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SPRING ARBOR OF KINSTON	3207 CAREY ROAD KINSTON, NC 28504

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, a follow-up survey, a state involved complaint investigation, and a county complaint investigation from January 28, 2025, to January 31, 2025. The county complaint investigation was initiated by the Lenoir County Department of Social Services on January 13, 2025.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#1) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #1's current FL-2 dated	D 234		

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01/28/25 revealed:
-Diagnoses included dementia and hypertension.
-He was semi-ambulatory.

Review of Resident #1's Resident Register revealed he was admitted to the facility on 09/18/23.

Review of Resident #1's two-step tuberculosis testing record revealed:
-Step one TB skin test was read as negative on 09/15/23 with no documented date of administration.
-Step two TB skin test was documented as a chest x-ray that was completed on 10/04/23 with chronic changes.

Review of Resident #1's chest x-ray dated 10/04/23 revealed:
-The indication was listed as sepsis.
-The principle problem list was acute respiratory failure with hypoxia.
-There was no mention of tuberculosis in the report.

Interview with the Resident Care Coordinator (RCC) on 01/31/25 at 2:13pm revealed:
-The RCD and marketing were responsible for ensuring the two-step TB skin test was completed on admission.
-She was not aware a chest x-ray had to be for the screening of TB to be used as a second step.
-She was not the RCD when Resident #1 was admitted and did not know why a two-step TB skin test was not completed.

Interview with the Administrator on 01/31/25 at 4:30pm revealed:
-She was aware a two step TB skin test was to be completed upon admission for each resident.

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D 234	Continued From page 2 -The sales and marketing along with the RCC were responsible for ensuring the 2 step TB skin test was completed. -She did not know why the two step TB test was not completed for Resident #1 when he was admitted. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	D 234		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 6 sampled residents (#1, #6) related to failing to inform a primary care provider (PCP) of skin breakdown (#6), and reported staff abuse of a resident (#1). The findings are: Review of the facility's Resident Skin Condition Observation form on 01/31/25 revealed: -There was a column where staff could circle any skin observations observed which included no open areas, a rash, bruises, redness/sores, excessive dryness, swelling, surgical scar and	D 273		

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open areas.
-There was a column to the right of the skin observation options for comments.
-There was a diagram of a person from the back and from the front where staff could document any areas observed on a resident's skin.
-There were directions to indicate the location of skin issues on the front or back of the body diagram.
-There was a sentence underlined below the descriptions to notify the Resident Care Coordinator (RCC) if residents have any skin conditions listed.
-Residents will have a complete skin condition observation completed within 48 hours of move in, quarterly, with re-admission from an alternative care setting, and upon return from any "leave" longer than three days.
-Personal Care Aides (PCAs) are to be instructed to promptly report to their supervisor if there are any unusual skin conditions observed while assisting a resident with showering, dressing, toileting or any other tasks (these may include bruises, skin tears, rashes, or open areas).
-The supervisor or a medication aide (MA) were responsible to follow up as appropriate and to document all accordingly.
-Staging a wound must always be identified and confirmed by a home health (HH) nurse, physician, or wound care management specialist.
-Staff at the facility may not stage wounds.

Review of Resident #6's current FL-2 dated 02/07/24 revealed:
-Diagnoses included heart failure, hypertension, anemia, anxiety, diverticulosis on intestine, and vitamin D deficiency.
-The resident's recommended level of care was assisted living (AL).
-The resident was continent of urine and bowel.

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D 273	Continued From page 4 -The resident required personal care assistance with bathing and dressing. -The resident's skin was thin and fragile. Review of Resident #6's Resident Register revealed she was admitted to the facility on 04/06/22. Review of Resident #6's Resident Service Plan Preview dated 01/02/25 revealed -The resident required assistance with her activities of daily living (ADL's). -She required continual supervision and hands on support for bathing. -She required hands-on support with dressing tasks. -The resident required guidance and light assistance with grooming. -She required hands-on, physical assistance for mobility and ambulation, toileting, and transfers. -There was no documentation related to a skin assessment for Resident #6. Review of Resident #6's electronic progress note dated 01/03/25 revealed: -There was a care plan meeting with the resident's family member, the Administrator, Vice President of Quality of Education, and the RCC. -The family member hired a private caregiver for Resident #6 to provide personal care in the mornings. Review of an assessment tool for Resident #6 revealed: -The RCC began the assessment tool on 01/02/25. -Resident #6 was admitted back to the facility from a family member's home on 01/02/25. -There was a skin evaluation section of the assessment tool.	D 273		

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-The RCC completed a skin evaluation on 01/08/25 at 11:48am.
-The skin evaluation included the skin color as "other, redness on buttocks."

Interview with the RCC on 01/31/25 at 11:09am revealed:
-She completed an assessment tool for Resident #6 on 01/02/25.
-She updated the resident's assessment tool on 01/06/25.
-There was no redness to the resident's buttocks on 01/06/25.
-When she updated the resident's assessment tool on 01/08/25 she documented that the resident had redness to her buttocks.
-When she updated the assessment tool on 01/08/25 the software program only printed the most recent entry in the system, which was 01/08/25.
-She did not notify the resident's primary care provider (PCP) about the redness she observed on the resident's buttocks on 01/08/25.
-She was not sure why she did not notify the resident's PCP, because she normally contacted a resident's PCP when there was a change in condition or changes in a resident's skin.

Review of Resident #6's Resident Skin Condition Observation form dated 01/04/25 revealed:
-A PCA completed the Skin Condition Observation form on 01/04/25.
-There were no descriptions of skin conditions circled.
-In the comment column the PCA documented that the resident's family member had been assisting the resident until the private caregiver began her care for the resident.
-The PCA documented that she checked on the resident and the family member to make sure

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they was okay.
-There were no areas of skin breakdown documented on either diagram.
-The RCC signed that she reviewed the form on 01/06/25.

