible Party were notified of the alleged abuse that occurred to Resident #3 in March	F 607	employee, placing the resident on 1:1 supervision if applicable, transferring the resident to the hospital for treatment and evaluation, notifying physician and implementing orders provided When Resident to Resident abuse has occurred, the residents must be separated and/or 1:1 supervision initiated. The Administrator, or designee, will conduct investigation of any areas of concern. Resident interviews, family interviews, and staff interviews may be used to investigate an incident. Investigations will be individualized to determine if abuse, neglect or misappropriation of property has occurred. The Administrator and/or designee will complete a 2-Hour or 24-Hour investigation and report must be completed and faxed in to Healthcare Personnel Registry. Facilities will use the Initial Report form and follow the guidelines for completion that are on the instruction sheet provided with the form. The facility will follow up with the 5-Working Day Report. In addition to reporting to the Healthcare Personnel Registry, the facility must also report to their local Division of Aging and Adult Services Adult Protective Services and contact the local police department. This education will be provided to new hires during the orientation process by the Director of Nursing and/or Licensed Educator. No staff shall work without this education effective 07/30/24.	

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F 607	Continued From page 20 2024 and July 2024 by the Director of Nursing on 07/26/2024. On 07/26/2024, the Licensed Administrator, Social Services Director, and Regional Vice President of Operations interviewed all dedicated Alzheimer Care staff who typically were assigned to work the Alzheimer care unit to gather details of alleged abuse. The Licensed Administrator, Social Services Director, and Regional Vice President of Operations reeducated each staff member on the abuse policy with emphasis on having a culture against barriers to reporting. Reeducation included types of abuse, how to prevent abuse, reporting abuse immediately to Licensed Administrator without fear of retaliatory or punitive measures. Nurse #3 was suspended on 07/25/2024 out of an abundance of precaution by the Licensed Administrator. On 07/26/24 the Administrator audited grievances for the last 30 days and Resident Council Minutes for any concerns related to abuse. There were no grievances noted in the Resident Council Minutes that included any abuse. Upon auditing grievances, the Administrator noted one neglect allegation on 06/29/24. The reporting of the allegation followed facility policy and Department of Health and Human Services regulation on reporting allegations of neglect. The neglect allegation was made known to the Administrator by facility staff immediately and the Administrator reported the allegation to the Department of Health and Human Services within the required reporting time frame for the Initial Allegation and the 5 day Investigation Report. The Initial Allegation report contained all aspects of the required report to include identification of other residents who have suffered abuse and assessed	F 607	4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator or Designee will monitor tag F607 for Abuse Reporting weekly for 4 weeks and monthly for 3 months or until resolved. The Administrator/Director of Nursing will ensure that all shifts have been covered during the monitoring period. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Director. Date of Compliance: 07/30/2024	

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if other residents were free from further potential harm. On 07/26/24 the Director of Nursing audited incident reports for the last 30 days for any abuse related incidents. There were no incident reports that involved abuse.

During in-service education that began on 07/26/24, all staff will be interviewed by the Administrator and/or designee. Staff will be asked to report any abuse or incident that they may have seen that they had not previously been reported. This will be completed on 07/29/24. If any abuse allegations are identified, the Administrator will follow facility policy and regulations to submit report of allegation to Department of Health and Human Services.

Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed.

On 07/26/2024, the Director of Nursing and/or Licensed Educator began in-servicing all staff in all departments (including agency staff) on the abuse prohibition/reporting policy. In addition to the facility policy on abuse, the training included:
Abuse can be physical in nature, including actions such as slapping, kicking, hitting, pushing, spitting, or threatening. Abuse can also occur when care is provided inappropriately; for example, if a nurse removes a bandage roughly, it may be considered abuse.
If a resident states that they were hurt by a staff member, this should be treated as a potential abuse case. Additionally, if a resident reacts by hitting or spitting at a staff member, it must be reported to a supervisor.

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If the suspected abuser is your supervisor, notify the administrator or Director of Nursing immediately. All instances of abuse should be reported to a supervisor immediately. This means notifying them at once or as soon as the resident's safety is ensured. If you are uncomfortable reporting to your supervisor, you may report confidentially to the corporate hotline.

