	-	ID HUMAN SERVICES				FORM APPROVED
		MEDICAID SERVICES				MB NO. 0938-0391
		· /	LE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		345126	B. WING			C 05/06/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
	LIVE CENTER			228 SMITH CHAPEL ROAD		
				MOUNT OLIVE, NC 28365		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	0		
	A compaint investiga 5/4/2022 to 5/6/2022. The following intakes NC00187858 and NC	were investigated:				
	One of the 8 complair substantiated resultin	-				
	Past-noncompliance	was identfied at:				
	CFR 483.12 at tag F6 (J)	600 at a scope and severity				
	The tag F600 constitu Care.	uted Substandard Quality of				
F 600 SS=J	A partial extended sur Free from Abuse and CFR(s): 483.12(a)(1)	Neglect	F 60	0		5/12/22
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to				
	§483.12(a) The facilit	y must-				
	physical abuse, corpo involuntary seclusion;					
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					05/12/2022

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

PRINTED: 06/09/2022

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/09/2022 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345126	B. WING _				C 06/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				22	28 SMITH CHAPEL ROAD		
MOUNTO	LIVE CENTER			М	OUNT OLIVE, NC 28365		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page Based on record revi Nurse Practitioner, st the facility failed to pr physical abuse by Re of resident and staff a Resident #2, who was planned as a supervis smoking area without Resident #1 for a ligh he refused, she "attact the face causing both ground. Resident #2 #1 while both residen Resident #1 sustainer with bleeding and an This abuse affected 1 resident-to-resident a Findings included: Resident #2 was adm diagnoses including of disorder. The Annual Minimum 4/16/22 indicated Resider MDS indicated Resider Resident #2's active of noted she was a super smoking assessment Resident is a supervisi remind resident of loo times; and Maintain resident of loo	e 1 iew, observation, psychiatric aff, and resident interviews, otect Resident #1 from esident #2 who had a history altercations. On 3/26/22 is assessed, and care sed smoker, was in the supervision. She asked t for her cigarette and when cked" him punching him in residents to fall to the continued hitting Resident ts were on the ground. d 3 scratches to his face abrasion to his left knee. I of 2 residents reviewed for litercations. Data Set (MDS) dated sident #2 was moderately and was ambulatory. The ent #2 was a smoker. care plan as of 3/25/22 ervised smoker per the . Interventions included: sed smoker; Inform and cation of smoking areas and esident's smoking materials e active care plan also		600			
	at nurses' station. The indicated Resident #2 behaviors related to c	e active care plan also					

Facility ID: 923344

If continuation sheet Page 2 of 9

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/09/2022 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345126	B. WING			(05/	C 06/2022
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP	CODE	_	
MOUNT O	LIVE CENTER			28 SMITH CHAPEL ROAD IOUNT OLIVE, NC 28365			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 600	physical aggression, oposition, clenched fist combative or resistive allow time for her to re Resident #2's active p 3/25/22 included Sero medication) 25 milligr times daily. A review of the facility of 3/25/22 revealed se allowed to smoke at op- to the smoking area w to 11:00 PM. During the was assigned to obset them with smoking sea A nursing note complet dated 3/27/22 revealed Resident #2 and Resi resulting in 3 scratches an abrasion to his left Emergency Room eva A review of the 5-day Director of Nursing or around 4:30 PM Nurs to the smoking area b was noted with scratch face and an abrasion of knee pain. Resider an ambulance to go to Emergency Medical S and he refused. Resider happened with Resider	d: Observe for signs of e.g. (for example), rigid body is, etc. If resident becomes a, postpone care/activity and egain composure. by chiatric medications as of oquel (antipsychotic ams (mg) by mouth two 's active smoking policy as upervised smokers were designated times. The door vas unlocked from 7:00 AM hose hours, a staff member erve smokers and assist afely. eted by Nurse Supervisor #1 ed an altercation with ident #1 on 3/26/22, es to Resident #1's face and c knee. Resident #1 refused aluation. report completed by the of 4/1/22 noted on 3/26/22 e Supervisor #1 was called by Nurse #1. Resident #1 ch marks and blood on his to his knee with complaints of #1 was asked if he wanted to the hospital or have Services (EMS) assess him dent #2 was taken to Nurse	F 600				

