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	345083	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTH AND REHABILITATION	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

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F 000	INITIAL COMMENTS A complaint survey was conducted from 03/27/23 through 03/31/23. The following intakes were investigated NC00200019, NC00199687, NC00192957, NC00192847, NC00200073 and NC00200254. 3 of the 8 allegations resulted in a deficiency. Intake NC0020019, NC00200073 and NC00200254 resulted in Immediate Jeopardy. Immediate Jeopardy was identified at: CFR. 483.12 at tag F600 at a scope and severity (J) CFR. 483.12 at tag F607 at a scope and severity (K) The tags F600 and F607 constituted Substandard Quality of Care. Immediate Jeopardy began on 03/22/23 and was removed on 03/29/23. A partial extended survey was conducted.	F 000		
F 600 SS=J	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	F 600		4/1/23

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

Electronically Signed | 04/19/2023

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F 600	Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, family, staff, Nurse Practitioner (NP), Medical Director (MD), and Law Enforcement interviews the facility failed to protect residents' rights to be free from sexual abuse for 1 of 3 residents sampled for abuse (Resident #1). The allegation of abuse occurred on 3/22/23 at approximately 5:30 AM when an agency staff member was rough, causing pain to the resident and inserted his finger into the vagina of Resident #1 while performing incontinence care. Resident #1 felt fearful, dirty, humiliated, violated, and borderline raped. The immediate jeopardy began on 3/22/23 when an agency staff member inserted his finger into Resident #1's vagina and was rough during incontinence care causing the resident pain. The immediate jeopardy was removed on 3/29/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. The findings included: Resident #1 was re-admitted to the facility on 9/29/22 with diagnoses that included chronic pulmonary embolism, senile degeneration of the brain, adult failure to thrive, epilepsy, anxiety, depression, and a personal history of traumatic brain injury.	F 600	1. The facility failed to protect a resident□s right to be free from abuse when a resident (Resident #1) alleged on 3/22/23, a male Nurse Aide (NA #1) on night shift inserted his finger into her vagina during incontinence care. On 3/22/23, Resident #1 was interviewed by the Administrator and Unit Manager, and it was determined that abuse did not occur and then Resident #1 was re-interviewed on 3/27/23 when statement was changed to indicate abuse. On 3/27/23 at 11:00am, the licensed nurse reported to the Administrator that Resident #1 was observed in her room with her daughter and was tearful and appeared emotionally distressed. On 3/27/23 at 11:15am, the licensed nurse completed a body audit for Resident #1 and no visual signs of injury were observed. On 3/27/23, the Social Worker (SW) completed a Psychosocial Assessment, and a trauma care plan was implemented. On 3/27/23 at 6:15pm, the Nurse Practitioner (NP) assessed Resident #1 and gave new orders for Trazodone 50mg at bedtime for insomnia. On 3/28/23, Psychiatry Services were provided and will be providing ongoing as needed. On 3/27/23 at 11:30am, the Administrator notified Nurse Aide #1, who was not in facility at time of notification, and the contracted staffing agency that Nurse Aide #1 is immediately suspended and will not be allowed back in the facility. 2. Effective 3/28/23, the Social Worker	

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F 600	Continued From page 2 A quarterly Minimum Data Set (MDS) dated 1/19/23 indicated Resident #1 was moderately cognitively impaired and was able to be understood and understands. She required extensive assistance of two staff for bed mobility, toileting, and personal hygiene. The assessment further indicated Resident #1 had no behaviors such as resistive to care or physical or verbal aggression, hallucinations, or delusions. The assessment indicated Resident #1 was always incontinent of bladder and frequently incontinent of bowel. A review of a hospice note dated 3/10/23 revealed Resident #1 had been admitted to hospice services on 10/14/22 for a primary diagnosis of idiopathic epilepsy. The medical record did not reflect a note for a formal discharge from hospice services during the week of 3/19/23 through 3/35/23. A Brief Interview of Mental Status dated 3/22/23 indicated Resident #1 was cognitively intact. A facility internal allegation report document dated 3/22/23 provided by the facility indicated on 3/22/23 "Resident #1 reported to staff that the third shift male nurse aide stuck his finger in her vagina when he was cleaning her from a bowel movement." It indicated the Administrator and Unit Manager #1 interviewed Resident #1 and was told by Resident #1 that the male NA was cleaning her from a bowel movement and his finger went into her vagina. It further indicated, during the interview, Resident #1 told the Administrator and the Unit Manager she asked NA #1 to finish her care and not provide any further care to her and was told by NA #1 that he needed to clean her thoroughly and that it was	F 600	completed abuse questionnaires and abuse education with cognitively intact residents to include identification and reporting without fear of retaliation. No additional concerns reported. Effective 3/28/23, the licensed nurses completed body audits on cognitively impaired residents to identify any signs of abuse. No concerns observed. On 3/28/2023, the Quality Assurance Process Improvement (QAPI) Committee (Administrator, Director of Nursing (DON), Regional Director of Clinical Services (RDCS), Social Worker (SW), Vice President of Operations (VPO), Vice President of Clinical and Quality (VPCQ) and Medical Director (MD) held an Ad Hoc meeting to discuss root cause analysis of the facility□s failure to protect a resident right to be free from abuse. Root cause analysis reflects that the facility was unable to determine the cause for the alleged abuse. 3. Effective 3/28/23, all current facility staff and agency staff were in-serviced on the Abuse, Neglect and Exploitation Policy by the Regional Director of Clinical Services, Director of Nursing, Social Worker and Administrator. Training topics included 1) prohibiting, preventing and recognizing what constitutes abuse (Examples included; resident, staff or family report of abuse, physical marks such as bruises appearing as hand or belt marks, injury of unknown source, sudden unexplained changes in behavior such as withdrawal from care, fear of certain persons or expressions of guilt or shame),	

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not his intent to make her uncomfortable. The document indicated Resident #1 stated that she believed that it happened because he needed to clean the feces off her and that it was not intentional.