Staff may fear retaliation or causing trouble, while residents may fear reprisals, losing caregivers, or not being believed. All staff should feel empowered to report abuse confidentially. Retaliation against any staff member who reports potential abuse will not be tolerated. If you feel retaliated against, contact the corporate hotline. Your message will be handled confidentially. You may remain anonymous, but this could limit our ability to clarify facts and notify you of the outcome.

Immediate steps must be taken to protect the residents. These steps should include the following: taking steps to prevent further potential abuse, conducting a thorough investigation of the alleged violation, reporting the alleged violation and investigation within required time frames, and upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the medical records. The police should be called. The MD must be notified immediately.

The Administrator and/or Director of Nursing should ensure that steps are taken to prevent further abuse from occurring. These actions may include but are not limited to: notifying the police if a crime is suspected, suspending the employee,

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placing the resident on 1:1 supervision if applicable, transferring the resident to the hospital for treatment and evaluation, notifying physician and implementing orders provided

When Resident to Resident abuse has occurred, the residents must be separated and/or 1:1 supervision initiated.

The Administrator, or designee, will conduct investigation of any areas of concern. Resident interviews, family interviews, and staff interviews may be used to investigate an incident. Investigations will be individualized to determine if abuse, neglect or misappropriation of property has occurred.

The Administrator and/or designee will complete a 2-Hour or 24-Hour investigation and report must be completed and faxed in to Healthcare Personnel Registry. Facilities will use the Initial Report form and follow the guidelines for completion that are on the instruction sheet provided with the form. The facility will follow up with the 5-Working Day Report. In addition to reporting to the Healthcare Personnel Registry, the facility must also report to their local Division of Aging and Adult Services Adult Protective Services and contact the local police department. This education will be provided to new hires during the orientation process by the Director of Nursing and/or Licensed Educator.

No staff shall work without this education effective 07/30/24.

Alleged date of immediate jeopardy removal: 07/30/24

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F 607	Continued From page 24 The credible allegation of immediate jeopardy removal was validated on 7/30/24. Inservice sign in sheets and materials were reviewed including the different types of abuse, how to prevent abuse, and reporting abuse immediately to Licensed Administrator without fear of retaliatory or punitive measures. The facility grievance log and resident council minutes for the past 30 days were reviewed with no issues raised concerning abuse. A review of 3 facility-initiated reports were reviewed for timeliness in reporting and notification of law enforcement and adult protective services with no concerns noted. Interviews were conducted in person and on the telephone with staff noted no further allegations of abuse or incidents that concerned them of abuse, and none were found. Staff were able to state the different types of abuse and to report anything they see or if a resident would tell them a facility staff member hurt them. Staff was able to state that any instance of abuse or suspected abuse was to be reported immediately to their supervisor or the Director of Nursing/Administrator and stated that they would not be retaliated against if they did report abuse or suspected abuse and the main goal was to protect the residents. The staff were able to say there were certain time frames in which the administrator or Director of Nursing had to report to the state, law enforcement, and adult protective services if something happened to a resident. The facility's immediate jeopardy removal date of 7/30/24 was verified.	F 607		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		8/14/24

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F 684	Continued From page 25 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff, Emergency Medical Services personnel, and the Medical Director, the facility failed to immediately initiate emergency medical services (EMS) on a pulseless, nonbreathing resident who was a full code. On 7/13/24 at approximately 12:03 AM Resident #1 was found to be unresponsive, pulseless, and not breathing. Nurse #1 began cardiopulmonary resuscitation (CPR) (a way to try to restart the heart and lungs if they stop) and yelled out "Code Blue". After approximately 2 minutes of (CPR) no other staff had come to assist Nurse #1 so she went to the door, saw a nurse assistant and yelled "Code Blue" she then resumed CPR on Resident #1. Nurse #2 arrived with the crash cart, applied the automatic external defibrillator (AED) pads and 2-person CPR was started. Staff failed to meet EMS at the door that was locked and with non-working doorbell. Emergency Medical Services record revealed dispatch received a call on 7/13/24 at 12:24 AM for a resident in cardiac arrest and was at the patient at 12:40 AM. Resident #1 was transferred to the hospital at 12:55 AM where she was pronounced deceased. This deficient practice was for 1 of 2 residents reviewed for emergent medical care (Resident #1). Immediate jeopardy began on 7/13/24 for	F 684	This Plan of Correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the facility or community as to the accuracy of the surveyors findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the facilitys or communitys policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The facility / community submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility / community or any employee, agent, officer, director, attorney, or shareholder of the facility / community or affiliated entities. F684: On 07/13/24, the facility failed to	

