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	345339	A. BUILDING _____ B. WING _____	C 05/06/2025

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WINDSOR REHABILITATION AND HEALTHCARE CENTER	1306 SOUTH KING STREET WINDSOR, NC 27983

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 5/6/2025. Event ID # QHHC11. The following intakes were investigated NC00229764 and NC00230076. One of the two allegations resulted in a deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §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, staff interview, and family interview, the facility failed to protect the resident's right to be free from abuse for one (Resident #1) of three residents reviewed for physical abuse. Resident #1, a severely cognitively impaired resident, was hit with a belt by a family member resulting in three whip-like marks on her left upper thigh and abdomen. A reasonable person would be traumatized by being hit with a belt. Findings included:	F 600	1. Resident #1 continues to reside in the facility. Resident #1 was removed from the presence of the abuser after the initial episode of abuse. Law enforcement was informed and the abuser was arrested. 2. All residents have the ability to be affected by the deficient practice. An audit was conducted with residents with a BiM's score of 11	5/19/25

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

Electronically Signed | 05/21/2025

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F 600	Continued From page 1 Resident #1 was admitted to the facility on 9/27/2024 and had diagnoses of a genetic-related intellectual disability and a neurological condition. Documentation on a quarterly Minimum Data Set (MDS) assessment dated 1/20/2025 revealed Resident #1 was severely cognitively impaired and was dependent on staff for all activities of daily living. Resident #1 was not coded as having any moods or behaviors on the MDS assessment. Documentation on a care plan dated as initiated 11/04/2024 revealed Resident #1 had an activity of daily living, self-care performance deficit relative to muscle weakness and malignant neuroleptic syndrome, a rare and life-threatening reaction to the use of antipsychotic medication. One of the interventions under this focus area was Resident #1's total dependence on staff for repositioning and turning in bed. There were no focus areas for behaviors on the care plan for Resident #1 before 4/23/2025. Documentation in a nursing progress note dated 4/23/2025 at 7:18 PM written by Nurse #2 stated, "This nurse was standing in (the) hallway in front of [readmission] patient room. As this nurse was standing there, I overheard [Resident #1] yelling. This nurse then overheard the sound of someone hitting someone, and then I overheard [Resident #1] yelling again. This nurse then went to inform, (the) unit manager of what was going on." Nurse #2 was interviewed on 5/6/2025 at 12:02 PM. Nurse #2 confirmed she was assigned to Resident #1 on 4/23/2025 for the 7:00 AM to 7:00	F 600	or higher. Audit questions include: Do you know about abuse? Do you know who to report abuse to? Do you feel safe in the facility? Do you have any concerns about abuse including visitors (physical, verbal, emotional, sexual, financial?) Skin assessments were conducted for all other residents for signs of abuse, i.e, welts, bruises of unknown origin. 3. All staff including nurses, certified nursing assistants, agency/contract staff, all ancillary staff, and all newly hired employees were educated on the Abuse Prevention Policy by the Director of Nurses/Assistant Director of Nurses by 5/19/2025. This education included 1:1 and group training sessions. The Administrator/designee will be the person who will ensure all licensed nurses, certified nursing assistants, agency/contract staff, all ancillary staff and all newly hired employees will be educated. No staff will work after 5/19/2025 until education is received. 4. The Dirctor of Nurses/Assistant Director of nurses weekly audits x 4 then monthly x 2 months with residents with a BIM's score of 11 or higer for any concerns or allegations of abuse. Skin checks will be conducted on all other reidents. Skin checks will be conducted weekly x 4 weeks then monthly x 2 months. Results of these audits will be presented to the Quality Assurance	