An observation and interview with Resident #1 on 3/27/23 at 9:15 AM revealed Resident #1 reported on 3/22/23; then she paused and tears began to roll down her cheeks, and stated discussing that morning bothered her because it made her feel fearful, dirty, humiliated, violated, and borderline raped when in NA #1 inserted a finger from his right hand into her vagina while performing incontinence care. While continuing to be tearful, Resident #1 stated at approximately 5:30 AM on the morning of 3/22/23 she had pressed her call light for pain medication. Resident #1 stated after the nurse had administered her pain medication and was leaving the room, NA #1 entered her room and asked if he could help her because the light was still on. Resident #1 stated she told NA #1 that she needed to be changed due to an incontinent episode. NA #1 stated he would provide incontinence care to her as he approached the right side of her bed. Resident #1 indicated NA#1 pulled back the covers to the foot of the bed, removed her soiled brief, then he told her to roll on her left side, but she needed a little physical assistance, so he placed his left hand on her right shoulder to hold her in place. Resident #1 verbalized as NA #1 began incontinence care, he ran his entire hand between her legs in a rough manner, which made her feel uncomfortable and she said "ouch". Resident #1 continued to indicate while NA #1 provided incontinence care he inserted a finger into her vagina and Resident #1 said she told NA #1, "no one else cleans me

2) recognizing and understanding behavioral symptoms of residents that may increase the risk of abuse such as aggressive wandering or elopement, resistance to care, outbursts, yelling, difficulty adjusting to new routines or staff and 3) that there is zero tolerance for resident abuse in the facility. Abuse questionnaires were also completed with current facility and agency staff to validate competency of education received and to identify any additional allegations of abuse. No additional concerns reported. The Administrator and Director of Nursing will be responsible for ensuring all staff are trained by tracking and reviewing the new hire and agency orientation packets for evidence of abuse training and signed acknowledgement of receipt during the daily reconciliation process. The daily reconciliation process is completed by the Administrator, Director of Nursing and Scheduler to validate actual staff hours worked and to ensure that newly hired facility and agency staff have received abuse education during the orientation and prior to first shift worked. Newly hired facility and agency staff and staff not receiving education by 3/28/23, will receive education prior to first worked shift by the Administrator and/or Director of Nursing. The contracted staffing agency currently sends background screens for all agency staff 24 hours a day, 7 days a week and the scheduler and DON were responsible for reviewing before staff were allowed to work. Effective 3/28/23 the Administrator and the DON will review these documents before allowing agency

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F 600	Continued From page 4 so roughly or puts their fingers there, neither should you," before telling him to put her brief on and not come back to her room. Resident #1 said NA #1 left the room after placing her brief on and she did not see him again that morning until right before 7:00 AM when he asked Resident #1 if she needed anything else before he left. Resident #1 stated she was frightened while lying in bed in her room alone and when a Nurse Aide (NA #2) entered her room to check on her around breakfast time, she recalled NA #2 asking her if she was ok and told her she was not acting like herself and encouraged her to share what was bothering her that morning. Resident #1 confirmed that she began telling NA #2 what had happened and then NA #2 told her to wait because she needed another staff member (NA#3) to hear what Resident #1 had to say. NA #3 entered the room and Resident #1 told both NA #2 and NA #3 that an African American male Nurse Aide (NA #1) on night shift had inserted his finger into her vagina while providing incontinence care shortly before night shift ended. An interview on 3/27/23 at 11:40 AM with NA #1 revealed he had been employed through an agency at the facility to work night shift as a NA. During the initial interview, NA #1 indicated he did not recall Resident #1 at all and stated he typically did not work on the unit which Resident #1 resided. He also indicated he had worked in the facility from 7:00 PM to 7:00 AM on Thursday, 3/23/23, but was not assigned to Resident #1. On 3/27/23 at 12:39 PM, a follow up interview was conducted with NA #1 which revealed NA #1 stated he had called the facility to reach the survey team and was directed to the Administrator who then informed him of the	F 600	staff to work their first shift at the facility. Effective 3/28/23, the Administrator and/or DON will complete abuse questionnaires with facility and agency staff to ensure understanding of the Abuse, Neglect and Exploitation Policy and to identify and prevent resident abuse and to validate understanding that the facility has a zero tolerance for resident abuse. Effective 3/28/23, agency orientation will be conducted by the Administrator or Director of Nursing and will include an abuse questionnaire along with abuse education to ensure staff competency. 4. To ensure the deficient practice does not recur the Director of Nursing or Administrator will complete abuse questionnaires with 5 staff weekly for 12 weeks. The Director of Nursing or Unit Managers will complete body audits on 3 cognitively impaired residents 2 times a week for 4 weeks and weekly for 8 weeks. The Administrator or Social Worker will complete abuse questionnaires on 3 cognitively intact residents 2 times a week for 4 weeks and then weekly for 8 weeks. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary.	

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allegation being investigated by the state agency. NA #1 then stated the Administrator had notified him that Resident #1 had made an allegation of sexual abuse against him for inserting his finger into her vagina during incontinence care on the morning of 3/22/23 and he would be suspended pending the facility's investigation. NA #1 indicated he did not recall this or Resident #1 telling him not to provide care to her on that morning; however, if he was assigned to this resident, he would have provided incontinence care to her at 1:00 AM, 3:00 AM, and 5:00 AM that morning and he would never intentionally had done that during care.

An interview on 3/27/23 at 12:12 PM with NA #2 revealed she was assigned to Resident #1's care from 7:00 AM to 3:00 PM on 3/22/23. NA #2 stated shortly after she began her shift (close to breakfast time) she entered Resident #1's room and noticed Resident #1 was very upset and NA #2 asked Resident#1 what was wrong. NA #2 explained as Resident #1 began to cry and started to tell her that a 3rd shift male NA had hurt her. NA #2 immediately yelled in to the hallway for NA #3 to come in the room because she was an agency NA and felt an employee of the facility needed to also hear any allegations made by Resident #1. NA #2 stated when NA #3 entered the room, Resident #1 remained crying and told both her and NA #3 that a 3rd shift male NA placed his finger into her vagina during incontinence care and that it hurt badly. NA #2 stated she stayed with Resident #1 while NA #3 went to tell the Unit Manager. NA #2 attempted to deliver Resident #1's breakfast tray while they waited, but NA #2 indicated Resident #1 was too upset to eat that morning. NA #2 continued explaining she told both the Unit Manager and the

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Administrator what Resident #1 had alleged and then went to finish delivering breakfast trays to the remainder of the unit. NA #2 stated she cared for Resident #1 along with NA #3 for the remainder of the shift and noticed that Resident #1 did not eat lunch that day as well and continued to cry intermittently throughout the day. NA #2 stated Resident #1 was hesitant and somewhat guarded each time she and NA #3 attempted to provide incontinence care to Resident #1 on 3/22/23.

An interview on 3/27/23 at 12:02 AM with NA #3 revealed she was not normally assigned to Resident #1 but frequently passed breakfast trays on that unit. NA #3 stated on the morning of 3/22/23 she was passing breakfast trays and overheard NA #2 yell for her to come into the room. NA #3 stated when she entered the room of Resident #1, with NA #2, Resident #1 was very tearful and began telling her and NA #2 that a male NA on 3rd shift had inserted his finger into her vagina during incontinence care and that it made her feel uncomfortable. NA #3 stated she immediately left the room and went to the Unit Manager to notify her of what Resident #1 had alleged. NA #3 stated the Unit Manager was entering the facility and she went to her office to explain how upset Resident #1 appeared and how she was tearful when talking about the allegation. NA #3 explained after speaking to the Unit Manager, she returned to the unit and began passing breakfast trays to the remainder of the hall. NA #3 stated she recalled Resident #1 being a bit guarded when she and NA #2 attempted to provide incontinence care to her the remainder of the day on 3/22/2. NA #3 also noticed when she attempted to provide a bath to Resident #1 today (on 3/27/23), Resident #1 was again tearful and

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slightly hesitant to allow her to provide bathing assistance.