Review of Resident #6's Resident Skin Condition Observation form dated 01/10/25 revealed:
-The column with options for skin observations had open areas circled.
-The comment column had a note "looks like bed sore."
-The diagram of a person from the back had a colored circle to the upper right of the resident's sacrum.
-The RCC signed that she reviewed the document on 01/10/25.
-There was an additional note under the diagram of the person from the front "responsible party (RP) notified at hospital as of 01/12/25."

Review of Resident #6's local Emergency Department (ED) records revealed:
-A wound evaluation was completed on 01/12/25.
-The resident was bedbound, incontinent, and required max assistance to turn and reposition in bed.
-The resident had an evolving deep tissue pressure injury to the sacrum, with an open area that was moist and pink.
-The peri wound (peri wound is the area of skin surrounding a wound) had purple and maroon discoloration.
-The peri wound was blanchable (blanchable means the skin does not have damaged capillaries).
-There was no odor and no drainage.
-There was documentation on 01/13/25 that the wound at the sacrum was 5 centimeters (cm) in length, 5 cm in width, 0 cm in depth, and the

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wound surface area was 25 cm.
-A Registered Nurse (RN) met with the resident's family member and private caregiver on 01/13/25 at 4:30pm to show them photographs of the resident's sacral area.
-The private caregiver reported that when she provided the resident with a shower on 01/09/25, the sacral area had a small pinkish area.
-The resident was discharged on 01/16/25 due to death.

Telephone interview with Resident #6's family member on 01/24/25 at 3:58pm revealed:
-She readmitted Resident #6 to the facility on 01/02/25.
-She had provided care for the resident at home for approximately 3 months.
-She visited with the resident at the facility from 01/02/25 to 01/06/25 and provided personal care.
-She hired a private caregiver to provide her family member with personal care each morning beginning 01/06/25.
-The private caregiver informed her that she observed some skin breakdown on the resident's buttocks when she provided personal care the morning of 01/11/25.
-She received a telephone call from facility staff the morning of 01/12/25, and was informed that her family member was in respiratory distress and needed to be transported to the local ED.

Telephone interview with Resident #6's family member on 01/31/25 at 4:00pm revealed:
-She observed a tiny blister to the right side of the resident's sacrum on 01/06/25.
-She noticed the tiny blister when she had the resident at home and applied oil of oregano to the resident's sacrum area.
-She continued to apply oregano oil to the resident's sacrum when she was re-admitted to

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the facility from 01/02/25 to 01/06/25.
-She instructed the private caregiver that she hired on 01/06/25 to apply the oregano oil to the resident's sacrum each day to prevent pressure ulcers.

Telephone interview with a PCA on 01/31/25 at 8:56am revealed:
-She worked at the facility as a PCA but was also qualified as a MA.
-She worked third shift and provided incontinence care and personal care services to Resident #6.
-The MAs informed PCAs that Resident #6 had a private caregiver that would provide personal care in the mornings.
-She continued to provide incontinence care and personal care to Resident #6 even though she had a private caregiver.
-The resident had resided at the facility approximately 3 months ago and was ambulatory.
-When the resident returned to the facility in January, she was not able to walk independently and required assistance with transfers and personal care.
-When the resident resided at the facility 3 months ago, she only required one person assist from the PCAs but when she returned in January 2025, she required two person assist.
-Most residents were checked on every 2 hours for incontinent care and personal care.
-When Resident #6 returned to the facility in January, PCAs were notified by either the Administrator or the RCC that Resident #6 required one hour checks for incontinent care and personal care.
-PCAs documented on a shift report for Resident #6 the date, time, location and initials of when Resident #6 was checked on every hour.
-Resident #6 usually went to the restroom twice a night.

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-She and another PCA provided transfer assistance to the toilet, and they returned the resident to her bed or chair.
-The resident sometimes preferred to rest in her chair instead of her bed.
-She observed a sore on Resident #6's bottom on her sacrum on 01/10/25.
-She completed a skin observation sheet and gave it to the MA on duty.
-The MA went with her and the other PCA to observe the resident's sacrum.
-The resident's sacrum had a red area half the size of a piece of notebook paper (5.5 inches x 8.5 inches, a regular sheet of notebook paper is 11 inches x 8.5 inches).
-She observed a small amount of wetness coming from the red skin area and there was no broken skin, however she described it as the beginning of a small bed sore.
-When she provided incontinence care, she was careful when wiping the resident and did not apply too much pressure because the resident complained of pain at the red area on her sacrum.
-As an MA and PCA, she knew a skin assessment was supposed to be completed when a resident was admitted or readmitted to the facility, she was not aware of a skin assessment being completed for Resident #6.
-The second shift PCAs should have reported to the oncoming third shift PCAs that the resident had a red area on her sacrum.
-She was not informed by any staff that the resident had a red area on her sacrum.
-The resident complained of pain when she attempted to put pants on her, she had facial grimacing and moaned when she attempted to put pants on the resident.
-When the resident wanted to sit in her recliner, she placed a blanket over the resident's waist and

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legs since she did not want to wear pants.
-Resident #6 told her that the pain was coming from her back and her whole body.

Telephone interview with Resident #6's paid private caregiver on 01/29/25 at 1:57pm revealed:
-She was hired by Resident #6's family member and began to provide personal care services for the resident on 01/06/25.
-When she bathed Resident #6 on 01/06/25 she did not observe any skin breakdown on her sacrum.
-She provided Resident #6 with a shower on 01/07/25 and observed a brown area that "looked close to her skin color" that was approximately the size of a pencil eraser.
-She provided a shower to Resident #6 on 01/08/25 and prior to her shower the resident reported for the first time that her bottom hurt.
-When she dried the resident off after her shower on 01/08/25 she observed a "skin tag" on the resident's sacrum that was approximately the size of a pencil eraser.
-She requested assistance from two PCAs to help her shower the resident on 01/09/25.
-She and the two PCAs showered Resident #6 on 01/09/25.
-When she dried of the resident, she again observed a small "skin tag" the size of a pencil eraser on the resident's sacrum.
-She applied a cream to the resident's sacrum that the family member had provided to use on the resident's bottom.
-She requested the same two PCAs to help her shower Resident #6 on 01/10/25.
-She observed the small "skin tag" approximately the size of a pencil eraser and applied a cream provided by the resident's family member to her bottom.
-When she arrived to provide personal care for