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F 600	Continued From page 2 PM shift. Nurse #2 provided the following information. Nurse #2 was in a room near Resident #1's room with another resident when she heard a sound like someone was being hit with a whip and someone calling out in pain. Nurse #2 stopped to listen, and she heard it again, the whipping sound and a cry of pain. Nurse #2 went out into the hallway, and she saw that two of the nurse aides (NA #1 and NA #2) had come out of the resident rooms they were in. Nurse #2 asked the two nurse aides if they had heard that too. Nurse #2 then heard the whipping sound and a cry of pain coming from Resident #1's room for a third time. One of the nurse aides stuck their head into Resident #1's room but then both nurse aides turned around and went back to care for other residents. Nurse #2, without going into Resident #1's room, went down the hall to get the Unit Manager. Nurse #2 found the Unit Manager and told her Resident #1 was "getting whooped." Nurse #2 stated she let the Unit Manager handle the situation because she knew it was Resident #1's family member in the room. Nurse #2 stated that the Unit Manager spoke with Resident #1's family member and the family member came out of the room to be escorted off the premises. Nurse #2 entered Resident #1's room and assisted the Unit Manager with a skin assessment. Resident #1 was lying on her right side and had 3 marks on her left hip. Nurse #2 completed a pain assessment and a skin assessment. Nurse #2 explained the red raised marks did not require treatment and Resident #1 did not appear to be in pain. Nurse #2 explained that she did not immediately go into Resident #1's room when she heard the whipping sound because there was a family member in the room. Nurse #2 further explained that she had been a nurse for a long time and had numerous training	F 600	and Performance Improvement (QAPI) Committee for three months for review and, if warranted, further action. 5. Alleged Date of Compliance: May 19, 2025	

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sessions on abuse, but she was in shock, and she had never encountered a family member hitting a resident.

NA #1 was interviewed on 5/6/2025 at 12:42 PM. NA #1 confirmed she was in a resident's room during the evening mealtime on 4/23/2025 when she heard clapping and hollering. NA #1 stated she went out into the hallway to see what the noise was and along with NA #2 peaked into Resident #1's room. NA #1 indicated the curtain was pulled so she could not see Resident #1 in the first bed but saw the back of what she assumed was a family member in the room. NA #1 reiterated she did not know what was happening, so she returned to assisting another resident with eating.

NA #2 was interviewed on 5/6/2025 at 1:54 PM. NA #2 stated she was assigned to care for Resident #1 for the 3:00 PM to 11:00 PM shift on 4/23/2025. NA #2 stated she was in the room next door assisting a resident in eating the evening meal when she heard a smacking or clapping sound. NA #2 indicated she stuck her head out of the room because it was an unusual sound and looked into the doorway of Resident #1's room. NA #2 said the curtain was pulled but Resident #1's family member peaked around the curtain and looked at her. NA #2 said she saw Nurse #2 in the hallway and Nurse #2 said she thought the family member was spanking Resident #1. NA #2 said she reentered the room next door to assist the other resident with eating. NA #2 revealed she did not hear any more noises from Resident #1's room. NA #2 confessed she did not know that the family member hitting Resident #1 was considered abuse. NA #2 was later told that it was considered abuse because it

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happened within the walls of the facility. NA #2 stated that Resident #1 sometimes resisted care but in general she was a sweet person.

The family member of Resident #1 was interviewed on 5/6/2025 at 3:01 PM. The family member revealed the following information. Someone from the facility called the family member and told her Resident #1 was exposing herself. The family member did not want to reveal who called her. The family member did not plan to go to the facility that day, but she went to the facility to discipline Resident #1. The family member confirmed she hit Resident #1 with her belt three to five times. The Assistant Director of Nursing (ADON) explained to the family member of Resident #1 that she was not allowed to do that in the facility. The family member stated she did not know it was wrong and considered abuse. If the family member had known disciplining Resident #1 with a belt would have the consequence of having the police called, it wouldn't have happened. The family member stated she was interviewed by the police and explained to them that she loved Resident #1, goes with her to every medical appointment, and stayed with her in the hospital when she almost died. The family member said she told the police she was not out to hurt Resident #1, but she needed to stop the behavior of undressing. The family member was sorry it happened, but she felt she needed to discipline Resident #1 when she entered the room and found her with her arm out of her gown. The family member confirmed Nurse #1 came into Resident #1's room, asked her what she was doing, and requested she leave. The family member stated other family members have been visiting Resident #1 but that she would not visit Resident #1 until all of this "blows over." The

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family member confirmed she was told she could have supervised visits, but she did not want to do that.