An interview on 3/27/23 at 1:32 PM with the Unit Manager revealed she arrived to the facility on 3/22/22 at approximately 8:00 AM she was approached by NA #3 who indicated she needed to notify her immediately of a concern for Resident #1 who had made her aware of accusations of sexual abuse by NA #1 during 3rd shift. The Unit Manager stated she took NA #3 into an office close by where NA #3 told her Resident #1 had made allegations that NA #1 head inserted his finger into her vagina during incontinence care at approximately 5:30 AM on the morning of 3/22/22 and was upset about it. The Unit Manager stated she initially attempted to telephone the Administrator but was unsuccessful due to low signal in the facility and therefore initiated a text service to contact the Administrator. The Unit Manager indicated the Administrator immediately returned a text notifying her he was entering the facility and would be to speak to her momentarily. The Unit Manager stated upon arrival the Administrator came to her office and NA #3 notified him of the allegations made by Resident #1 against NA #1. The Unit Manager indicated while the Administrator spoke with NA #2 and NA #3, she proceeded to Resident #1's room where she found her tearful and upset. The Unit Manager stated she assessed Resident #1's skin (arms, legs, and perineal area) and found there to be no redness, irritation, or obvious discomfort to touch noted by Resident #1 during the exam. The Unit Manager indicated she provided her assessment findings directly to the Administrator following the exam. The Unit Manager and the Administrator went to interview Resident #1 in her room and

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found her less tearful when she told them that NA #1 had inserted his finger into her vagina during incontinence care on the morning of 3/22/22 and thought it was because he had to get her clean and not necessarily intentional. The Unit Manager also verified Resident #1 had been discharged from hospice services during the week of 3/19-3/25; however, she was not able to verify the exact date.

An observation and interview with Resident #1's Family Member on 3/27/23 at 9:55 AM revealed Family Member stated she received a phone call from the Administrator on 3/22/23 while she was at work who said he needed to make her aware of a sensitive topic. Family Member stated the Administrator called her in the afternoon to tell her Resident #1 had made an allegation that a nurse aide (NA #1) had inserted his finger into her vagina while performing incontinence care and that he felt it was not intentional and Resident #1 had reported NA #1 told her during care it was not done intentionally and that she did not want male NAs to provide peri-care for her after this incident. Family Member stated the Administrator said he would have NA #1 not provide further care to Resident #1 and place an intervention on Resident #1's care plan of her preference to have female NAs to provide peri-care. She stated she arrived at the facility around 6 PM on the evening of 3/22/23 and noticed Resident #1 was tearful and not of her normal demeanor. Family Member asked Resident #1 about the occurrence that happened on night shift regarding NA #1 and stated Resident #1 became increasingly tearful explaining she was frightened by NA #1 and felt like he had likely done it on purpose, and she did not want him care for her again. She stated Resident #1 described how rough NA #1 cleaned

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her and about NA #1 inserting his finger into her vagina which caused discomfort. The Family Member reported her friend contacted law enforcement and reported what happened to Resident #1 for her on 03/23/23. Family Member stated following the conversation the friend requested the family member provide a name of the accused (NA#1) so the report could be filed with local law enforcement. Family Member explained the following morning she called the facility and spoke to someone in Administration requesting the name of the alleged perpetrator, but the facility was unwilling to provide a name at the time. The Family Member stated she returned to the facility around 6:30 PM on 3/23/23 to visit Resident #1. The Family Member went on to explain at approximately 7:30 PM, she was sitting at the bedside of Resident #1 and noticed a gentleman in the hallway entering the closet which was located diagonally across the hallway from Resident #1's door. She stated NA #1 glanced into Resident #1's room. The Family Member immediately asked Resident #1 if this gentleman in the hallway was the staff member she had described who had touched her inappropriately during care. The Family Member stated at the time Resident #1 was positioned in a manner that she was unable to visualize NA #1; however, when he exited the door across the hall and began speaking to a staff member outside of Resident #1's room, Resident #1 immediately spoke up and identified this gentleman to be NA #1. Family Member stated at the time she was concerned but fearful to confront the gentleman and therefore after visiting for approximately three to four hours that evening, she again contacted the friend who informed her the local law enforcement had been contacted and would handle the concern without her having to cause

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confrontation with the facility employees.

A review of the police report dated 3/23/23 at 2:00 PM revealed the Sheriff's Department filed a intake report for an incident labeled as "14-27.5 11AM, Attempt 2nd Degree Sex Offense" which included details [Resident #1] was touched in her genital area with a hand and fingers inserted into her vagina. Page 2 of the report included the following narrative: "[Resident #1] a 72 year old female is a patient of the [facility]. [Resident #1] reported to the facility staff that her nighttime (3rd shift) CNA/Care provider (name unknown at time of this report). [Resident #1] asked for changing due to a toileting need. A male CNA came in and rolled her over, took his hand, ran it up her private area in an uncomfortable way and then inserted his finder in her vagina. [Resident #1] told her [family member] that she yelled out to him that he was hurting her. [Resident #1] told the family member that no other staff had ever cleaned her that way. The facility Administrator notified the [family member]. [Resident #1] has been in the facility since September 2022 and wears briefs for her toileting. She is mentally competent but needs physical assistance."

An interview with local law enforcement detectives on 3/27/23 at 3:30 PM revealed Detective #1 and Detective #2 had been assigned to this case and indicated they had interviewed Resident #1 just prior to this interview on 3/27/23 and found her to be very tearful as she explained on 3/22/23 a male NA (NA #1) on night shift had provided her incontinence care in a manner that made her feel uncomfortable and inserted his finger into her vagina. Detective #1 indicated he and Detective #2 would be conducting a full investigation including background check and

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criminal record checks on NA #1 and the local law enforcement's investigation would be ongoing.

An interview on 3/27/23 at 10:20 AM with the Administrator revealed he was made aware of the allegation of potential sexual abuse related to Resident #1 on the morning of 3/22/23 when he received a text from the Unit Manager. The Administrator indicated he proceeded to the Unit Manager's office upon arriving at the facility at approximately 8:00 AM. When he arrived at the unit manager's office, he was notified that Resident #1 had alleged that NA #1 had inserted his finger into her vagina while providing incontinence care and that she was upset about the situation. The Administrator indicated he spoke to the NA's whom Resident #1 had talked about the incident with that morning. The Administrator also stated after he was notified of the incident, he and the Unit Manager went to Resident #1's room to interview her regarding the allegation. The Administrator stated Resident #1 informed him the incident occurred while NA #1 was providing incontinence care. The Administrator stated on 3/22/23, he contacted Resident #1's Responsible party by telephone to notify her of her mother's allegation. The Administrator explained he thought both Resident #1 and her Responsible party where in agreement with the resolution to add an intervention to Resident #1's care plan to include the preference to have female nurse aides provide incontinence care and therefore no other actions were taken by the facility.