Facility ID: 923344

If continuation sheet Page 3 of 9

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	0: 06/09/2022 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345126	B. WING		_		_ 06/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST			
MOUNT O	LIVE CENTER			228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 283			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	was notified on 3/26/2 the two residents and of knee pain. The phy the knee. A review of the x-ray in Resident #1's knee red degenerative changes On 5/4/22 at 10:00 AN interviewed. Resident outside in the smoking his own business when outside and asked him indicated he told her m me. I fell to the ground she was still punching and that was when Ne Nurse #1 came. On 5/4/22 at 12:00 PN interviewed and state 3/26/22, Resident #1 interviewed separatel Resident #2 what hap stated Resident #1 sta finished it". Resident #1 Nurse Supervisor #1 in was being assessed a was put on 1:1 supervisor	t #2 was immediately supervision. The e facility Medical Director the altercation between of Resident #1's complaint sician ordered an x-ray of report dated 3/26/22 of vealed only normal s, no acute abnormality. M Resident #1 was #1 indicated he was sitting g area on 3/26/22 minding en Resident #2 came in for a light. Resident #1 no and "she just punched d, and we rolled around, and me until I got her off me" urse Supervisor #1 was d after the incident on and Resident #2 were y. She stated she asked upened, and Resident #2 arted "s**t with her, so she #2 was asked if she put her and she stated "yes." indicated while Resident #1 and treated, Resident #2 vision, the Psychiatric oner was notified and chotic medication was original dosing. She int #2 recently had a	F 600				

If continuation sheet Page 4 of 9

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	0: 06/09/2022 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED		
		345126	B. WING			(05/	06/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
MOUNT O	LIVE CENTER			228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 283			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	stated Resident #1 wa given first aid for his in refused an ambulance refused Emergency M him.) She noted Resi oriented to person, pla reported that Residen I knew this was going Supervisor #1 revealed member to observe th She further revealed, someone to observe th Assistants (NAs) in th rather have people we indicated Resident #1 had a physical alterca 3/26/22, but she knew residents had verbal a Supervisor #1 noted t was unlocked, and re- could go out there if th Supervisor #1 stated supervised smokers' a electronic charts. Nur- she knew that Reside smoker. In an interview on 5/5 Supervisor #2 stated verbally aggressive "r seen physical behavio On 5/5/22 at 4:00 PM stated Resident #2 wa because of her cognit very aggressive espe	ion. Nurse Supervisor #1 as interviewed after he was njuries. (Resident #1 had e to go to the hospital and ledical Services to assess dent #1 was alert and ace, time, and situation. She t #1 said, "she attacked me, to happen." Nurse ed she did not assign a staff ne smoking area on 3/26/22. "I didn't realize we needed he smoking area at all ere were 8 or 9 Nursing e facility, and she would orking the floor. She and Resident #2 had not tion prior to the one on <i>v</i> of two times those two altercations. Nurse he door to the smoking area sidents that do not smoke ney wanted. Nurse safe smokers and assessments were in their se Supervisor #1 reported nt #2 was a supervised	F 60	0			

Facility ID: 923344

If continuation sheet Page 5 of 9

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/09/2022 APPROVED 0: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345126	B. WING		-	(05/() 06/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
				228 SMITH CHAPEL ROAD			
	LIVE CENTER			MOUNT OLIVE, NC 2836	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	to her several times. Resident #3, who was intact, was interviewe stated he had been the with being hit with a m state a date or time. If months ago Resident On 5/6/22 at 3:10 PM Resident #2 did not life explained that when s become aggressive, e smoking. The Social V some staff were bette #2, because you need way that was not dem A review of notes of a with the Nurse Practit physical altercation w Resident #1 on 3/26/2 by Resident #2. The r was prescribed an an that she had a history altercations and has h toward staff. In an interview with the Practitioner (NP) on 5 stated she was called altercation between the The NP stated she che	6/22 but had been assigned a assessed as cognitively d on 5/5/22 at 4:30 PM, and areatened by Resident #2 hetal chair. He could not He further stated that a few #2 had spit on him. , the Social Worker stated ke to be told no. She she was told no she would especially when it was about Worker also indicated that r at re-directing Resident ded to approach her in a handing or negative. psychiatry telehealth visit ioner on 4/1/22 revealed the ith Resident #2 and 22 was completely instigated hote indicated Resident #2 tipsychotic medication and r of previous physical had aggressive episodes	F 60		EFICIENCY)		
	reduction on 3/11/22. had always been outs	ng prior to a gradual dose The NP stated Resident #2 spoken and noted Resident life and the NP felt that was					

