STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0607	A. BUILDING: _____ B. WING _____	C 09/08/2023

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THE GARDENS OF TAYLOR GLEN RET COM	3700 TAYLOR GLEN LANE CONCORD, NC 28027

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L 000	INITIAL COMMENTS A complaint investigation was conducted from 09/07/23 through 09/08/23. The following intakes were investigated NC00206127 and NC00206139. Three of three allegations resulted in deficiencies. Event ID GTTZ11. Past-noncompliance was identified at: N.C. G.S § 131E-117. Declaration of patient's rights and 10A NCAC 13D .2210. Tag 415 resulted in a Type B violation. The facility came back in compliance effective 08/10/2023.	L 000		
L 050	.2210(B) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (b) A facility shall ensure that the Division of Health Service Regulation is notified within 24 hours of the facility's becoming aware of any allegation against health care personnel of any act listed in G.S. 131E-256(a)(1). This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement the abuse policy and procedure by not reporting an allegation of abuse to the Division of Health Service Regulation (DHSR) within 24-hours for 1 of 3 residents reviewed for abuse (Resident #1).	L 050	The submission of the following allegation of compliance does not constitute an admission or agreement by the provider as to whether there were alleged deficient practices. 1. Address how corrective action will be accomplished for those residents found to	9/8/23

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L 050	Continued From page 1 Findings included: The facility policy titled, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" revised April 2021, read in part: "All reports of resident abuse ...are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse is suspected ...the suspicion must be reported immediately to the administrator and to other officials according to state law. "Immediately" is defined as: a. Within two hours of an allegation involving abuse or result in in serious bodily injury; or b. Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. The Administrator was interviewed on 09/07/23 at 9:45 AM. She stated an incident occurred on 08/04/23 with Resident #1 when a staff member willfully hit a resident with her shoe. The Administrator stated an investigation was started on 8/7/23 when camera footage of the 08/04/23 incident was viewed. Review of the facility's documentation of the 08/04/23 abuse incident revealed no evidence an initial report was sent to DHSR within 24-hours of being notified on 08/04/23 of the allegation of abuse involving Medication Aide (MA) #1 and Resident #1. Further review revealed the initial report was not submitted by the facility to DHSR until 08/07/23 at 1:37 PM via fax transmission. The initial report noted the facility became aware of an allegation of abuse by MA #1 toward Resident #1 on 08/04/23 at 8:30 PM. During an interview on 09/07/23 at 2:12 PM, the	L 050	have been affected by the deficient practice: On Friday, August 4th 2023, the previous facility Director of Nursing was notified that there was a potential allegation of abuse according to staff statements. The previous Director of Nursing failed to report this incident on August 4th, within the required timeframe. A 24-hour initial report was completed and sent to DHSR on Monday, August 7th 2023 at 1:35 PM. Subsequently, a 5-day investigation report was sent on August 10th, 2023 at 2:08 PM, within 5 working days of the incident on 8/4/23. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents on Memory Care unit, where Resident #1 resides, were assessed for skin condition changes with no negative findings on August 7th, 2023. The results of these audits revealed no other residents were affected by the alleged deficient practice. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur: Widespread, specific education on reportables and abuse was done on 8/7/23. On 8/8/23 specific education was conducted with management team during stand-up meeting on abuse reporting requirements and criteria, as well as a	

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L 050	Continued From page 2 former Director of Nursing (DON) confirmed she was notified by the Nursing Supervisor of the allegation of abuse involving MA #1 and Resident #1 on 08/04/23. The Nursing Supervisor told the former DON that CNA #2 witnessed the event, and was very upset about it, and wanted her to view the camera footage. The former DON stated she spoke with MA #1 and CNA #2 on 08/04/23. She noted she was "not able to access the camera, it didn't work." The former DON stated she thought a reportable should be done based on information she had received that MA #1 had poured water on resident and asked the Nursing Supervisor to complete it. The former DON stated when she attempted to notify the Regional Director of Clinical Services (RDCS) that evening 8/4/23, she was not available. The RDCS had contacted the Regional Director of Operations (RDO) to return the call. The former DON stated the RDO called her the evening of 08/04/23 and told the former DON not to report it, as it was not a reportable event. A follow-up interview was done with the Administrator on 09/07/23 at 3:03 PM. She was asked for a timeline regarding the 08/04/23 incident. She stated she was on vacation 08/04/23 and heard about the incident on 08/07/23 when she received the video. She said the former DON had access from home to view the camera and should have viewed it via her phone or computer when the alleged abuse was reported. She noted with abuse concerns the facility was to report it within the required parameters. The Administrator reviewed the actions that had been taken to ensure staff knew when to report incidents. Education and monitoring had been completed with staff and audits had been done since 8-8-23. The Administrator stated education had been done on	L 050	review of the incident on 8/4/23 and how the reporting criteria was not followed. On 8/8/23, an educational call was sent to all employees on payroll outlining abuse policies and reporting. 4. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained: Administrator or Designee will interview 2 staff members weekly for 4 weeks to determine all events that qualify as reportable incidents were reported timely according to applicable regulations. QAPI committee for recommendations on continuing/discontinuing monitoring to ensure solutions are sustained. Ad-Hoc QAPI was held on August 9th, 2023 and in agreement with the plan of correction. Completion date: August 9th, 2023	