An interview with the Nurse Practitioner on 3/28/23 at 8:30 AM revealed she was not aware of the allegation made by Resident #1 on 3/22/23. The NP stated she had a telehealth visit with her

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on 3/27/23 and felt Resident #1 to be cognitively intact and able to make her needs known with no known history of delusions or hallucinations. The NP indicated Resident #1 had been discharged from hospice services the week prior due to improvement.

The Administrator was notified of immediate jeopardy via telephone on 3/28/23 at 12:30 PM.

The facility provided the following Credible Allegation of Immediate Jeopardy removal:

F600: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to protect a resident's right to be free from abuse when a resident (Resident #1) alleged on 3/22/23, a male Nurse Aide (NA #1) on night shift inserted his finger into her vagina during incontinence care.

On 3/22/23, Resident #1 was interviewed by the Administrator and Unit Manager and it was determined that abuse did not occur and then Resident #1 was re-interviewed on 3/27/23 when statement was changed to indicate abuse.

On 3/27/23 at 11:00am, the licensed nurse reported to the Administrator that Resident #1 was observed in her room with her daughter and was tearful and appeared emotionally distressed.

On 3/27/23 at 11:15am, the licensed nurse completed a body audit for Resident #1 and no visual signs of injury were observed. On 3/27/23, the Social Worker (SW) completed a Psychosocial Assessment, and a trauma care

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plan was implemented. On 3/27/23 at 6:15pm, the Nurse Practitioner (NP) assessed Resident #1 and gave new orders for Trazodone 50mg at bedtime for insomnia. On 3/28/23, Psychiatry Services were provided and will be providing ongoing as needed.

On 3/27/23 at 11:30am, the Administrator notified Nurse Aide #1, who was not in facility at time of notification, and the contracted staffing agency that Nurse Aide #1 is immediately suspended and will not be allowed back in the facility.

Effective 3/28/23, the Social Worker completed abuse questionnaires and abuse education with cognitively intact residents to include identification and reporting without fear of retaliation. No additional concerns reported.

Effective 3/28/23, the licensed nurses completed body audits on cognitively impaired residents to identify any signs of abuse. No concerns observed.

On 3/28/2023, the Quality Assurance Process Improvement (QAPI) Committee (Administrator, Director of Nursing (DON), Regional Director of Clinical Services (RDCS), Social Worker (SW), Vice President of Operations (VPO), Vice President of Clinical and Quality (VPCQ) and Medical Director (MD) held an Ad Hoc meeting to discuss root cause analysis of the facility's failure to protect a resident right to be free from abuse. Root cause analysis reflects that the facility was unable to determine the cause for the alleged abuse.

The following plan was formulated by the facility to address the identified issues:

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Effective 3/28/23, all current facility staff and agency staff were in-serviced on the Abuse, Neglect and Exploitation Policy by the Regional Director of Clinical Services, Director of Nursing, Social Worker and Administrator. Training topics included 1) prohibiting, preventing and recognizing what constitutes abuse (Examples included; resident, staff or family report of abuse, physical marks such as bruises appearing as hand or belt marks, injury of unknown source, sudden unexplained changes in behavior such as withdrawal from care, fear of certain persons or expressions of guilt or shame), 2) recognizing and understanding behavioral symptoms of residents that may increase the risk of abuse such as aggressive wandering or elopement, resistance to care, outbursts, yelling, difficulty adjusting to new routines or staff and 3) that there is zero tolerance for resident abuse in the facility. Abuse questionnaires were also completed with current facility and agency staff to validate competency of education received and to identify any additional allegations of abuse. No additional concerns reported.

The Administrator and Director of Nursing will be responsible for ensuring all staff are trained by tracking and reviewing the new hire and agency orientation packets for evidence of abuse training and signed acknowledgement of receipt during the daily reconciliation process. The daily reconciliation process is completed by the Administrator, Director of Nursing and Scheduler to validate actual staff hours worked and to ensure that newly hired facility and agency staff have received abuse education during the orientation and prior to first shift worked. Newly hired facility and agency staff and staff not

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receiving education by 3/28/23, will receive education prior to first worked shift by the Administrator and/or Director of Nursing.

The contracted staffing agency currently sends background screens for all agency staff 24 hours a day, 7 days a week and the scheduler and DON were responsible for reviewing before staff were allowed to work. Effective 3/28/23 the Administrator and the DON will review these documents before allowing agency staff to work their first shift at the facility.

Effective 3/28/23, the Administrator and/or DON will complete abuse questionnaires with facility and agency staff to ensure understanding of the Abuse, Neglect and Exploitation Policy and to identify and prevent resident abuse and to validate understanding that the facility has a zero tolerance for resident abuse.

Effective 3/28/23, agency orientation will be conducted by the Administrator or Director of Nursing and will include an abuse questionnaire along with abuse education to ensure staff competency.

Effective 3/28/23, the Administrator is ultimately responsible for the implementation and completion of this removal plan.

Alleged Date of IJ Removal: 3/29/23

On 3/31/23, the facility's corrective action plan for immediate jeopardy removal effective 3/29/23 was validated by the following: Staff interviews revealed they had received education on the Abuse, Neglect and Exploitation Policy. All staff were educated on prohibiting, preventing and

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F 600	Continued From page 16 recognizing what constitutes abuse, recognizing and understanding behavioral symptoms of abuse and that there is zero tolerance of abuse in the facility. Abuse questionnaires were reviewed and competency validation of education.	F 600		
F 607 SS=K	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §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	F 607		4/1/23

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F 607	Continued From page 17 by: Based on record review and interviews with the resident and staff, the facility failed to protect residents when contracted Nurse Aide (NA) #1 was allowed to work an entire 12 hour shift providing resident care after Resident #1 reported the NA stuck his finger in her vagina when he was cleaning her from a bowel movement and they failed to implement their abuse policy for reporting when the allegation of sexual abuse was not reported to local law enforcement, and Adult Protective Services (APS) within 2 hours. In addition, the facility failed to notify the state agency of an allegation of sexual abuse within 2 hours. This was for 1 of 3 residents (Resident #1) reviewed for abuse and the deficient practice had the potential to affect other facility residents. The immediate jeopardy began on 03/22/23 when the facility allowed NA #1 to work a resident care assignment after Resident #1 reported that NA #1 inserted his finger into her vagina during incontinence care. The immediate jeopardy was removed on 03/29/23 when the facility implemented a credible allegation of jeopardy removal. The facility will remain out compliance at a lower scope and severity "E" (no actual harm with potential for harm) to ensure education is completed and monitoring systems put into place are effective. Example #2 for Resident #1 was cited at a lower scope and severity of D. Findings included: A review of the facility's policy titled, "Abuse, Neglect, and Exploitation" dated revised 03/02/2023 indicated all alleged violations	F 607	1. The facility failed to protect all residents after a resident (Resident #1) alleged a male Nurse Aide (NA #1) on night shift inserted his finger into her vagina during incontinence care and the NA #1 continued to work in the facility after the allegation was made. The facility further failed to assess all residents for abuse and failed to report the allegation to the facility□s Medical Director (MD) and/or Nurse Practitioner (NP). Resident #1 admitted to the facility for long-term care on 8/27/22 with diagnosis of senile degeneration of the brain, traumatic brain injury, depression, anxiety, epilepsy, gastritis, and adult failure to thrive and recently discharged from hospice services on 3/24/23. On 3/22/23, after initial interviews, assessments and investigation, the facility determined that resident abuse did not occur, and care plan updated to reflect resident preference for female caregiver during incontinence care. On 3/27/23 at 11:00am, the licensed nurse reported to the Administrator that Resident #1 was observed in her room with her daughter and was tearful and appeared emotionally distressed. Administrator and Nurse Manager immediately interviewed Resident #1 and documented her verbal statement of 3/22/23 incident with an allegation of abuse and emotional distress. Nurse aide #1 was immediately suspended pending investigation. On 3/27/23 at 11:15am, the licensed nurse completed a body audit for Resident #1 and no visual signs of injury were	