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F 684	Continued From page 26 Resident # 1 when the facility failed to immediately initiate EMS. Immediate jeopardy was removed on 7/27/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. The findings included: Resident #1 was admitted into the facility on 7/10/24 with diagnoses of metabolic encephalopathy, dementia, hypertension, left anterior fascicular block (an abnormal condition of the left bottom half of the heart), atherosclerotic heart disease (a buildup of fats in and on the artery wall of the heart), and dependence on oxygen. A review of Resident #1's July 2024 physician orders indicated an order dated 7/10/24 for a full code/CPR. A review of Resident #1's advance directive paperwork signed by a family member dated 7/11/24 indicated Resident #1 was a full code. On 7/23/24 at 4:58 PM a telephone interview was conducted with Nurse #1. She revealed that on 7/13/24 she went into Resident #1's room to administer eye drops at approximately 12:03 AM. When she went in the room, she noted Resident #1 had not responded when she said her name and noted that her pupil had not dilated when she put in the eye drop. Nurse #1 then did a sternal rub with no response, checked Resident #1's	F 684	immediately initiate emergency medical services (EMS) on a pulseless, nonbreathing resident who was full code. On 07/13/2024 at approximately 12:03 am Resident #1 was found to be unresponsive, pulseless, and not breathing. Nurse #1 began cardiopulmonary resuscitation (CPR) and yelled out Code Blue. After approximately 2 minutes of CPR no other staff had come to assist Nurse #1 so she went to the door, saw a nurse assistant and yelled Code Blue she then resumed CPR on Resident #1. Nurse #2 arrived with the crash cart, applied the automatic external defibrillator (AED) pads and the 2-person CPR was started. Staff failed to meet EMS at the door that was locked and with non-working doorbell. Emergency Medical Services record revealed dispatch received a call on 07/13/2024 at 12:24 am for a resident in cardiac arrest and was at the patient at 12:40 am. Resident #1 was transferred to the hospital at 12:55 am where she was pronounced deceased. 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 07/24/24 Interviews revealed that resident was unresponsive, code status was checked, and cardiopulmonary resuscitation was started at 12:03 am. The primary licensed nurse called aloud for help and the certified nursing assistant came to Resident #1□s room to assist. The certified nursing assistant then	