Documentation in the nursing progress notes dated 4/23/2025 at 7:12 PM by the Unit Manager stated, "This nurse was notified around 6:00 PM by the floor nurse that [Resident #1's family member] was whooping her. This nurse immediately went to [Resident #1's] room and observed [Resident #1] laying in the bed, kind of on her right side and [Resident #1's family member] standing beside the bed with her hands on her hips and a belt in her left hand. I immediately asked what was going on and [Resident #1's family member] responded back to me by repeating what I had just asked her. I then asked her if she was hitting her (Resident #1) with the belt that she was holding and [Resident #1's family member] responded that she (Resident #1) was acting out with behaviors. I then proceeded to tell [Resident #1's family member] that she cannot beat/hit her and that while she is here in this facility, she (Resident #1) is our responsibility. I then asked [Resident#1's family member] what behaviors she is referring to and [Resident #1's family member] stated that [Resident #1] had took her gown off and was naked in the bed. I asked [Resident #1's family member] to step out of the room and then I walked to the nursing station and called my DON (Director of Nursing) and Administrator and was informed to tell [Resident #1's family member] to leave and to call 911. 911 was called and [Resident #1's family member] was walked to the front door by staff."

The Unit Manager was interviewed on 5/6/2025 at 11:20 AM. The Unit Manager described the

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following events as happening on the evening of 4/23/2025. The Unit Manager was coming up to the nursing station from another hallway when Nurse #2 approached her at the nursing station stating, "Her [family member] is whopping her." The Unit Manager was confused and asked Nurse #2 who and what was going on. Nurse #2 described Resident #1's location and that it sounded like Resident #1 was being "whopped." Nurse #2 explained to the Unit Manager she did not go into the room but described what it sounded like. The Unit Manager went down the hall and entered Resident #1's room to see the family member with her hands on her hips and her belt in one of her hands. The Unit Manager asked the family member what was going on and the family member responded by repeating what she said. The Unit Manager asked the family member if she was hitting Resident #1 and the family member responded that Resident #1 was "acting out." The Unit Manager explained to the family member of Resident #1 that although they were family members, she was not allowed to hit her with a belt in the facility because the residents were under their care. The Unit Manager asked her to step out. The Unit Manager observed that Resident #1 was on her right side in bed and when she lifted her gown there were raised red marks like she was hit with a belt. The family member stood in the hallway and the ADON was talking to her. The Unit Manager then called the Administrator and the Director of Nursing, who were not in the building. The Administrator told the Unit Manager to inform the family member of Resident #1 to leave the building and to call 911. The Unit Manager had the ADON walk the family member of Resident #1 to the front door and instruct her not to return to the building until the Administrator or DON called her. The police

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came to the building to conduct interviews with Nurse #2, NA #1, NA #2, and herself. Resident #1's family left the facility before the police arrived. The police took pictures of the red marks on Resident #1. The Unit Manager was not told by the family member of Resident #1, but it was assumed she hit her with her belt because of the noise described by Nurse #2. The Unit Manager stated this was an unexpected action from the family member and she had never indicated before this that she would do anything like this to Resident #1.

The ADON was interviewed on 5/6/2025 at 12:50 PM. The ADON stated on 4/23/2025 she overheard someone talking in the hallway about the family member of Resident #1 whipping Resident #1 with a belt. The ADON revealed she went down the hallway and saw the family member in the hallway. The ADON asked the family member what happened, and she was told by the family member she was spanking her with a belt to discipline her. The ADON revealed she had to explain that she was not allowed to do that in the facility and walked her to the building door so she could leave.

An attempt to interview Resident #1 was made on 5/6/2025 at 12:36 PM. Resident #1 was not able to express her recollection of the events of 4/23/2025.

Documentation on a weekly skin assessment dated 4/23/2025 at 6:54 PM revealed Resident #1 as assessed as having "Slight redness and whip-like marks to front of left thigh. Small, red whip-like marks to left upper abdomen area."

Documentation on a pain interview dated

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4/23/2025 at 7:04 PM revealed Resident #1 was in no pain and had no indicators of pain.

Documentation in a nursing progress note dated 4/23/2025 at 8:35 PM revealed the nurse practitioner was made aware of the incident with Resident #1 and requested she be sent out to the emergency room for evaluation.

Documentation in the nursing progress notes dated 4/24/2025 at 4:04 AM stated, "Resident [#1] left the facility via stretcher at [8:50 PM] on 4/23/25 and returned to the facility by stretcher at [9:50 PM] with no new orders. Skin assessment by the writer noted to be [within normal limits]. No break in skin. Resident alert and oriented. Pleasant mood. No distress noted."

Documentation in Resident #1's care plan was updated on 4/23/2025 with the focus area for the potential for harm injury from others relative to cognitive loss and behaviors of undressing. The goal was for Resident #1 to have no injuries due to harm from others and will remain in a safe environment through the next review. The intervention was supervised visits with a family member in a common area with a staff member present.