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F 607	Continued From page 18 involving abuse are reported immediately to the Administrator, state agency, and to all other required agencies (e.g., Adult Protective Services (APS) and local law enforcement when applicable) within the specified timeframes: a) immediately, but no later than 2 hours after the allegation is made, if the event that cause the allegation involved abuse or result in serious bodily injury or b) not later than 24 hours if the event cause the allegation do not involve abuse or do not result in serious bodily injury. Resident #1 was re-admitted to the facility on 9/29/22. A quarterly Minimum Data Set (MDS) dated 1/19/23 indicated Resident #1 was moderately cognitively impaired. An internal facility document titled "allegation report" dated 3/22/23 written by the Administrator indicated on 3/22/23 "[Resident #1] reported to staff that the third shift male nurse aide [NA #1] stuck his finger in her vagina when he was cleaning her from a bowel movement." It indicated the Administrator and Unit Manager #1 interviewed Resident #1 and were told by Resident #1 that the male NA was cleaning her from a bowel movement and his finger went into her vagina. It further indicated, during the interview, Resident #1 told the Administrator and the Unit Manager she asked NA #1 to finish her care and not provide any further care to her. A review of the facility's Facility Reported Incident (FRI) log indicated the incident between Resident #1 and Nurse Aide #1 on 3/22/23 was not reported to the local law enforcement or APS during the required timeframes for submission of	F 607	observed. On 3/27/23, the Social Worker (SW) completed a Psychosocial Assessment, and a trauma care plan was implemented. On 3/27/23 at 6:15pm, the Nurse Practitioner (NP) assessed Resident #1 and gave new orders for Trazodone 50mg at bedtime for insomnia. On 3/28/23, Psychiatry Services were provided and will be providing ongoing as needed. 2. On 3/28/23, the Administrator and Regional Director of Clinical Services reviewed resident grievances between 1/1/23-3/28/23 to identify any potential allegations of abuse for appropriate investigation and reporting. No additional concerns identified. Effective 3/28/23, the Social Worker completed abuse questionnaires and abuse education with cognitively intact residents to include identification and reporting without fear of retaliation. No additional concerns reported. Effective 3/28/23, the licensed nurses completed body audits on cognitively impaired residents to identify any signs of abuse. No concerns observed. On 3/28/2023, the Quality Assurance Process Improvement (QAPI) Committee (Administrator, Director of Nursing (DON), Regional Director of Clinical Services (RDCS), Social Worker (SW), Vice President of Operations (VPO), Vice President of Clinical and Quality (VPCQ) and Medical Director (MD) held an Ad Hoc meeting to discuss root cause analysis of the facility□s failure to1) protect all residents after an allegation of sexual abuse was made and;	

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F 607	Continued From page 19 the initial report. The allegation was not reported by the facility to APS or local law enforcement until 3/27/23. The facility was unable to provide evidence of interventions taken to identify and protect other facility residents who could have been affected by abuse following the allegation of staff to resident abuse involving NA #1 and Resident #1 on 3/22/23. An interview with Resident #1 on 3/27/23 at 9:15 AM revealed on 3/22/23 Nurse Aide (NA #2) entered her room to check on her around breakfast time. She recalled NA #2 asking her if she was ok and told her she was not acting like herself and encouraged her to share what was bothering her that morning. Resident #1 confirmed that she began telling NA #2 what had happened and then NA #2 told her to wait because she needed another staff member (NA #3) to hear what Resident #1 had to say. NA #3 entered the room and Resident #1 described the physical appearance of a male NA (NA #1) who worked the night shift and told both NA #2 and NA #3 that he had inserted his finger into her vagina while providing incontinence care shortly before night shift ended that morning. An interview on 3/27/23 at 1:32 PM with the Unit Manager revealed she arrived to the facility on 3/22/22 at approximately 8:00 AM when she was approached by NA #3 who indicated she needed to notify her immediately of a concern for Resident #1 who had made to her aware of accusations of sexual abuse by NA #1 during 3rd shift. The Unit Manager stated she took NA #3 into an office close by where NA #3 told her Resident #1 had made allegations that NA #1	F 607	2) assess all other residents and; 3) report the allegation to the facility□s MD and/or NP. Root cause analysis determined that appropriate resident protection, assessment and reporting was not completed due to the facility□s failure to properly identify what constitutes an allegation of abuse during the interview process and initiate appropriate steps following an abuse allegation. 3. Effective 3/28/23, the Regional Director of Clinical Services (RDCS) completed education with the Administrator, DON, Social Worker and Nurse Managers on completing a comprehensive investigation and quality interview to fully analyze and properly identify and respond to potential abuse. Education included protection of residents from physical and psychosocial harm during and after the investigation, immediate response by removing the alleged staff from resident care to ensure resident safety, assessing all other residents for abuse, reporting to Administrator, Medical Director and/or Nurse Practitioner, state agencies, examining the alleged victim for any signs of injury, increasing supervision, protection from retaliation and providing emotional support and counseling to the resident during and after the investigation as needed. Newly hired Administrators, Director of Nursing, Social Workers, and Nurse Managers will receive education during orientation and prior to first worked shift. The RDCS or Vice President of Operations (VPO) will be responsible for	