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F 684	Continued From page 27 radial and carotid pulses which were absent and noted no respirations. She noted Resident #1's skin was still warm, so she yelled code blue and started CPR. She stated that after approximately 2 minutes no other staff had come to the room, so she stopped compressions and went to the door of the room. She stated that she saw a nursing assistant and yelled code blue and returned to Resident #1's bedside to continue compressions. Nurse #1 stated that Nurse #2 came in with the crash cart, applied the AED pads and they, Nurse #1 and #2, started 2-man CPR. Nurse #1 stated that Resident #1's roommate was upset asking what was going on because the curtain was pulled around the bed, so the decision was made to move Resident #1 to the sunroom to relive the roommate's agitation and give EMS more room to work. She revealed that at some point Nurse Aide #1 had stated she was going to go let EMS in so when the AED said pause and assess the patient, Nurse #1 and Nurse #2 pushed Resident #1's bed out of the room. Approximately halfway down the hall they met EMS, so Nurse #1 stopped and gave report while Nurse Aide #1 assisted Nurse #2 in pushing Resident #1 to the sunroom. Nurse #1 stated that EMS asked her if Resident #1 was hospice or a do not resuscitate which she replied no that Resident #1 was a full code. Nurse #1 further stated that she did not call 911 when she found Resident #1 because she was busy doing CPR and thought the other nurse or anyone who heard her would call 911. On 7/23/24 at 11:30 AM a telephone interview was conducted with Nurse #2. He indicated that on 7/13/24 Nurse Assistant #1 came over to the 1200 hall and said he was needed on the 1100 hall for a unresponsive resident. He was not sure	F 684	retrieved the crash cart and called for additional assistance. The secondary licensed nurse arrived to bedside to assist with cardiopulmonary resuscitation to include use of automated external defibrillator and following automated external defibrillator prompts. The certified nursing assistant then called 911 after the arrival of the secondary licensed nurse arrived on scene to assist with cardiopulmonary resuscitation. The certified nursing assistant called 911 from nursing station and returned to resident #1□s room to continue assistance with code until arrival of 911 emergency services. The certified nursing assistant then ran to the ambulance entrance door and as she was opening the door, the emergency services personnel was approaching the door with the stretcher. The emergency services personnel followed the certified nursing assistant to the location of Resident #1. First responder was a fireman as noted from the entering the facility. Per camera footage and sound, a responder was at the door talking at 12:33:01 am. The door was locked at that time. Then upon camera footage and sound, rescue lights and truck back up sound noted to end at 12:34:32 am. The door remained locked and was opened by certified nursing assistant at 12:34:44 am. Patient was pronounced deceased on 07/13/2024 by UNC Health Southeastern Emergency Department staff after arrival by EMS. 2.Address how the facility will identify other residents having the potential to be	

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F 684	Continued From page 28 of the time but he thought it was around 12:00 AM. Nurse #2 took the crash cart to the room where Nurse #1 was doing CPR. Nurse #2 applied the AED pads and took over compressions while Nurse #1 used the bag-valve-mask (allows for oxygenation and ventilation of a patient until a more definitive airway can be established). Nurse #2 stated that at some point Nurse Assistant #1 had stated she was going to go let EMS in and left the room. During resuscitation attempts Resident #1's roommate became upset so the decision was made when the AED directed the nurses to pause and assess the resident that they would quickly move the resident to the sunroom by the nurse's station. Nurse #2 stated that he checked the pulse and respirations while Nurse #1 pushed the bed into the hall and when Nurse #1 stopped to give report to EMS Nurse Aide #1 took her spot. It took approximately 15-30 seconds to move Resident #1 to the sunroom since they were basically running while pushing Resident #1's bed, when they arrived at the sunroom, he resumed compressions until Emergency Medical Services (EMS) took over. Nurse #2 stated they did CPR for approximately 20-25 minutes in total before EMS took over. Nurse #2 stated that he did not call 911 because he was called over and thought they had already been called by the nurse who had her, because that was how it usually happened. He indicated that usually someone goes and waits at the door for EMS and did not think to ask if that was occurring because it was like an automatic thing that was done the same as calling 911. On 7/23/24 at 11:52 AM a telephone interview was conducted with Nurse Assistant #1. She stated that on 7/13/24 she went to the room about	F 684	affected by the same deficient practice. All other residents have the potential to be affected by these deficient practices. On 07/23/24 the Director of Nursing and the Licensed Administrator audited all residents requiring cardiopulmonary resuscitation in the past 30 days to ensure no concerns. The audit was completed on 7/23/24. Results included findings of one additional resident requiring cardiopulmonary resuscitation with no identified concerns. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Education of current cardiopulmonary resuscitation process to initiate Basic Life Support cardiopulmonary resuscitation as defined by the American Heart Association or American Red Cross equivalent was initiated 07/24/24 by Director of Nursing and/or designated Licensed Nurse Educator for all licensed nursing staff, to include agency licensed nurses, on the cardiopulmonary resuscitation (CPR) protocol. Education on the revised policy: 1. If a resident is noted with a significant change of condition the staff member should immediately alert the nurse for the resident and a code blue called over the intercom. 2. All nurses and staff should promptly respond to the room where the code is occurring. Staff should first ensure that residents are not left in unsafe or compromised positions by addressing their immediate needs. Once these needs	

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the same time as Nurse #2 and saw Nurse #1 doing chest compressions on Resident #1. She stated that at some point she thought that EMS should be arriving, and knew that someone had to let them in. She stated she looked out the window and saw the lights, so she went to make sure someone was there to let them in. She stated anyone could let EMS in the door and the other nursing assistant was watching both halls while she helped with Resident #1 and tried to keep an eye out for the ambulance to arrive. Nurse Aide #1 stated that as she was going down the hall with EMS, she saw Nurse #1 and Nurse #2 pushing Resident #1's bed down the hall. Nurse #1 stopped to give report and she helped Nurse #2 push Resident #1's bed into the sunroom. She further stated that she was unsure of how long EMS waited to enter the building.