An interview was conducted with the facility Social Worker on 5/6/2025 at 12:08 PM. The Social Worker revealed Resident #1's family member was very involved in her care both attending medical appointments with her and attending care plan conferences. The Social Worker stated she was shocked when she heard Resident #1's family member hit her with a belt. The Social Worker revealed the Administrator requested she call Resident #1's family member on 4/25/2025 to

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F 600	Continued From page 9 notify her she would only be allowed to have supervised visits with Resident #1 for a period of time. The Social Worker indicated that to her knowledge Resident #1's family member had not been back to the facility. An interview was conducted with the facility Administrator on 5/6/2025 at 1:36 PM. The facility administrator revealed that Resident #1 tried to get the staff's attention without understanding what she was doing because she had a childlike mind. The Administrator indicated the family member of Resident #1 would say things jokingly that would insinuate she would stop Resident #1 from "acting out" but family dynamics were not seen as an issue. The Administrator explained Resident #1's family member, who struck her with a belt, would often bring Resident #1's young daughter to the facility to visit her. The police and the facility explained to Resident #1 after the incident that the family member would not be allowed to visit her for a while. Resident #1 became inconsolable on the day of the event because in her mind it meant she would not be able to see her daughter and the family member ever again. The Administrator confirmed the Social Worker called the family member to notify her she would only be allowed 20-minute supervised visits with Resident #1 until it was deemed she was safe. The Administrator stated she expected the staff to intervene immediately if abuse occurred in the facility no matter the source or situation.	F 600		
F 607 SS=G	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:	F 607		5/19/25

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F 607	Continued From page 10 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care 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 and family interviews, the facility failed to immediately identify abuse and respond to intervene to protect a resident from physical abuse. Facility staff delayed intervention when Resident #1, a severely cognitively impaired resident, was hit with a belt by a family member resulting in three whip-like marks on her left upper thigh and abdomen and a visit to the emergency room. The facility also failed to notify the state agency	F 607	1. Resident #1 was removed from the presence of the abuser after the initial episode of abuse. Law enforcement was informed and the abuser was arrested. 2. All residents have the ability to be affected by the deficient practice.	

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F 607	Continued From page 11 within two hours of physical abuse that occurred in the facility. This occurred for 1 (Resident #1) of 3 residents reviewed for adherence to abuse policies and procedures during physical abuse investigations. Findings included: a. Documentation on the undated facility abuse policies and procedures revealed under the heading of identification of abuse, neglect, and exploitation, "the facility will identify events, occurrences, patterns, and trends that may constitute: ... Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." Documentation on the undated facility abuse policies and procedures also revealed in part, "When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occurs, the following procedure will be initiated: All staff, where applicable will: Respond to the needs of the resident and protect him/her from further incident." Resident #1 was admitted to the facility on 9/27/2024 and had diagnoses of a genetic-related intellectual disability and a neurological condition. Documentation on a quarterly Minimum Data Set (MDS) assessment dated 1/20/2025 revealed Resident #1 was severely cognitively impaired and was dependent on staff for all activities of daily living. Resident #1 was not coded as having any moods or behaviors on the MDS assessment. Documentation in a nursing progress note dated 4/23/2025 at 7:18 PM written by Nurse #2 stated,	F 607	3. All staff including nurses, certified nursing assistants, agency/contract staff, all ancillay staff and all newly hired employees will be educated on the Abuse Prevention Policy. The policy describes the right for residents to be free from abuse, negelect, exploitation or mistreatment and their obligation under state and federal law to report abuse by the Administrator or designee. This will include signs of abuse, reporting timeframes. All education will be completed by the Director of Nurses/Assistant Director of Nurses or designee by 5/19/2025. This education will include 1:1 and group training sessions. The Administrator/designee will be the person who will ensure all licensed nurses, certiied nursing assistants agency/contract staff, all ancillary staff and newly hired employees will be educated. No staff will work after date util education has been received.The Administrator was in-serviced by the V.P of Clinicals on 5/8/2025 on the state and federal timeframes for reporting actual abuse and suspected abuse. New hires will receive training upon hire. 4. The Administrator or designee will conduct Weekly audits x 4 then monthly audits x 2 to assess staff's understanding of the what	

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	345339	A. BUILDING _____ B. WING _____	C 05/06/2025