Facility ID: 923344

If continuation sheet Page 6 of 9

-					FORM	0: 06/09/2022 1 APPROVED 0. 0938-0391
T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	345126	B. WING		_) 06/2022
ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		2	28 SMITH CHAPEL ROAD			
LIVE CENTER		Ν	MOUNT OLIVE, NC 2830	65		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
part of the reason Res aggressive. On 5/4/22 at 4:45 PM Administrator stated F to be a supervised sm assessment indicated sharing smoking mate	sident #2 was so I in an interview, the Resident #2 was assessed noker. The smoking I Resident #2 was observed erials with other residents	F 600				
She was unable to ex #1 was unaware the f assign a staff membe between the times of	xplain why Nurse Supervisor facility protocol was to r to the smoking area 7:00 AM and 11:00 PM.					
action plan with a con	npletion date of 3/28/22.					
resident-to-resident al involved in a resident 3/26/22 with another r resulting in minor injur Resident #2 was asse Smoker; she has a ca to smoking area and I and asking other resid Facility had a plan in p activities supervised b date of this event, the Supervisor #1) failed smoking area, and Re smoking area where s resident-to-resident al resident (Resident #1 event and an immedia initiated. Resident #1 the scratches he sust	Itercations. She was -to-resident altercation on resident (Resident #1), ries to the other resident. essed to be a Supervised are planned history of going looking for cigarette butts dents for smoking materials. place to have all smoking by staff, however, on the e supervisor (Nurse to assign someone to the esident #2 went to the she got into a Itercation with a male). Staff responded to the ate investigation was received first-aid care for tained on his face and an					
	S FOR MEDICARE & I S FOR MEDICARE & I S DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER LIVE CENTER SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR I Continued From page part of the reason Re- aggressive. On 5/4/22 at 4:45 PM Administrator stated F to be a supervised sm assessment indicated sharing smoking mate and that was why she She was unable to ex #1 was unaware the f assign a staff membe between the times of The facility provided t action plan with a com 1. Resident #2 had a resident-to-resident a involved in a resident: 3/26/22 with another in resulting in minor inju Resident #2 was asses Smoker; she has a ca to smoking area and ia and asking other resident activities supervised b date of this event, the Supervisor #1) failed smoking area, and Re- smoking area where so resident-to-resident a resident (Resident #1 the scratches he sust x-ray to rule-out injury	CORRECTION IDENTIFICATION NUMBER: 345126 ROVIDER OR SUPPLIER LIVE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 part of the reason Resident #2 was so	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLER/CL/A IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING 345126 B. WING ROVIDER OR SUPPLIER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 6 part of the reason Resident #2 was so aggressive. F 6000 On 5/4/22 at 4:45 PM in an interview, the Administrator stated Resident #2 was observed sharing smoking materials with other residents and that was why she was a supervised smoker. She was unable to explain why Nurse Supervisor #1 was unaware the facility protocol was to assign a staff member to the smoking area between the times of 7:00 AM and 11:00 PM. The facility provided the following corrective action plan with a completion date of 3/28/22. 1. Resident #2 was assessed to be a Supervised minor injuries to the other resident. Resident #2 was assessed to be a Supervised Smoker; she has a care planned history of resident-to-resident altercation on 3/26/22 with another resident (Resident #1), resulting in minor injuries to the other resident. Resident #2 was assessed to be a Supervised Smoker; she has a care planned history of going to smoking area and looking for cigarette butts and asking other resident for smoking materials. Facility had a plan in place to have all smoking activities supervised by staff, however, on the date of this event, the supervisor (Nurse Supervisor #1) failed to assign someone to the smoking area, and Resident #2 went to the	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER: V2) MULTIPLE CONSTRUCTION A BUILDING SUMDER OR SUPPLIER 346126 B. WING LIVE CENTER STREET ADDRESS, CITY, ST 228 SMTH CHAPEL ROAD MOUNT OLIVE, NC 283 SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) D PREFIX (RACH CORREC (RACH CORREC (RACH CORREC REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX (RACH CORREC (CACC CORREC (CACC CORREC CONTINUED FOR page 6 part of the reason Resident #2 was so aggressive. F 600 On 5/4/22 at 4:45 PM in an interview, the Administrator stated Resident #2 was so sessment indicated Resident #2 was sobserved sharing smoking materials with other residents and that was why she was a supervised smoker. She was unable to explain why Nurse Supervisor #1 was unaware the facility protocol was to assign a staff member to the smoking area between the times of 7:00 AM and 11:00 PM. The facility provided the following corrective action plan with a completion date of 3/28/22. 1. Resident #2 was assessed to be a Supervised (Resident #1), resulting in minor injuries to the other resident. Resident #2 was assessed to be a Supervised Smoker, she has a care planneh history of ging to smoking area, and Resident #2 went to the smoking ar	MENT OF HEALTH AND HUMAN SERVICES SFOR MEDICARE & MEDICALO SERVICES SFOR MEDICARE & MEDICALO SERVICES SFOR MEDICARE & MEDICALO SERVICES UNIT PROVIDENCE & UN	MENT OF HEALTH AND HUMAN SERVICES OMB NO SFORM EDICARE & MEDICALD SERVICES OMB NO preservices (1) provincer support and the service of the