On 7/25/24 at 3:17 PM an additional telephone interview was conducted with Nurse Assistant #1. She stated that she was the one who called 911 on 7/13/24 and thought it was because Nurse #2 instructed her to do so. She further stated that she thought one of the nurses had already called EMS because that was what usually happened, so she didn't think to ask.

A review of the Emergency Medical Services report dated 7/13/24 indicated the call was received at 12:20 AM and they arrived at the facility at 12:34 AM. The report indicated the local fire department and an EMS supervisor were on scene waiting for staff to open the locked doors so they could enter the building. It was noted that facility staff (Nurse #1 and Nurse #2) were rushing down the hallway pushing a resident's bed. When the EMS supervisor was notified that Resident #1 was neither hospice or a do not

are met, they should quickly proceed to the room to see if their assistance is required.
3. The staff nurse responsible for resident begins an assessment of the resident, applies the AED, and implements CPR if the resident is a full code status. Another staff member should be verifying the code status by reviewing the physician orders for the resident.
4. A staff member should immediately upon initiation of CPR call 911. This person should then go to the ambulance entrance and await emergency medical staffs arrival. Once they arrive the staff member should ensure that they are taken to the room where CPR is being performed. Once emergency medical staff have arrived in the room this staff member may begin assisting other residents.
5. Another staff member should call MD, prepare paperwork for transfer and calling family. The paperwork should be taken to the room and given to the nurse assigned to the resident or emergency medical staff.
6. Staff should follow the American Heart Association basic life support procedures based on their most recent training.
The CPR policy has been reviewed and revised as of 07/26/24 to reflect additional instruction for CPR. This education will be completed by the Director of Nursing Services and/or Licensed Nurse Educator for all licensed nursing staff. The Director of Nursing will ensure no licensed nursing staff (to include agency licensed nursing staff) will work after 7/26/24 without this

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F 684	Continued From page 30 resuscitate by Nurse #1, EMS went to the resident and determined the resident was pulseless, apneic (not breathing) and warm to touch. EMS began CPR, cardiac pads were placed with an initial rhythm of asystole (no heart rate). The resident was placed on 15 liters of oxygen and assisted with ventilation via a bag-valve mask, intubation was attempted but was unsuccessful. Resident #1 was transported to the Hospital at 12:51 AM. On 7/24/24 at 9:00 AM a telephone interview was conducted with Paramedic #1. He stated that when EMS arrived at the facility his supervisor and the local fire department were on scene, but he was unsure how long they had been there. He stated that they were waiting to be let in and called dispatch so the facility could be notified they were at the door. Paramedic #1 stated that there were two doorbells at the door, but he was unsure if they worked. He stated that when they were going down the hall to the room, they noted a male (Nurse # 2) and female (Nurse #1) pushing a bed quickly down the hall and as they got closer, he heard the AED say start compressions. The female (Nurse #1) stopped to answer questions and gave report and the male (Nurse #2) kept pushing the bed quickly towards the nurse's station. Paramedic #1 stated that his supervisor asked if the resident was a hospice patient or a do not resuscitate and the nurse stated no. His supervisor then instructed them to go to the patient (Resident #1). Paramedic #1 stated that Resident #1's skin was still warm and CPR was continued. An observation of the ambulance entrance was completed on 7/25/24 at 1:30 PM with the Administrator. It was noted that there were two	F 684	education. The Director of Nursing and/or Licensed Nurse Educator will ensure all newly hired licensed staff members, to include agency licensed staff members, will receive this education by 07/26/24. The Director of Nursing will ensure no licensed nurse, to include agency licensed nursing staff, will work without this education after 07/26/24. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator and/or Director of Nursing will monitor tag F684 for Cardiopulmonary Resuscitation Response by completing Mock Codes on various shifts weekly for 4 weeks and monthly for 3 months or until resolved. The Administrator/Director of Nursing will ensure that all shifts have been covered during the monitoring period. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Director. Date of Compliance: 07/30/2024	