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F 607	Continued From page 20 inserted his finger into her vagina during incontinence care at approximately 5:30 AM on the morning of 3/22/22 and was upset about it. The Unit Manager stated she initially attempted to telephone the Administrator but was unsuccessful due to low cellular signal in the facility and therefore initiated a text message to contact the Administrator via an internal text system utilized for staff communication. The Unit Manager indicated the Administrator immediately returned a text notifying her he was entering the facility and would be to speak to her momentarily. The Unit Manager stated upon arrival the Administrator came to her office and NA #3 notified him of the allegations made by Resident #1 against NA #1. The Unit Manager indicated while the Administrator spoke with NA #2 and NA #3, she proceeded to Resident #1's room where she found her tearful and upset. The Unit Manager stated she assessed Resident #1's skin (arms, legs, and perineal area) and found there to be no redness, irritation, or obvious discomfort to touch noted by Resident #1 during the exam. The Unit Manager indicated she provided her assessment findings directly to the Administrator following the exam. The Unit Manager and the Administrator went to interview Resident #1 in her room and found her less tearful when she told them that NA #1 had inserted his finger into her vagina during incontinence care on the morning of 3/22/23 and thought it was because he had to get her clean and not necessarily intentional. A review of the timecard for NA #1 revealed he worked from 7:03 PM on 3/23/23 through 7:00 AM on 3/24/23. A review of the daily nurse staffing schedule dated 3/23/23 revealed NA #1 was assigned a	F 607	providing and tracking completion of leadership training. Effective 3/28/23, all current facility staff and agency staff were in-serviced on the Abuse, Neglect and Exploitation Policy by the Regional Director of Clinical Services, Director of Nursing, Social Worker and Administrator. Training topics included 1) prohibiting, preventing and recognizing what constitutes abuse (Examples included; resident, staff or family report of abuse, physical marks such as bruises appearing as hand or belt marks, injury of unknown source, sudden unexplained changes in behavior such as withdrawal from care, fear of certain persons or expressions of guilt or shame), 2) recognizing and understanding behavioral symptoms of residents that may increase the risk of abuse such as aggressive wandering or elopement, resistance to care, outbursts, yelling, difficulty adjusting to new routines or staff, 3) immediately ensuring resident safety by removing accused individual from residents□ care and 4) reporting allegations of abuse to the Administrator and/or the Director of Nursing in-person or verbally immediately following resident protection and 5) a zero tolerance for resident abuse in the facility. Abuse questionnaires were also completed to validate staff competency of education received and to identify any additional allegations of abuse. No additional concerns reported. The Administrator and Director of Nursing will be responsible for ensuring all staff are trained by tracking and reviewing new hire and agency orientation packets for evidence of abuse	

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F 607	Continued From page 21 resident care assignment which covered rooms 302, 304, 305, and the entire 500 hall from 7:00 PM until 11:00 PM. It further revealed NA #1 was assigned to a resident care assignment which covered all rooms on the 400 and 500 hall unit from 11:00 PM on 3/23/23 until 7:00 AM on 3/24/23. An interview on 3/27/23 at 11:40 AM with NA #1 revealed he had been employed through an agency at the facility to work night shift (7:00 PM to 7:00 AM) as an NA. During the initial interview, NA #1 indicated he did not recall Resident #1 at all and stated he typically did not work on the unit which Resident #1 resided. During the interview, NA #1 indicated he had not been contacted by the facility regarding the allegation made by Resident #1. He also indicated he had worked a resident care assignment in the facility from 7:00 PM to 7:00 AM on 3/23/23 into the morning of 3/24/23 but was not assigned to Resident #1. He stated he had not worked in the facility since the morning of 3/24/23; however, was scheduled to work later in the week. A follow-up interview with the Unit Manager on 3/28/23 at 10:58 AM revealed she was asked later in the day by the Administrator on 3/22/23 to interview two female residents on the assignment completed by NA #1 on 3/22/23 which resulted in no further concerns from care noted and had she no further involvement in the investigation. The Unit Manager stated she was not asked to interview all alert and oriented residents in the facility regarding potential abuse or whether they felt safe in the facility. The Unit Manager stated there were no physical body exams performed on any other resident in the facility on 3/22/23 when the allegation was made with the exception of	F 607	training and signed acknowledgement of receipt during the daily reconciliation process. The daily reconciliation process is completed by the Administrator, Director of Nursing and Scheduler to validate actual staff hours worked and to ensure that newly hired facility and agency staff have received abuse education during the orientation and prior to first shift worked. Newly hired facility and agency staff and staff not receiving education by 3/28/23, will receive education prior to next worked shift by the Administrator and/or Director of Nursing. Effective 3/28/23, the Administrator and/or Director of Nursing completed abuse questionnaires with current facility and agency staff to ensure understanding of the Abuse, Neglect and Exploitation Policy and to identify and prevent resident abuse and to validate understanding that the facility has a zero tolerance for resident abuse. Effective 3/28/23, the Vice President of Operations, Vice President of Clinical and Quality and/or Regional Director of Clinical Services will provide regional oversight to the facility in-person or via telephone for any allegation of resident abuse to ensure all residents are protected after an allegation of abuse is made to include immediate removal of alleged perpetrator, assessment of all residents and notification to the Medical Director or Nurse Practitioner. 4. To ensure the deficient practice does not recur the Director of Nursing or Administrator will complete abuse questionnaires with 5 staff weekly for 12	

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F 607	Continued From page 22 Resident #1 and body checks were not conducted on any other resident until another allegation of abuse was made on the following day which was not related to NA #1. She also indicated she was asked by Administration not to make any documentation into the medical record of the physical assessment or allegations because the Administrator needed to speak to the family of Resident #1 about the occurrence. The Unit Manager stated she had never been asked to make any documentation after the family was notified of the allegation. An interview on 3/27/23 at 10:20 AM with the Administrator revealed he was made aware of the allegation of potential sexual abuse related to Resident #1 on the morning of 3/22/23 when he received a text from the Unit Manager. The Administrator indicated he proceeded to the Unit Manager's office upon arriving to the facility at approximately 8:00 AM. When he arrived at the Unit Manager's office, he was notified that Resident #1 had alleged that NA #1 had inserted his finger into her vagina while providing incontinence care and that she was upset about the situation. The Administrator indicated he spoke to the NAs (NA #2 and NA #3) whom Resident #1 had talked with about the incident that morning. The Administrator also stated after he was notified of the incident, he and the Unit Manager went down to Resident #1's room to interview her regarding the allegation. The Administrator stated Resident #1 informed him the incident occurred while NA #1 was providing incontinence care. The Administrator explained during his interview, Resident #1 indicated she believed the situation happened due to NA #1 having to clean her. The Administrator stated because Resident #1 had not believed the	F 607	weeks. The Director of Nursing or Unit Managers will complete body audits on 3 cognitively impaired residents 2 times a week for 4 weeks and weekly for 8 weeks. The Administrator or Social Worker will complete abuse questionnaires on 3 cognitively intact residents 2 times a week for 4 weeks and then weekly for 8 weeks. The Regional Director of Clinical Services or Vice President of Operations will review grievances weekly for 12 weeks to identify any possible allegations of abuse and ensure proper reporting is completed if indicated. The Regional Director of Clinical Services or Vice President of Operations will assess the Administrator, Director of Nursing, Social Worker, and Nurse Managers competency of Reporting and Identifying Abuse using abuse questionnaires weekly for 4 weeks and monthly for two months. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. 4/1/23	

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incident was intentional, the facility filed the concern as a grievance instead of investigating the allegation for potential sexual abuse. The Administrator stated on 3/22/23, he contacted Resident #1's Responsible Party by telephone to notify her of the allegation. The Administrator explained he thought both Resident #1 and her Responsible Party were in agreement with the resolution to add an intervention to Resident #1's care plan to include the preference to have female nurse aides provide incontinence care and therefore no other actions were taken by the facility to protect Resident #1 or other residents at risk for sexual abuse. The Administrator acknowledged had the allegation been handled as a potential sexual abuse, he would have been responsible for notifying the local law enforcement and APS, but neither were notified due to the allegation not determined to be intentional by the facility. He further stated NA #1 was not prevented from working a resident care assignment following the allegation made by Resident #1.