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the resident on 01/11/25 the resident was not wearing pants.
-She observed a small "skin tag" on the resident's buttocks.
-She did not observe any skin breakdown or any open areas on the resident's buttocks.
-The resident's family member contacted her by telephone the morning of 01/12/25 to ask her to go observe Resident #6 to see if she needed to go to the hospital because the facility had called the family member to inform the resident needed to be sent to the ED.
-When she entered Resident #6's room at the facility, the resident opened her eyes and did not look right, she told facility staff to send the resident to the ED.
-She saw Resident #6 at the hospital on 01/13/25 with the family member and was shown photographs of the resident's buttocks.
-She described the photographs the ED nurse provided of the resident's buttocks as "looked like a whole bunch of bumps, redness, skin breakdown with boils."

Interview with a second PCA on 01/30/25 at 4:09pm revealed:
-She worked with Resident #6 twice.
-She could not remember the exact date but when she worked with another PCA, resident required two person assistance for incontinence care and personal care.
-She and another PCA provided incontinence care to Resident #6 on 01/10/25.
and observed skin breakdown on the resident's sacrum that was "very red," open, and about the size of a quarter.
-She and the PCA that provided personal care informed the MA on duty.
-The MA on duty went and observed the resident's sacrum and applied a cream on the

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resident's sacrum.
-She and the PCA helped to reposition the resident to take pressure off her sacrum.
-The MA had reported to the PCAs that the resident's family member did not want staff to reposition the resident if she was asleep.
-She and the repositioned the resident in her recliner and her bed every hour when the resident was not asleep to help keep pressure off her sacrum.

Interview with a third PCA on 01/31/25 at 10:19am revealed:
-She usually worked first shift at the facility.
-She worked first and second shift on 01/10/25 and returned to work first shift on 01/11/25.
-The resident's private caregiver asked her to assist with personal care for the resident on 01/10/25 on first shift.
-The private caregiver showed her an area of skin at the resident's sacrum.
-She observed a brownish area of skin above the resident's sacrum that was approximately the size of a quarter.
-She reported the brownish area of skin to the MA on duty.
-When she arrived at work for first shift on 01/11/25 two PCAs notified her that the resident had a red area on her sacrum.
-The two PCAs that worked third shift asked her to come assist the resident to stand up.
-She observed a brownish, scaley area that was round spot at the resident's sacrum that was approximately the size of a quarter.
-There was a small amount of drainage, no odor and it looked like the beginning of skin breakdown.
-Resident #6 did not like to wear pants and complained of pain when she was touched anywhere.

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(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) COMPLETE DATE
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-When the resident preferred to sit in her recliner without pants, she would place a blanket on the resident that covered her from the waist and covered her feet.
-When there was a change in a resident's condition such as a bruise, bedsore, or confusion PCAs were expected to notify the MAs.

Interview with a MA on 01/29/25 at 5:05pm revealed:
-He worked with Resident #6 and usually worked 2nd shift.
-He first observed a red area of what appeared to be the beginning of skin breakdown on 01/09/25.
-The red area was on the right side of the resident's sacrum and did not appear inflamed.
-He contacted Resident #6's family member on 01/09/25 to report his observation.
-The family member informed him that when she last saw the resident on 01/06/25 she observed a small dry scaly area on her sacrum.
-He reported his observation to the RCC on 01/09/25 and explained to the RCC that it "needed some attention because it was gonna get worse."
-When a resident had a change in condition, skin breakdown, bruise, any changes the MAs were expected to notify the RCC and the RCC would notify the resident's PCP.
-If the RCC was not available, the MAs could also notify the resident's PCP.
-He was not sure if the RCC notified Resident #6's PCP about the skin breakdown he reported to her.

Interview with the RCC on 01/30/25 at 3:05pm revealed:
-She was notified by a MA on 01/09/25 that Resident #6 had skin breakdown on her sacrum.
-She planned to notify the PCP of the skin

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breakdown on the resident's sacrum if the MA did not notify the PCP while he was on duty.
-She was notified by a PCA that observed the resident's skin on 01/10/25 and observed a small red area on the resident's sacrum.
-She went to observe the resident's sacrum on 01/10/25 and observed an area of redness about the size of a nickel at the resident's sacrum, there were no open areas on her skin, no drainage and no odor.
-She could not remember if she notified Resident #6's PCP of the change in skin condition on her sacrum.
-There was a care plan meeting held on 01/03/25 with Resident #6's family member, the Administrator, the Vice President of Education and Quality, and the RCC.
-The family member was asked if the resident had any concerns about the resident's skin and the family member reported no.

Review of a text on the Administrators cellular telephone dated 01/10/25 at 6:36am revealed:
-The PCA that was working third shift on 01/10/25 sent her a text message of a photograph of Resident #6's skin breakdown on her sacrum.
-The text message was sent on 01/10/25 at 6:36am to the Administrator.
-The photograph showed the resident's sacrum with her skin the color of brown and was approximately the size of a half sheet of notebook paper (5.5 inches x 8.5 inches).

Interview with the Administrator on 01/31/25 at 11:34am revealed:
-She did not do anything with the photograph sent to her on 01/01/25, because the PCP had already been notified of the resident's skin breakdown.
-She may have shown the photograph to the RCC, but she could not remember.

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-The area on the resident's buttocks did not appear to have any skin breakdown, so she did not notify the resident's PCP.
-To her knowledge the RCC had already notified Resident #6's PCP about the skin breakdown on her buttocks.
-She should have followed up with the RCC to ensure the resident's PCP had been notified on skin breakdown on her buttocks.