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F 607	Continued From page 12 "This nurse was standing in (the) hallway in front of [readmission] patient room. As this nurse was standing there, I overheard [Resident #1] yelling. This nurse then overheard the sound of someone hitting someone, and then I overheard [Resident #1] yelling again. This nurse then went to inform, (the) unit manager of what was going on." Nurse #2 was interviewed on 5/6/2025 at 12:02 PM. Nurse #2 confirmed she was assigned to Resident #1 on 4/23/2025 for the 7:00 AM to 7:00 PM shift. Nurse #2 provided the following information. Nurse #2 was in a room near Resident #1's room with another resident when she heard a sound like someone was being hit with a whip and someone calling out in pain. Nurse #2 stopped to listen, and she heard it again, the whipping sound and a cry of pain. Nurse #2 went out into the hallway, and she saw that two of the nurse aides (NA #1 and NA #2) had come out of the resident rooms they were in. Nurse #2 asked the two nurse aides if they had heard that too. Nurse #2 then heard the whipping sound and a cry of pain coming from Resident #1's room for a third time. One of the nurse aides stuck their head into Resident #1's room but then both nurse aides turned around and went back to care for other residents. Nurse #2, without going into Resident #1's room, went down the hall to get the Unit Manager. Nurse #2 found the Unit Manager and told her Resident #1 was "getting whooped." Nurse #2 stated she let the Unit Manager handle the situation because she knew it was Resident #1's family member in the room. Nurse #2 stated that the Unit Manager spoke with Resident #1's family member and the family member came out of the room to be escorted off the premises. Nurse #2 explained that she did not immediately go into Resident #1's room when she	F 607	constitues abuse and the immeidate interventions that staff should take in the event that abuse is wittnessed. The Administrator or designee will conduct monthly audits of incidents reports and investigations for three months, then quarterly, to ensure that all reports are logged, investigated promptly and reported to appropriate agencies as required. The results of these audits will be reported to the Quality Assessment and Performance Improvement (QAPI) Committee for three months for review and, if warranted, further action. 5. Alleged date of Compliance: May 19, 2025.	

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heard the whipping sound because there was a family member in the room. Nurse #2 further explained that she had been a nurse for a long time and had numerous training sessions on abuse, but she was in shock, and she had never encountered a family member hitting a resident. Nurse #2 admitted that if she saw or heard another resident whipping Resident #1 with a belt she would have gone into the room and intervened immediately.

NA #1 was interviewed on 5/6/2025 at 12:42 PM. NA #1 disclosed that she was not assigned to care for Resident #1 on the evening shift on 4/23/2025. NA #1 confirmed she was in a resident's room during the evening mealtime on 4/23/2025 when she heard clapping and hollering. NA #1 stated she went out into the hallway to see what the noise was and along with NA #2 peaked into Resident #1's room. NA #1 indicated the curtain was pulled so she could not see Resident #1 in the first bed but saw the back of what she assumed was a family member in the room. NA #1 reiterated she did not know what was happening, so she returned to assisting another resident with eating.

NA #2 was interviewed on 5/6/2025 at 1:54 PM. NA #2 stated she was assigned to care for Resident #1 for the 3:00 PM to 11:00 PM shift on 4/23/2025. NA #2 stated she was in the room next door assisting a resident in eating the evening meal when she heard a smacking or clapping sound. NA #2 indicated she stuck her head out of the room because it was an unusual sound and looked into the doorway of Resident #1's room. NA #2 said the curtain was pulled but Resident #1's family member peaked around the curtain and looked at her. NA #2 said she saw

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Nurse #2 in the hallway and Nurse #2 said she thought the family member was spanking Resident #1. NA #2 said she reentered the room next door to assist the other resident with eating. NA #2 revealed she did not hear any more noises from Resident #1's room. NA #2 confessed she did not know that the family member hitting Resident #1 was considered abuse. NA #2 was later told that it was considered abuse because it happened within the walls of the facility.

The family member of Resident #1 was interviewed on 5/6/2025 at 3:01 PM. The family member revealed the following information. Someone from the facility called the family member and told her Resident #1 was exposing herself. The family member did not plan to go to the facility that day, but she went to the facility to discipline Resident #1. The family member confirmed she hit Resident #1 with her belt three to five times. The Assistant Director of Nursing (ADON) explained to the family member of Resident #1 that she was not allowed to do that in the facility. The family member stated she did not know disciplining Resident #1 with a belt was wrong and considered abuse.