An interview with Resident #1's Family Member on 3/27/23 at 9:55 AM revealed she left the facility that evening of 3/22/23 around 8:00 PM and she contacted a friend about what Resident #1 had told her. Resident #1's Family Member reported the friend she contacted told her the incident needed to be reported to local law enforcement and that she would handle this on Resident #1's behalf. The Family Member reported her friend contacted law enforcement and reported what happened to Resident #1 for her on 3/23/23.

A review of the police report dated 3/23/23 at 2:00 PM revealed Rutherfordton County Sherriff

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Department filed a intake report for an incident labeled as "14-27.5 11A, Attempt 2nd Degree Sex Offense" which included details [Resident #1] was touched in her genital area with a hand and fingers inserted into her vagina. Page 2 of the report included the following narrative: "[Resident #1] a 72 year old female is a patient of the [facility]. [Resident #1] reported to the facility staff that her nighttime (3rd shift) CNA/Care provider (name unknown at time of this report). [Resident #1] asked for changing due to a toileting need. A male CNA came in and rolled her over, took his hand, ran it up her private area in an uncomfortable way and then inserted his finder in her vagina. [Resident #1] told her [family member] that she yelled out to him that he was hurting her. [Resident #1] told the family member that no other staff had ever cleaned her that way. The facility Administrator notified the [family member]. [Resident #1] has been in the facility since September 2022 and wears briefs for her toileting. She is mentally competent but needs physical assistance."

An interview with local law enforcement detectives on 3/27/23 at 3:30 PM revealed Detective #1 and Detective #2 had been assigned to this case and indicated they had interviewed Resident #1 just prior to this interview on 3/27/23 and found her to be very tearful as she explained on 3/22/23 a male NA (NA #1) on night shift had provided her incontinence care in a manner that made her feel uncomfortable and inserted his finger into her vagina. Detective #1 indicated he and Detective #2 would be conducting a full investigation including background check and criminal record checks on NA #1 and the local law enforcement's investigation would be ongoing.

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On 3/27/23 at 12:39 PM, a follow up interview was conducted with NA #1 which revealed NA #1 stated he had called the facility to reach the survey team on 3/27/23 and was directed to the Administrator who then informed him of the allegation being investigated by the state agency. NA #1 then stated the Administrator had notified him that Resident #1 had made an allegation of sexual abuse against him for inserting his finger into her vagina during incontinence care on the morning of 3/22/23 and he would be suspended pending the facility's investigation. NA #1 indicated he did not recall this or Resident #1 telling him not to provide care to her on that morning; however, if he was assigned to this resident, he would have provided incontinence care to her at 1:00 AM, 3:00 AM, and 5:00 AM that morning and he would never intentionally had done that during care.

The Administrator was notified of immediate jeopardy via telephone on 3/28/23 at 12:30 PM.

The facility provided the following immediate jeopardy removal plan.

F607: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to protect all residents after a resident (Resident #1) alleged a male Nurse Aide (NA #1) on night shift inserted his finger into her vagina during incontinence care and the NA #1 continued to work in the facility after the allegation was made. The facility further failed to assess all residents for abuse and failed to report the allegation to the facility's Medical Director (MD)

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and/or Nurse Practitioner (NP).

The facility failed to report a crime against a resident of alleged sexual abuse to local law enforcement and Adult Protective Services (APS) when on 3/22/23, Resident #1 reported Nurse Aide (NA) #1 put his finger in her vagina during incontinent care.

Resident #1 admitted to the facility for long-term care on 8/27/22 with diagnosis of senile degeneration of the brain, traumatic brain injury, depression, anxiety, epilepsy, gastritis, and adult failure to thrive and recently discharged from hospice services on 3/24/23. On 3/22/23, after initial interviews, assessments and investigation, the facility determined that resident abuse did not occur, and care plan updated to reflect resident preference for female caregiver during incontinence care.

On 3/27/23 at 11:00am, the licensed nurse reported to the Administrator that Resident #1 was observed in her room with her daughter and was tearful and appeared emotionally distressed. Administrator and Nurse Manager immediately interviewed Resident #1 and documented her verbal statement of 3/22/23 incident with an allegation of abuse and emotional distress. Nurse aide #1 was immediately suspended pending investigation.

On 3/27/23 at 11:15am, the licensed nurse completed a body audit for Resident #1 and no visual signs of injury were observed. On 3/27/23, the Social Worker (SW) completed a Psychosocial Assessment, and a trauma care plan was implemented. On 3/27/23 at 6:15pm, the Nurse Practitioner (NP) assessed Resident

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#1 and gave new orders for Trazodone 50mg at bedtime for insomnia. On 3/28/23, Psychiatry Services were provided and will be providing ongoing as needed.

On 3/27/23 at 11:00am, the licensed nurse reported to the Administrator that Resident #1 was observed in her room with her daughter and was tearful and appeared emotionally distressed. Administrator and Nurse Manager immediately interviewed Resident #1 and documented her verbal statement of 3/22/23 incident with an allegation of abuse and emotional distress. Nurse aide #1 was immediately suspended pending investigation. The Administrator completed an initial two-hour Abuse report and submitted it to the North Carolina State Agency, notified Adult Protective Services (APS), local law enforcement and the facility Medical Director within 2 hours of the allegation being made.

On 3/28/23, the Administrator and Regional Director of Clinical Services reviewed resident grievances between 1/1/23-3/28/23 to identify any potential allegations of abuse for appropriate investigation and for appropriate reporting to local law enforcement and Adult Protective Services. No additional concerns identified.

Effective 3/28/23, the Social Worker completed abuse questionnaires and abuse education with cognitively intact residents to include identification and reporting without fear of retaliation. No additional concerns reported.
Effective 3/28/23, the licensed nurses completed body audits on cognitively impaired residents to identify any signs of abuse. No concerns observed.