Interview with the Administrator on 01/30/25 at 2:40pm revealed:
-The MAs and/or RCC were expected to notify a resident's PCP whenever there was a change in condition, a new symptom, new skin breakdown, a bruise, or any concerns to the resident's PCP.
-The PCP for Resident #6 should have been contacted the first time a staff person observed skin breakdown on the resident.
-The PCP needed to review what staff observed and may need to order a medication, place orders for repositioning, or for a referral.
-The PCA should have reported her observation of a "bed sore" that she documented on a skin observation sheet on 01/10/25.
-To her knowledge the PCA did not notify the MA on duty of her skin observation sheet.
-If she had known about the PCAs skin observation, she would have returned to the facility immediately to ensure the resident's PCP was notified.
-PCAs completed hourly checks on Resident #6 for incontinence care and to see if the resident needed anything.

Telephone interview with the facility's contracted PCP on 01/30/25 at 10:24am revealed:
-She was the resident's PCP when she resided at the facility in the past.
-She discharged the resident from her services

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on 09/05/24 so Resident #6's family member could provide the resident with a PCP with a more holistic approach to treatment.

Telephone interview with the facility's contracted PCP on 01/31/25 at 2:20pm revealed:
-She had not been the PCP for Resident #6 since September 2024.
-She was only able to answer questions in general about pressure ulcers and was not able to answer questions related specifically to Resident #6.
-Pressure ulcers usually developed on a boney prominence on an individual.
-Pressure ulcers started to develop on individuals due to a decrease in blood circulation, with no oxygen getting to the tissue below a boney prominence which could cause the tissue to die.
-Pressure ulcers could develop when a resident sat in the same position and was not repositioned frequently to decrease pressure to boney prominence areas such as the sacrum.
-She would want to be notified if any of her residents at the facility that she followed had any redness or open areas near their sacrum.
-She would recommend that the resident be turned every one to two hours, and have staff reposition the resident with pillows.
-She would recommend home health services to provide wound care and order medications as needed to help prevent the progression of the pressure ulcer and for wound healing care.
-Skin breakdown could lead to an infection for any resident.

Attempted telephone interview with Resident #3's former PCP on 05/11/23 at 3:30pm was unsuccessful.

2. Review of Resident #1's current FL-2 dated

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D 273	Continued From page 17 01/28/25 revealed: -Diagnoses included dementia and hypertension. -He was semi-ambulatory. Review of Resident #1's Resident Register revealed he was admitted to the facility on 09/18/23. Review of Resident #1's Incident Report dated 12/28/24 revealed: -The date of the incident was 12/20/24 and the type of incident was documented as "alleged abuse from employee". -The time of the incident was documented as 3:00pm. -The description of the incident was documented as 2 personal care aide (PCA) and a medication aide (MA) were assisting a resident to change soiled clothes when the resident struck the MA in the face and the MA then struck the resident in the face before leaving the room. -There was documentation the Administrator and the Resident Care Coordinator (RCC)/Special Care Unit Coordinator (SCC) were notified on 12/28/24. (It was not specified which director was notified.) -There was no documentation Resident #1's primary care provider (PCP) was notified. Review of Initial Allegation Report dated 12/29/24 revealed: -The incident occurred on 12/20/24 and involved Resident #1. -The facility was made aware of the incident on 12/28/24 at 9:30pm when the Administrator and the SCC were notified that a staff member in the special care unit (SCU) slapped a resident on the forehead due to frustration. -There was no physical harm and no mental harm reported.	D 273		

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-There was an attached fax transmission verification report to the Health Care Personnel Registry (HCPR) dated 12/29/24.

Review of the Investigation Report dated 12/29/24 revealed:
-There were 2 witnesses who were present and saw the incident occur between Resident #1 and a staff member on 12/20/24.
-There was a third person who later was made aware of the incident and this person reported the incident.
-There was substantial risk for injury/harm for Resident #1.
-There was documentation the local Department of Social Services was notified on 12/29/24.
-There was documentation that local law enforcement was not notified.
-There was an attached fax transmission verification report to the HCPR dated 12/31/24.

Review of an incident report by the local law enforcement dated 01/29/25 revealed:
-The facility notified them at 4:02pm on 01/29/25 that an assault had occurred on 12/20/24.
-Resident #1 became combative due to his dementia while staff attempted to complete personal care tasks.
-Resident #1 hit the staff in the upper chest area and the staff struck Resident #1 in the right side of his chin.

Interview with a PCA on 01/30/25 at 3:58pm revealed:
-She worked on the SCU on 12/20/24.
-She, another PCA and the MA on duty were changing Resident #1.
-Resident #1 hit the MA and the MA hit Resident #1 in the face.
-She did not report the incident to management

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that night.
-The MA was "kind of aggressive" and made her uncomfortable.

Interview with a second PCA on 01/30/21 at 4:14pm revealed:
-She was assisting with personal care for Resident #1 on 12/20/24 when he hit the MA.
-She saw the MA pause and then hit Resident #1 in the face with a closed fist.
-She did not report the incident that night because she was waiting for the SCC to return to work.

Telephone interview with Resident #1's PCP on 01/30/25 at 10:25am revealed:
-She was not aware Resident #1 had been assaulted.
-She expected to be notified if there was injury or if a resident was hit in the face or head so she could follow-up just as she would if he hit his head during a fall.

Interview with the RCC on 01/31/25 at 2:13pm revealed the Resident's primary care provider should be notified immediately so the resident could be assessed for injury.

Interview with the current SCC on 01/30/25 at 2:52pm revealed:
-She was a MA/supervisor until she became the SCC on 01/24/25.
-She reported the incident that occurred on 12/20/24 to the previous SCC on 12/28/24.
-The Administrator was responsible for taking on the investigation and making any notifications that were required.
-She did not notify Resident #1's PCP of the incident.