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L 050	Continued From page 3	L 050		

reporting incidents of abuse within the reporting guidelines, audits started 08/08/23, education was completed with all staff on payroll on 08/08/23 and information was reported during an ad hoc Quality Assessment and Performance Improvement meeting on 08/09/23. All staff were in-serviced on the proper reporting procedures. Documented attendance roster sheets were provided.

The facility provided the following corrective action plan with a completion date of 08/09/23 for the Timely Reporting of Abuse.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On Friday, August 4, 2023, the previous facility Director of Nursing was notified that there was a potential allegation of abuse according to staff statements. The previous Director of Nursing failed to report this incident on August 4th, within the required timeframe. A 24-hour initial report was completed and sent to DHSR on Monday, August 7, 2023 at 1:35 PM. Subsequently, a 5-day investigation report was sent on August 10, 2023 at 2:08 PM, within 5 working days of the incident on 8/4/23.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents on Memory Care unit, where Resident #1 resides, were assessed for skin condition changes with no negative findings on August 7, 2023. The results of these audits revealed no other residents were affected by the alleged deficient practice.

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L 050	Continued From page 4 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur: Widespread, specific education on reportables and abuse was done on 8/7/23. On 8/8/23 specific education was conducted with management team during stand-up meeting on abuse reporting requirements and criteria, as well as a review of the incident on 8/4/23 and how the reporting criteria was not followed. On 8/8/23, an educational call was sent to all employees on payroll outlining abuse policies and reporting. 4. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained: Administrator or Designee will interview 2 staff members weekly for 4 weeks to determine all events that qualify as reportable incidents were reported timely according to applicable regulations. QAPI committee for recommendations on continuing/discontinuing monitoring to ensure solutions are sustained. Ad-Hoc QAPI was held on August 9, 2023, and in agreement with the plan of correction. Completion date: August 9, 2023 Validation of the corrective action plan was done on 09/07/23. The initial report was sent in on 08/07/23. Records reviewed showed that residents on the memory care unit did have a skin assessment. Interviews with staff confirmed they received education on abuse reporting and record review confirmed monitoring was done. Based on the validation of the corrective action plan the	L 050		

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L 050	Continued From page 5 facility was in compliance on August 10, 2023.	L 050		
L415	131E-117 Declaration of Patient Rights All facilities shall treat their patients in accordance with the provisions of this Part. Every patient shall have the following rights: (1) To be treated with consideration, respect, and full recognition of personal dignity and individuality; (2) To receive care, treatment and services which are adequate, appropriate, and in compliance with relevant federal and State statutes and rules; (3) To receive at the time of admission and during the stay, a written statement of the services provided by the facility, including those required to be offered on an as-needed basis, and of related charges. Charges for services not covered under Medicare or Medicaid shall be specified. Upon receiving this statement, the patient shall sign a written receipt which must be on file in the facility and available for inspection; (4) To have on file in the patient's record a written or verbal order of the attending physician containing any information as the attending physician deems appropriate or necessary, together with the proposed schedule of medical treatment. The patient shall give prior informed consent to participation in experimental research. Written evidence of compliance with this subdivision, including signed acknowledgements by the patient, shall be retained by the facility in the patient's file;	L415		9/8/23