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	345054	A. BUILDING _____ B. WING _____	C 07/31/2024

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doorbells on the right side of the door and an interview with the Administrator revealed that one of the doorbells did not work and the other notified a nursing station that was no longer in use.

A review of the hospital emergency room record dated 7/13/24 revealed Resident #1 arrived at the Emergency Room at 1:18 AM in cardiac arrest and had been undergoing active cardiac resuscitation for approximately one hour. Resident #1 received a central line in her right femoral artery at 1:20 AM and the medications Epinephrine and Calcium were administered. Resident #1 received multiple rounds of CPR, but it was unsuccessful, and Resident #1 was pronounced deceased at 12:08 AM. (The time of death documented in the hospital record was inaccurate.)

An interview was conducted on 7/25/24 at 4:36 PM with the Interim Director of Nursing. He stated that the normal protocol was for 911 to be called as soon as staff were aware of the code blue and that anyone could call 911. He further stated that staff were trained through the American Heart Association initially and were recertified as required. He indicated that "Code Blue" drills were held quarterly and if during the drill an area of vulnerability was noted then that area would be sent to quality assurance and staff educated to ensure the best possible outcome for both the residents and staff. He further indicated that Nurses #1 and #2 were initially trained by the American Heart Association and if they were part of a drill and were noted to be an area of vulnerability 1-on-1 training would be completed and the area would be monitored and sent to quality assurance. He stated that along with 911

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being notified immediately, someone should have gone to the ambulance entrance and waited for EMS to arrive.

On 7/23/24 at 2:10 PM a telephone interview was conducted with the Medical Director. She stated that Resident #1 was frail and in poor health when she was admitted into the facility. She further stated that she had planned on discussing palliative care or hospice with the family. However, during her initial visit Resident #1 was having an acute episode and she wanted it resolved prior to talking to the family. The Medical Director stated she was surprised that Resident #1 was a full code and she understood it was what the family had wanted. The Medical Director stated her plan had been to discuss palliative care or hospice with the family on her next visit. The Medical Director indicated that the facility should have called 911 immediately and continued CPR until EMS arrived on scene and took over. She was not aware of the lapse in time between when Resident #1 was found pulseless and 911 called.

An interview was conducted on 7/25/24 at 4:36 PM with the Administrator who stated that 911 should have been activated immediately and someone should have been designated to wait at the ambulance door for EMS to arrive.

The Administrator was notified of Immediate Jeopardy on 7/25/24 at 12:25 PM.

The facility presented the following credible allegation of immediate jeopardy removal:

" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as

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a result of the noncompliance;

On 7/13/24, the facility failed to immediately seek emergent medical care for Resident #1. Resident #1 was identified as pulseless and not breathing. The resident coded at approximately 12:03 AM and emergency services were contacted at 12:20 AM. The facility failed to have an effective protocol in place for who was responsible for calling emergency services. Additionally, the facility failed to immediately let emergency services enter the facility when they responded to the call. Resident #1's code status was full code. Resident #1 was taken to the hospital at 12:51 AM and was pronounced deceased in the Emergency Room.

The Director of Nursing and the Licensed Administrator began interviewing staff involved in the cardiopulmonary resuscitation (CPR) event of Resident #1 for areas of opportunity for improvement on 7/23/24. This was completed on 7/24/24. Interviews revealed that resident was unresponsive, code status was checked, and cardiopulmonary resuscitation was started at 12:03 am. The primary licensed nurse called aloud for help and the certified nursing assistant came to Resident #1's room to assist. The certified nursing assistant then retrieved the crash cart and called for additional assistance. The secondary licensed nurse arrived to bedside to assist with cardiopulmonary resuscitation to include use of automated external defibrillator and following automated external defibrillator prompts. The certified nursing assistant then called 911 after the arrival of the secondary licensed nurse arrived on scene to assist with cardiopulmonary resuscitation. The certified nursing assistant called 911 from nursing station

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and returned to resident #1's room to continue assistance with code until arrival of 911 emergency services.