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D 273	Continued From page 20 Interview with the previous SCC on 01/31/25 at 2:51pm revealed: -The current SCC called her on 12/28/24 to report the allegation of abuse. -She did not notify Resident #1's PCP of the allegation of abuse. Interview with the Administrator on 01/31/25 at 4:30pm revealed: -She assumed someone had notified Resident #1's PCP of the alleged assault. -The incident was reported 8 days after it had occurred and there had been no injury reported, but the RCC, MA or SCC should have notified the PCP. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. _____ The facility failed to ensure notification to Resident #6's PCP for skin breakdown on four different occasions where staff observed skin breakdown on the resident's sacrum, the resident was sent to the local ED and was found to have a wound on her sacrum measuring 5 centimeters (cm) in length, 5 cm in width and 0 cm in depth. The resident was admitted to the local hospital and passed away on 01/16/25 due to an unrelated condition and failure to notify a resident's PCP that the resident had been hit in the face by a staff member with a closed fist (#2). This failure resulted in substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on January 30, 2025, for this violation.	D 273		

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D 273	Continued From page 21 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED March 2, 2025.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure for 1 of 5 sampled residents (#2) received a therapeutic diet as ordered. The findings are: Review of Resident #2's current FL-2 dated 01/21/25 revealed: -Diagnoses included respiratory disease and dementia. -There was an order for pureed diet with thickened liquids. (consistency of the liquids was not specified.) Review of Resident #2's diet order dated 01/24/25 revealed she was to be served a mechanical soft modified texture regular diet with nectar thickened liquids. Review of Resident #2's speech pathology services dysphagia management report dated 01/20/25 revealed: -Resident #2 was at risk of complications from	D 310		

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dysphagia if the patient's condition was not identified and treated including increased decline in overall cognitive and physical function related to dysphagia and at increased risk of aspiration and choking on food, liquid and medication and complications resulting from dehydration and malnutrition and secondary comorbidities associated with dysphagia.
-Resident #2 was evaluated to by trials of mechanical soft texture meal for potential advancement of the diet from pureed to mechanical soft consistency.
-Diet recommendation was a pureed diet and nectar thick liquids however there was documentation Resident #2 tolerated mechanic soft textures.

1. Observation of the breakfast service in the Special Care Unit (SCU) on 01/29/25 revealed Resident #2 was served water and milk that were not nectar thickened liquids.

Interview with the personal care aide (PCA) on 01/29/25 at 7:30am revealed:
-The facility was out of thickener packets yesterday and she thought they were still out of thickener packets this morning.
-She knew that Resident #2 required nectar thickened liquids to prevent the resident from choking.

The state surveyor asked the medication aide (MA) to remove the resident's milk and water because it was not nectar thickened.

Observation of a MA on 01/29/25 at 7:40am revealed:
-The MA came from the kitchen and removed the resident's milk and water from the table.
-She added a nectar thickened packet to the

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resident's water and milk.
-She stirred the water and milk and returned both to the resident's table.

Interview with the MA on 01/29/25 at 7:40am revealed:
-The kitchen was out of thickener packets yesterday afternoon.
-When she went to check the kitchen this morning, she obtained thickener packets for Resident #2.
-Resident #2 required nectar thickened liquids to prevent aspiration.

Refer to interview with the Resident Care Coordinator (RCC) on 01/31/25 at 2:13pm.

Refer to interview with the previous Special Care Unit Coordinator (SCC) on 01/31/25 at 2:51pm.

Refer to interview with Resident #2's primary care provider (PCP) on 01/30/25 at 10:25am.

Refer to interview with the Administrator on 01/31/25 at 4:30pm.

2. Observation of the dinner meal service in the Special Care Unit (SCU) on 01/29/25 at 5:00pm revealed Resident #2 was served 2 manicotti, a side salad of lettuce and diced tomato and a 2 oz pre-portioned pack of sliced apples with the peel intact along with nectar thickened water, tea and milk.

Review of a diet spread sheet provided by the facility on 01/31/25 revealed:
-Chopped bananas should be served as fruit of choice to residents on a mechanical soft diet.
-One-half cup of chopped spinach should be served in place of mixed green salad to residents

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D 310	Continued From page 24 on a mechanical soft diet. Interview with the Special Care Unit Coordinator (SCC) on 01/29/25 at 5:24pm revealed: -Resident #2 was on a pureed diet in the past and the mechanical soft diet just began that day. -She asked the cook about the food that was to be served, and the cook told her the salad and apple slices were "soft enough". -She did not feel comfortable serving the apples with the skin on to any resident because the peel was easy to choke on. Interview with the Kitchen Manager on 01/30/25 at 9:40am revealed: -Salad and apple slices should not be served as part of a mechanical soft modified texture diet. -There was a reference for pureed and mechanical soft modified consistency posted for staff above the prep station to guide staff. -He thought Resident #2's diet was mechanical soft meat only and thought he may need to get clarification. Interview with the cook on 01/30/25 at 2:25pm revealed: -She served salad and apple slices as part of a mechanical soft diet the previous evening. -She thought a mechanical soft diet was only for meats that were to be served. -Meats and vegetables should be soft enough to mash with a fork for a mechanical soft diet. -She was taught that the mechanical soft was for meats only by the previous Kitchen Manager and that was how it was done at the last facility she cooked for. -She did not know where the therapeutic diet extensions menus were located. Refer to interview with the Resident Care	D 310		

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D 310	Continued From page 25 Coordinator (RCC) on 01/31/25 at 2:13pm. Refer to interview with the previous Special Care Unit Coordinator (SCC) on 01/31/25 at 2:51pm. Refer to interview with Resident #2's primary care provider (PCP) on 01/30/25 at 10:25am. Refer to interview with the Administrator on 01/31/25 at 4:30pm. _____ Interview with the RCC on 01/31/25 at 2:13pm revealed: -Milk and Boost should be thickened to ordered consistency. -Resident #2 was on a pureed diet until the mechanical soft diet order was signed. -Tossed salad and apple slices should not be served if a mechanical soft diet was ordered. -She did not know why kitchen staff thought mechanical soft diet was only meant for meats. Interview with the previous SCC on 01/31/25 at 2:51 revealed: -The SCC was responsible for ensuring staff had access to current diet orders that included thickened liquids consistency and texture modification. -Floor staff were responsible for thickening liquids as ordered. -Kitchen staff were responsible for texture modifications as ordered. -Therapeutic diet descriptions were posted in the medication room for staff reference. -Residents were prescribed modified texture diets when there were swallowing difficulties. tooth decay, difficulty breathing and risk for choking. -Speech pathology conducted trainings on thickened liquids and modified texture diets for	D 310		