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F 607	Continued From page 28 On 3/28/2023, the Quality Assurance Process Improvement (QAPI) Committee (Administrator, Director of Nursing (DON), Regional Director of Clinical Services (RDCS), Social Worker (SW), Vice President of Operations (VPO), Vice President of Clinical and Quality (VPCQ) and Medical Director (MD) held an Ad Hoc meeting to discuss root cause analysis of the facility's failure to1) protect all residents after an allegation of sexual abuse was made and; 2) assess all other residents and; 3) report the allegation to the facility's MD and/or NP. Root cause analysis determined that appropriate resident protection, assessment and reporting was not completed due to the facility's failure to properly identify what constitutes an allegation of abuse during the interview process and initiate appropriate steps following an abuse allegation. Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: Effective 3/28/23, the Regional Director of Clinical Services (RDCS) completed education with the Administrator, DON, Social Worker and Nurse Managers on completing a comprehensive investigation and quality interview to fully analyze and properly identify and respond to potential abuse. Education included protection of residents from physical and psychosocial harm during and after the investigation, immediate response by removing the alleged staff from resident care to ensure resident safety, assessing all other residents for abuse, reporting to Administrator, Medical Director and/or Nurse Practitioner, state agencies, examining the alleged victim for any signs of injury, increasing	F 607		

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supervision, protection from retaliation and providing emotional support and counseling to the resident during and after the investigation as needed.

Newly hired Administrators, Director of Nursing, Social Workers, and Nurse Managers will receive education during orientation and prior to first worked shift.

The RDCS or Vice President of Operations (VPO) will be responsible for providing and tracking completion of leadership training.

Effective 3/28/23, all current facility staff and agency staff were in-serviced on the Abuse, Neglect and Exploitation Policy by the Regional Director of Clinical Services, Director of Nursing, Social Worker and Administrator. Training topics included 1) prohibiting, preventing and recognizing what constitutes abuse (Examples included; resident, staff or family report of abuse, physical marks such as bruises appearing as hand or belt marks, injury of unknown source, sudden unexplained changes in behavior such as withdrawal from care, fear of certain persons or expressions of guilt or shame), 2) recognizing and understanding behavioral symptoms of residents that may increase the risk of abuse such as aggressive wandering or elopement, resistance to care, outbursts, yelling, difficulty adjusting to new routines or staff, 3) immediately ensuring resident safety by removing accused individual from residents' care and 4) reporting allegations of abuse to the Administrator and/or the Director of Nursing in-person or verbally immediately following resident protection and 5) a zero tolerance for resident abuse in the facility. Abuse questionnaires were also completed to

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validate staff competency of education received and to identify any additional allegations of abuse. No additional concerns reported. The Administrator and Director of Nursing will be responsible for ensuring all staff are trained by tracking and reviewing new hire and agency orientation packets for evidence of abuse training and signed acknowledgement of receipt during the daily reconciliation process. The daily reconciliation process is completed by the Administrator, Director of Nursing and Scheduler to validate actual staff hours worked and to ensure that newly hired facility and agency staff have received abuse education during the orientation and prior to first shift worked. Newly hired facility and agency staff and staff not receiving education by 3/28/23, will receive education prior to next worked shift by the Administrator and/or Director of Nursing.

Effective 3/28/23, the Administrator and/or Director of Nursing completed abuse questionnaires with current facility and agency staff to ensure understanding of the Abuse, Neglect and Exploitation Policy and to identify and prevent resident abuse and to validate understanding that the facility has a zero tolerance for resident abuse.

Effective 3/28/23, the Vice President of Operations, Vice President of Clinical and Quality and/or Regional Director of Clinical Services will provide regional oversight to the facility in-person or via telephone for any allegation of resident abuse to ensure all residents are protected after an allegation of abuse is made to include immediate removal of alleged perpetrator, assessment of all residents and notification to the Medical Director or Nurse Practitioner.

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F 607	Continued From page 31 Effective 3/28/23, the Regional Director of Clinical Services (RDCS) completed education with the Administrator and Director of Nursing on reporting allegations of abuse to local law enforcement and Adult Protective Services immediately, but not later than 2 hours after the allegation is made if the allegations involve abuse or result in serious bodily injury per the facility Abuse, Neglect and Exploitation policy and CMS guidelines. Newly hired Administrators and Directors of Nursing will receive education during orientation and prior to the first worked shift. The RDCS or Vice President of Operations (VPO) will be responsible for providing and tracking completion of abuse reporting. Effective 3/28/23, the Regional Director of Clinical Services, Director of Nursing, Administrator and Social Worker provided education to current facility and agency staff of the requirement of reporting abuse allegations to Adult Protective Services and Law Enforcement immediately, but not later than 2 hours after the allegation is made if the allegations involve abuse or result in serious bodily injury per the facility Abuse, Neglect and Exploitation policy and CMS guidelines. It is the responsibility of the Administrator to ensure appropriate reporting. Effective 3/28/23, the Administrator is ultimately responsible for the implementation and completion of this removal plan. Alleged Date of IJ Removal: 3/29/23 On 3/31/23, the facility's immediate jeopardy removal plan effective 3/29/23 was validated by	F 607		

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the following: Administrative staff interviews revealed they had received education on completing a comprehensive investigation and quality interview to fully analyze and properly identify and respond to potential abuse as well as removal of alleged staff from resident care assignments to ensure resident safety. All staff were educated on reporting abuse allegations to Adult Protective Services and Law Enforcement immediately, but not later than 2 hours after the allegation is made. The Abuse, Neglect and Exploitation policy were reviewed with all staff.

2. An internal facility document titled "allegation report" dated 3/22/23 written by the Administrator indicated on 3/22/23 "Resident #1 reported to staff that the third shift male nurse aide stuck his finger in her vagina when he was cleaning her from a bowel movement." It indicated the Administrator and Unit Manager #1 interviewed Resident #1 and was told by Resident #1 that the male NA was cleaning her from a bowel movement and his finger went into her vagina. It further indicated, during the interview, Resident #1 told the Administrator and the Unit Manager she asked NA #1 to finish her care and not provide any further care to her.
A review of the facility's Facility Reported Incident (FRI) log indicated the incident between Resident #1 and Nurse Aide #1 on 3/22/23 was not reported to the state agency during the required timeframes for submission of the initial report. The allegation was not reported by the state agency until 3/27/23.

An interview on 3/27/23 at 10:20 AM with the Administrator revealed he was made aware of the allegation of potential sexual abuse related to Resident #1 on the morning of 3/22/23 when he

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F 607	Continued From page 33 received a text from the Unit Manager. The Administrator indicated he proceeded to the Unit Manager's office upon arriving at the facility at approximately 8:00 AM. When he arrived at the unit manager's office, he was notified that Resident #1 had alleged that NA #1 had inserted his finger into her vagina while providing incontinence care and that she was upset about the situation. The Administrator stated Resident #1 informed him the incident occurred while NA #1 was providing incontinence care. The Administrator explained during his interview, Resident #1 indicated she believed the situation happened due to NA #1 having to clean her. The Administrator stated because Resident #1 had not believed the incident was intentional, the facility filed the concern as a grievance instead of investigating the allegation for potential sexual abuse. The Administrator acknowledged had the allegation been handled as a potential sexual abuse, he would have been responsible for notifying the state agency, but the state agency was not notified due to the allegation not determined to be intentional by the facility.	F 607		