The certified nursing assistant then ran to the ambulance entrance door and as she was opening the door, the emergency services personnel was approaching the door with the stretcher. The emergency services personnel followed the certified nursing assistant to the location of Resident #1. First responder was a fireman as noted from the entering the facility. Per camera footage and sound, a responder was at the door talking at 12:33:01 am. The door was locked at that time. Then upon camera footage and sound, rescue lights and truck back up sound noted to end at 12:34:32 am. The door remained locked and was opened by certified nursing assistant at 12:34:44 am.

Current process at time of event was to perform cardiopulmonary resuscitation process to initiate Basic Life Support cardiopulmonary resuscitation as defined by the American Heart Association or American Red Cross equivalent to include calling 911 services immediately upon initiation of CPR. The facility acknowledges the nurse is CPR certified and as such was trained to activate 911. The facility acknowledges our policy didn't specifically state to activate 911, and ensure access to the facility by emergency services, as such the facility has adjusted their policy.

All other residents have the potential to be affected by these deficient practices.

On 7/23/24 the Director of Nursing and the Licensed Administrator audited all residents requiring cardiopulmonary resuscitation in the

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past 30 days to ensure no concerns. The audit was completed on 7/23/24. Results included findings of one additional resident requiring cardiopulmonary resuscitation with no identified concerns.

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

Education of current cardiopulmonary resuscitation process to initiate Basic Life Support cardiopulmonary resuscitation as defined by the American Heart Association or American Red Cross equivalent was initiated 7/24/24 by Director of Nursing and/or designated Licensed Nurse Educator for all licensed nursing staff, to include agency licensed nurses, on the cardiopulmonary resuscitation (CPR) protocol. Education on the revised policy:
1. If a resident is noted with a significant change of condition the staff member should immediately alert the nurse for the resident and a code blue called over the intercom.
2. All nurses and staff should promptly respond to the room where the code is occurring. Staff should first ensure that residents are not left in unsafe or compromised positions by addressing their immediate needs. Once these needs are met, they should quickly proceed to the room to see if their assistance is required.
3. The staff nurse responsible for resident begins an assessment of the resident, applies the AED, and implements CPR if the resident is a full code status. Another staff member should be verifying the code status by reviewing the physician orders for the resident.
4. A staff member should immediately upon

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initiation of CPR call 911. This person should then go to the ambulance entrance and await emergency medical staffs' arrival. Once they arrive the staff member should ensure that they are taken to the room where CPR is being performed. Once emergency medical staff have arrived in the room this staff member may begin assisting other residents.
5. Another staff member should call MD, prepare paperwork for transfer and calling family. The paperwork should be taken to the room and given to the nurse assigned to the resident or emergency medical staff.
6. Staff should follow the American Heart Association basic life support procedures based on their most recent training.

The CPR policy has been reviewed and revised as of 7/26/24 to reflect additional instruction for CPR. This education will be completed by the Director of Nursing Services and/or Licensed Nurse Educator for all licensed nursing staff. The Director of Nursing will ensure no licensed nursing staff (to include agency licensed nursing staff) will work after 7/26/24 without this education.

The Director of Nursing and/or Licensed Nurse Educator will ensure all newly hired licensed staff members, to include agency licensed staff members, will receive this education by 7/26/24. The Director of Nursing will ensure no licensed nurse, to include agency licensed nursing staff, will work without this education after 7/26/24.

Alleged date of immediate jeopardy removal: 7/27/24

The credible allegation of immediate jeopardy

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F 684	Continued From page 37 removal was validated on 7/30/24 by reviewing the audit, the revised CPR policy, and the education the nursing staff received which included changes in condition, code status, and the CPR policy. The licensed and unlicensed nursing staff were able to verbalize the education that was given to them. The immediate jeopardy removal date of 7/27/24 was verified.	F 684		