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D 310	Continued From page 26 floor staff. Telephone interview with Resident #2's PCP on 01/30/25 at 10:25am revealed: -Resident #2 had difficulty swallowing and speech therapy was requested to complete a swallow evaluation. -She was contacted by speech pathology following the study and she wrote an order for mechanical soft diet with nectar thick liquids based on the conversation with speech pathology on 01/24/25. -A salad and whole apple slices were not appropriate foods to serve for a mechanical soft diet. -Serving the wrong texture increased the risk that Resident #2 would choke. Interview with the Administrator on 01/31/25 at 4:30pm revealed: -Mechanical soft diet should consist of ground foods or foods that a fork would go through easily. -Speech therapy conducted an in-service training on 11/13/24 that included kitchen and floor staff. -Mechanical soft diet meant the entire meal should be mechanically soft, not meat only. -Resident #2 had some swallowing difficulties and was improving but could still aspirate if not given the appropriate diet.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

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D 338	Continued From page 27 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure all residents were free from physical abuse related to staff failing to protect residents in the Special Care Unit (SCU) when they did not report a resident being physically assaulted by a staff member (Resident #1). The findings are: Review of the facility's Resident Abuse policy dated January 2021 revealed: -Any team member who witnesses or becomes aware of or suspects any type of resident abuse must report it immediately to the Executive Director (ED) or designee if the Administrator was not available. -Staff should assure the resident's safety by removing the resident from an unsafe situation and remove an alleged perpetrator from the scene and take steps to assure this individual did not have unsupervised contact the the alleged victim and that there was no possibility of the alleged perpetrator committing similar or other offenses against other residents. -The resident's primary care physician should be contacted within one hour if the situation required the physician. Review of Resident #1's current FL-2 dated 01/28/25 revealed: -Diagnoses included dementia and hypertension. -He was semi-ambulatory. Review of Resident #1's Resident Register revealed he was admitted to the facility on	D 338		

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D 338	Continued From page 28 09/18/23. Review of Resident #1's Incident Report dated 12/28/24 revealed: -The date of the incident was 12/20/24 and the type of incident was documented as "alleged abuse from employee". -The time of the incident is documented as 3:00pm. -The description of the incident was documented as 2 personal care aides (PCA) and a medication aide (MA) were assisting a resident to change soiled clothes when the resident struck the MA in the face and the MA then struck the resident in the face before leaving the room. -There was documentation the Administrator and the Resident Coordinator (RCC)/Special Care Unit Coordinator (SCC) on 12/28/24. (It was not specified which director was notified.) Review of an Initial Allegation Report dated 12/29/24 revealed: -The incident occurred on 12/20/24 and involved Resident #1. -The facility was made aware of the incident on 12/28/24 at 9:30pm when the Administrator and the SCC were notified that a staff member in the special care unit (SCU) slapped a resident on the forehead due to frustration. -There was no physical harm and no mental harm reported. -There was an attached fax transmission verification report to the Health Care Personnel Registry (HCPR) dated 12/29/24. Review of an Investigation Report dated 12/29/24 revealed: -There were 2 witnesses who were present and saw the incident occur between Resident #1 and a staff member on 12/20/24.	D 338		

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-There was a third person who later was made aware of the incident and this person reported the incident.
-There was substantial risk for injury/harm to Resident #1.
-There was documentation the local Department of Social Services was notified on 12/29/24.
-There was documentation that local law enforcement was not notified.
-There was an attached fax transmission verification report to the HCPR dated 12/31/24.

Review of an incident report by the local law enforcement dated 01/29/25 revealed:
-The facility notified them at 4:02pm on 01/29/25 that an assault had occurred on 12/20/24.
-Resident #1 became combative due to his dementia while staff attempted to complete personal care tasks.
-Resident #1 hit the staff in the upper chest area and the staff struck Resident #1 in the right side of his chin.

Review of Resident #1's electronic medication administration record (eMAR) for December 2024 revealed:
-There was documentation the accused MA administered medication at 8:00am and 9:00am on 12/23/24, 12/24/24, 12/25/24 and on 12/28/24.
-There was documentation the accused MA administered medications at 8:00pm on 12/20/24, 12/24/24 and 12/28/24.
-There was a total of 6 shifts the accused MA continued to work in the SCU after the incident that occurred on 12/20/24 in addition to continuing the evening shift on 12/20/24.

Interview with a PCA on 01/30/25 at 3:58pm revealed:
-She worked on the SCU on 12/20/24.

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D 338	Continued From page 30 -She, another PCA and the MA on duty were changing Resident #1. -Resident #1 hit the MA and the MA hit Resident #1 in the face. -She did not report the incident to management that night because she was supposed to report incidents to her supervisor and the MA was the supervisor on duty at the time. -The MA was "kind of aggressive" and made her uncomfortable. -She did not report the incident until she was asked about it because she was afraid nothing would be done and the MA would retaliate. -She was not sure what the policy was prior to the incident but knew the facility's policy was for allegations of abuse to be reported immediately because of an in-service that was conducted since the incident. Interview with a second PCA on 01/30/21 at 4:14pm revealed: -She was assisting with personal care for Resident #1 on 12/20/24 when he hit the MA. -She saw the MA pause and then hit Resident #1 in the face with a closed fist. -She did not report the incident that night because she was waiting for the CCD to return to work. -She was supposed to report the incident to her supervisor but the MA was the supervisor on duty at the time of the incident and it was difficult to get in touch with management after they were gone from the facility. -She was aware the facility policy was to report allegations of abuse immediately because of annual trainings and a recent inservice but she was afraid the MA would try to retaliate. Interview with the current SCC on 01/30/25 at 2:52pm revealed:	D 338		

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-She was a MA/Supervisor until she became the SCC on 01/24/25.
-Staff were expected to get an abuser away from the resident and notify the supervisor immediately so the abuser is not able to harm residents.
-Staff were trained on this upon hire and she thought the training was repeated annually.
-The accused staff "sorta told on herself" and she began asking other staff about what they may have seen.
-She spoke with the two witnesses and reported the allegation to the SCC at the time.
-The accused finished out the shift on 12/20/24 and worked at least two more shifts before anyone was made aware of the allegation of abuse.