Facility ID: 923344

If continuation sheet Page 7 of 9

		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
345126		345126	B. WING _		C 05/06/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
MOUNT O				228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 600	Continued From page 7 notified and responded to the facility without additional action taken. Resident #2 was placed on 1:1 and has continued 1:1 supervision since 03/26/22. Resident #2 had a Gradual Dose Reduction on 3/11/22 for her Seroquel (antipsychotic medication). Psychiatric Service provider notified and increased her Seroquel back to original dosing on 03/26/22. Social Service Director is actively working on finding alternative placement		F6	500	
	care. The resident wi discharged without the responsible party.2. All residents have Interviews were cond residents to determin with resident's behav	the potential to be affected. lucted with staff and e if there are any concerns iors. Interviews were			
	Social Services Direc	ted on 03/28/22; no other			
	resident altercations all staff, including full needed) and Agency without education pro provided by the Clinic Weekend Supervisor Nurse Executive to e	se Prevention and resident to was initiated on 3/26/22 for time, part time, PRN (as staff. No staff shall work ovided; education was cal Management team. was educated by the Center nsure that staff are noking Area for monitoring.			
	appropriate supervisi will monitor Resident	or resident smoking areas for on from 7 am - 11 pm and #2 1:1 daily to ensure ty for all; 1:1 monitoring			

Facility ID: 923344

If continuation sheet Page 8 of 9

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/09/2022 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	i í		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345126	B. WING					C 06/2022
NAME OF PI	ROVIDER OR SUPPLIER		L		STREET ADDRESS, CITY, STATE, ZIP C	ODE	•	
MOUNT O	LIVE CENTER				228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF			(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	IX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD B		COMPLETION DATE
F 600	monitoring audits will Assurance and Perfor Committee monthly w responsible for ongoin Committee Members Director of Nursing, M Director of Nursing, Ir Services Director and Onsite validation was through staff interview review. Staff were interview review. Staff were interview review. Staff were interview resident-to-resident a reporting, notification, 1:1 supervision for Re audits of 1:1 supervisi implemented. Observ and review of audits of smoking area validate implemented as indic plan. Review of education weekend supervisor (assigning staff to obs education was compli- audited for possible re interviews verified no	nt #2. Results of these be brought to the Quality rmance Improvement vith the QAPI Committee ing compliance. QAPI Responsible: Administrator, Medical Director, Assistant infection Preventionist, Social I the Activity Director. completed on 5/6/22 vs, observation, and record erviewed to validate d on abuse intervention, and action. In-services to be provided on Itercation intervention, and action. Observation of esident #2 and a review of ion verified 1:1 was ration of the smoking area of staff supervision of the ed supervision was ated in the corrective action ation conducted with the (Nurse Supervisor #1) about erve smoking area verified eted. Review of residents esident abuse and resident additional issues were 's action plan was validated	F	600				

Facility ID: 923344

If continuation sheet Page 9 of 9