The Unit Manager was interviewed on 5/6/2025 at 11:20 AM. The Unit Manager described the following events as happening on the evening of 4/23/2025. The Unit Manager was coming up to the nursing station from another hallway when Nurse #2 approached her at the nursing station stating, "Her [family member] is whopping her." The Unit Manager was confused and asked Nurse #2 who and what was going on. Nurse #2 described Resident #1's location and that it sounded like Resident #1 was being "whopped." Nurse #2 explained to the Unit Manager she did

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not go into the room but described what it sounded like. The Unit Manager went down the hall and entered Resident #1's room to see the family member with her hands on her hips and her belt in one of her hands. The Unit Manager asked the family member what was going on and the family member responded by repeating what she said. The Unit Manager asked the family member if she was hitting Resident #1 and the family member responded that Resident #1 was "acting out." The Unit Manager explained to the family member of Resident #1 that although they were family members, she was not allowed to hit her with a belt in the facility because the residents were under their care. The Unit Manager asked her to step out of the room. The Unit Manager observed that Resident #1 was on her right side in bed and when she lifted her gown there were raised red marks like she was hit with a belt. The Unit Manager was not told by the family member of Resident #1, but it was assumed she hit her with her belt because of the noise described by Nurse #2.

The ADON was interviewed on 5/6/2025 at 12:50 PM. The ADON stated on 4/23/2025 she overheard someone talking in the hallway about the family member of Resident #1 whipping Resident #1 with a belt. The ADON revealed she went down the hallway and saw the family member in the hallway. The ADON asked the family member what happened, and she was told by the family member she was spanking her with a belt to discipline her. The ADON revealed she had to explain that she was not allowed to do that in the facility and walked her to the building door so she could leave.

Documentation on a weekly skin assessment

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dated 4/23/2025 at 6:54 PM revealed Resident #1 as assessed as having "Slight redness and whip-like marks to the front of left thigh. Small, red whip-like marks to the left upper abdomen area."

Documentation in a nursing progress note dated 4/23/2025 at 8:35 PM revealed the nurse practitioner was made aware of the incident with Resident #1 and requested she be sent out to the emergency room for evaluation.

Documentation in the nursing progress notes dated 4/24/2025 at 4:04 AM indicated Resident #1 was transported to the emergency room at 8:50 PM on 4/23/2025 via a stretcher for evaluation and returned to the facility at 9:50 PM on 4/23/2025 with no new orders. A skin assessment performed upon her return to the facility revealed Resident #1 did not have any broken or open skin areas.

Documentation in the nursing progress notes dated 4/24/2025 at 4:04 AM stated, "Resident [#1] left the facility via stretcher at [8:50 PM] on 4/23/25 and returned to the facility by stretcher at [9:50 PM] with no new orders. Skin assessment by the writer noted to be [within normal limits]. No break in skin. Resident alert and oriented. Pleasant mood. No distress noted."

An interview was conducted with the facility Administrator on 5/6/2025 at 1:36 PM. The Administrator stated she expected the staff to intervene immediately if abuse occurred in the facility despite the source or situation.

b. Documentation on the undated facility abuse policies and procedures revealed in part, "The

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Director of Nursing, Administrator, or designee will notify the appropriate agencies within specified timeframes: Immediately, but no later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, ..."

Documentation on an initial allegation report revealed the facility became aware of an incident of abuse on 4/23/2025 with the allegation details, "It was alleged by staff that [Resident #1's family member], [Family Member Name], physically abused her by beating her with a belt." Details of the physical or mental injury/harm were, "[Resident #1] sustained whelps to her lower extremity as a result of the incident." The faxed initial allegation report was sent to the state agency on 4/24/2025 at 10:41 AM.

An interview with the facility Administrator was conducted on 5/6/2025 at 3:14 PM. The Administrator stated she was not in the facility when she was called by the Unit Manager notifying her of the allegation Resident #1's family member hit Resident #1 with a belt. The Administrator thought notifying the local police department immediately fulfilled the obligation of notifying the appropriate agencies within 2 hours. The Administrator admitted she came into the facility the next day, 4/24/2025, to fax the state agency of the abuse allegation regarding Resident #1. The Administrator confirmed her first attempt to contact the state agency was on 4/24/2025 at 10:41 AM.