Interview with the previous SCC on 01/31/25 at 2:51pm revealed:
-The current SCC called her on 12/28/24 to report the allegation of abuse that occurred on 12/20/24.
-She notified the Administrator and began collecting statements from the witnesses.
-There were 2 witnesses to the incident that occurred on 12/20/24.
-The witnesses did not report the abuse to her on 12/20/24 or anytime prior to the investigation.
-The MA that was accused was the supervisor on duty but there was a master list of management contact numbers available to staff in the SCU.

Interview with the RCC on 01/31/25 at 2:13pm revealed:
-Abuse should be reported immediately even when managers were out of the building.
-Staff should report immediately to ensure the safety of residents and to be sure abuse does not continue.
-Staff were trained in the expectation of reporting abuse upon hire through online trainings.

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-Staff were given a handbook that contained expectations of abuse reporting when they were hired.

Interview with Resident #1's Power of Attorney (POA) on 01/30/25 at 3:37pm revealed:
-The facility reported to her at the end of December 2024 (exact date unknown) that a staff member hit her family member.
-She told the facility she did not wish to press charges but she thought local law enforcement had been notified by the facility.
-Resident #1 told her he did not know what happened.
-She thought the two staff who witnessed the assault were just as responsible because they did not report the abuse.

Telephone interview with a Sergeant with the local law enforcement office on 01/31/25 at 1:27pm revealed notifications should be made as soon as possible so an incident could be investigated early to determine the extent of injury if there was any.

Telephone interview with the Victim Services Specialist with the local law enforcement office on 01/31/25 at 11:11am revealed quicker reporting led to quicker gathering of evidence.

Interview with the Administrator on 01/29/25 at 12:12pm revealed:
-The alleged incident that occurred on 12/20/24 was not reported until 12/28/24 and it should have been reported immediately.
-She thought the witnesses did not report the allegation because they were afraid.

Second interview with the Administrator on 01/31/25 at 4:30pm revealed:

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D 338	Continued From page 33 -The accused staff worked a few nights after the incident before it was reported to management and she thought Resident #1 could have been afraid and wondered if the accused staff would have abused other residents. -Staff had access to management contact numbers for reporting incidents and she was always available by phone. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. _____ The facility failed to ensure residents that resided in the Special Care Unit were free of abuse when 2 staff witnessed a medication aide assault a resident and did not report the incident, allowing the medication aide to continue to work the rest of the shift and at least 3 more shifts with residents, without management's knowledge of abuse. This failure placed the residents at substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/31/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 2, 2025.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments	D 358		

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by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#1) who was ordered a medication used to reduce swelling.

The findings are:

Review of Resident #1's current FL-2 dated 01/28/25 revealed:
-Diagnoses included dementia and hypertension.
-He was semi-ambulatory.

Review of Resident #1's Resident Register revealed he was admitted to the facility on 09/18/23.

Review of Resident #1's nursing note dated 11/29/24 at 3:25pm revealed:
-Resident #1's feet were swollen.
-He was sent to the local emergency department for evaluation.

Review of Resident #1's second nursing note dated 11/29/24 at 9:32pm revealed:
-The local emergency department called to report Resident #1 would be returning to the facility that night.
-Lasix had been administered.
-The caller suggested follow-up with the primary care provider (PCP) for an order for lasix due to fluid retention.

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D 358	Continued From page 35 Review of Resident #1's physician's order dated 12/09/24 revealed: -Furosemide 20mg, one-half tablet (10mg) was to be administered each day. (Furosemide is a diuretic medication used to treat fluid retention and is marketed under the trade name Lasix) -There were instructions to fax the order to pharmacy. Review of Resident #1's routine primary care visit summary dated 01/14/25 revealed: -The primary purpose of the visit was hypertension and dementia. -There was trace pitting edema. -Resident #1's current medications included furosemide 20mg, one-half tablet (10mg) was to be administered each day for edema of lower extremities. Review of Resident #1's physician's order dated 01/29/25 revealed: -Lasix was to be discontinued and effective 01/14/25. -There were instructions to fax the order to pharmacy. Review of Resident #1's electronic medication administration record (eMAR) for December 2024 revealed there was no entry for furosemide (Lasix) to be administered and no documentation furosemide was administered. Review of Resident #1's eMAR for January 2025 revealed there was no entry for furosemide (Lasix) and no documentation furosemide was administered. Telephone interview with the pharmacist for the facility's contracted pharmacy on 01/30/25 at	D 358		

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D 358	Continued From page 36 10:20am revealed: -They had not received an order for Resident #1 to be administered furosemide. -They had not dispensed furosemide for Resident #1. -Observation of Resident #1 on 01/29/31 at 4:19pm revealed he was sitting it a wheelchair and no swelling was noted in lower extremities. Telephone interview with Resident #1's primary care provider (PCP) on 01/30/25 at 10:25am revealed: -Resident #1 had pitting edema in both feet and legs. -Edema could lead to decreased pain and ulcerations if it was untreated and the area continued to swell. -She thought Resident #1 was receiving furosemide as ordered because there was little to no edema when she saw him on 01/14/25. -The facility was responsible for faxing orders to the pharmacy when they were written and she wrote"please fax to pharmacy" on the order itself. -She would leave a copy of the order and would email a copy to the facility to ensure the order was completed. Interview with a medication aide (MA) on 01/29/25 at 2:46pm revealed: -She was not aware a an order to administer furosemide to Resident #1. -She had never administered furosemide to Resident #1. -MAs were responsible for initiating a new order tracking form when a new order was received. -MAs were responsible for calling the pharmacy to ensure the order was received once the order was faxed. -The tracking forms were left for on coming shifts	D 358		

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until the medication arrived at the facility and the form was completed.

Interview with the Special Care Unit Coordinator (SCC) on 01/30/25 at 2:52pm revealed:
-The MA was responsible for faxing new orders to the pharmacy when they were received and to initiate a "new order tracking form".
-The MA was to make a copy of the order to attach to the order tracking form and the form was placed with the 24 hour shift report and passed on to the oncoming shift until it was completed.
-The SCC received an email for each order but she had just taken the SCC position and did not know what was supposed to be done with the emailed order or the process for following-up to ensure tracking forms and orders were completed.

Interview with the Resident Care Coordinator (RCC) on 01/31/25 at 2:13pm revealed:
-New order tracking forms were initiated by the MA when orders were received.
-The order was to be faxed to the pharmacy, a copy of the order was attached to the tracking form and the original order with the fax confirmation sheet was placed in the resident's record and the form was passed shift to shift until each step was completed.
-She did not know what happened with Resident #1's order for furosemide but someone did not follow the process and she did not know why.

Interview with the Administrator on 01/31/25 at 4:30pm revealed:
-The MA was expected to fax new orders to the pharmacy and initiate the new order tracking form.
-New orders were faxed and emailed to her, the

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D 358	Continued From page 38 RCC and the SCC. -She expected new orders that were not completed with final approval on the eMAR to be discussed in morning stand up meetings. -She never instructed the RCD or CDD on a follow-up process to ensure the orders and tracking forms were completed. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	D 358		
D 457	10A NCAC 13F .1212 (h) Reporting Of Accidents And Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (h) The facility shall immediately report any assault resulting in harm to a resident or other person in the facility to the local law enforcement authority. This Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to immediately notify local law enforcement regarding physical assault of residents including 1 of 5 sampled residents (#1) when a resident in the Special Care Unit (SCU) hit a staff member and she retaliated by hitting the resident in the face. The findings are: Review of the facility's Resident Abuse policy dated January 2021 revealed:	D 457		

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-Any team member who witnesses or becomes aware of or suspects any type of resident abuse must report it immediately to the Executive Director (ED) or designee if the Administrator was not available.
-Staff should assure the resident's safety by removing the resident from an unsafe situation and remove an alleged perpetrator from the scene and take steps to assure this individual did not have unsupervised contact the the alleged victim and that there was no possibility of the alleged perpetrator committing similar or other offenses against other residents.
-The Administrator should review state reporting requirements and timelines and initiate reporting to the Health Care Personnel Registry within 24 hours of becoming aware of the allegation.

Review of Resident #1's current FL-2 dated 01/28/25 revealed:
-Diagnoses included dementia and hypertension.
-He was semi-ambulatory.

Review of Resident #1's Resident Register revealed he was admitted to the facility on 09/18/23.

Review of Resident #1's Incident Report dated 12/28/24 revealed:
-The date of the incident was 12/20/24 and the type of incident was documented as "alleged abuse from employee".
-The description of the incident was documented as 2 personal care aides (PCAs) and a medication aide (MA) were assisting a resident to change soiled clothes when the resident struck the MA in the face and the MA then struck the resident in the face before leaving the room.
-There was documentation the Administrator and the Resident Care Coordinator (RCC)/Special

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054071	A. BUILDING: _____ B. WING _____	R 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF KINSTON	3207 CAREY ROAD KINSTON, NC 28504

(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) COMPLETE DATE
D 457	Continued From page 40	D 457		

Care Unit Coordinator (SCC) were notified on 12/28/24. (It was not specified which director was notified.)

Review of an Initial Allegation Report revealed:
-The incident occurred on 12/20/24 and involved Resident #1.
-The facility was made aware of the incident on 12/28/24 when the Administrator and the SCC were notified that a staff member in the special care unit (SCU) slapped a resident on the forehead due to frustration.
-There was no physical harm and no mental harm reported.
-There was substantial risk for injury/harm to Resident #1.
-There was documentation that local law enforcement was not notified.
-There was an attached fax transmission verification report to the Health Care Personnel Registry (HCPR) dated 12/29/24.

Review of the Investigation Report for the incident that occurred on 12/20/24 revealed:
-There were 2 witnesses who were present and saw the incident occur.
-There ws a third person who later ws made aware of the incident and this person reported the incident.
-In the section of the investigation form that asks if the incident resulted in physical injury/harm or substantial risk of injury/harm, "yes" was documented with notation that the Resident #1 was at risk for harm due to the staff member hitting him in the face.
-There was documentation the local Department of Social Services was notified on 12/29/24.
-There was documentation that local law enforcement was not notified.
-There was an attached fax transmission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 457	Continued From page 41 verification report to the HCPR dated 12/31/24. Telephone interview with a Sergeant with the local law enforcement office on 01/31/25 at 1:27pm revealed notifications should be made as soon as possible so an incident could be investigated early to determine the extent of injury if there was any. Telephone interview with the Victim Services Specialist with the local law enforcement office on 01/31/25 at 11:11am revealed quicker reporting lead to quicker gathering of evidence. Interview with Resident #1's Power of Attorney (POA) on 01/30/25 at 3:37pm revealed: -The facility reported to her that a staff member hit her family member. -She told the facility she did not wish to press charges but she thought local law enforcement had been notified. Interview with the Administrator on 01/29/25 at 3:50pm revealed: -She did not notify local law enforcement of the allegation of abuse. -She was aware local law enforcement was supposed to be notified but she did not notify them because Resident #1's POA said there was no need for police involvement. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	D 457		