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L415	Continued From page 6 (5) To receive respect and privacy in the patient's medical care program. Case discussion, consultation, examination, and treatment shall remain confidential and shall be conducted discreetly. Personal and medical records shall be confidential and the written consent of the patient shall be obtained for their release to any individual, other than family members, except as needed in case of the patient's transfer to another health care institution or as required by law or third party payment contract; (6) To be free from mental and physical abuse and, except in emergencies, to be free from chemical and physical restraints unless authorized for a specified period of time by a physician according to clear and indicated medical need; (7) To receive from the administrator or staff of the facility a reasonable response to all requests; (8) To associate and communicate privately and without restriction with persons and groups of the patient's choice on the patient's initiative or that of the persons or groups at any reasonable hour; to send and receive mail promptly and unopened, unless the patient is unable to open and read personal mail; to have access at any reasonable hour to a telephone where the patient may speak privately; and to have access to writing instruments, stationery, and postage; (9) To manage the patient's financial affairs unless authority has been delegated to another pursuant to a power of attorney, or written agreement, or some other person or agency has been appointed for this purpose pursuant to law.	L415		

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L415	Continued From page 7 Nothing shall prevent the patient and facility from entering a written agreement for the facility to manage the patient's financial affairs. In the event that the facility manages the patient's financial affairs, it shall have an accounting available for inspection and shall furnish the patient with a quarterly statement of the patient's account. The patient shall have reasonable access to this account at reasonable hours; the patient or facility may terminate the agreement for the facility to manage the patient's financial affairs at any time upon five days' notice. (10) To enjoy privacy in visits by the patient's spouse, and, if both are inpatients of the facility, they shall be afforded the opportunity where feasible to share a room; (11) To enjoy privacy in the patient's room; (12) To present grievances and recommend changes in policies and services, personally or through other persons or in combination with others, on the patient's personal behalf or that of others to the facility's staff, the community advisory committee, the administrator, the Department, or other persons or groups without fear of reprisal, restraint, interference, coercion, or discrimination; (13) To not be required to perform services for the facility without personal consent and the written approval of the attending physician; (14) To retain, to secure storage for, and to use personal clothing and possessions, where reasonable; (15) To not be transferred or discharged from	L415		

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L415	Continued From page 8 a facility except for medical reasons, the patient's own or other patients' welfare, nonpayment for the stay, or when the transfer or discharge is mandated under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act. The patient shall be given at least five days' advance notice to ensure orderly transfer or discharge, unless the attending physician orders immediate transfer, and these actions, and the reasons for them, shall be documented in the patient's medical record; (16) To be notified within 10 days after the facility has been issued a provisional license because of violation of licensure regulations or received notice of revocation of license by the North Carolina Department of Health and Human Services and the basis on which the provisional license or notice of revocation of license was issued. The patient's responsible family member or guardian shall also be notified. (1977, c. 897, s. 1; 1983, c. 775, s. 1; 1989, c. 75; 1997-443, s. 11A.118(a).) This Rule is not met as evidenced by: Type B violation. Based on record review, video recording review and interviews with residents, staff, Physician Assistant and police officer, the facility failed to protect Resident #1's right to be free from mental and physical abuse. Medication Aide (MA) #1 was observed restricting Resident #1's rollator (walker with wheels) movement with her foot, throwing water from a plastic cup toward Resident #1 and hitting the resident with her shoe. Resident #1 did not experience bruising but did experience fear according to the Nurse	L415	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; To ensure resident safety, the accused employee was immediately removed from Resident #1's assignment and the RN supervisor and CNA provided medicine administration and direct patient care. A full skin assessment was completed on Resident #1 on 8/7/23, with indications of latent bruising on the left upper extremity.	

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L415	Continued From page 9 Supervisor who assessed her after the incident. This deficient practice affected one of three sampled residents reviewed for abuse. Findings included: Resident #1 was admitted to the Assisted Living Facility on 03/15/08 and transferred to the memory care unit at the facility on 10/04/21. She had multiple diagnoses that included dementia. A Skin Evaluation for Resident #1 dated 08/02/23 indicated no existing issues. Review of Resident #1's care plan indicated she had care areas for Cognitive Loss/Dementia initiated on 06/29/23 and Mood State interventions for Anxiety and Insomnia initiated on 06/29/23. Review of email correspondence provided by the Administrator on 09/07/23 was done. It included camera video footage of an incident 08/04/23 with Resident #1 in the Memory Care Unit's living room. The video from 08/04/23 was viewed with the Administrator on 09/07/23 at 3:15 PM. Resident #1 was seated on the couch with Medication Aide #1 in front of her. Medication Aide #1 was observed with a cup of water and a medication cup in her left hand, standing at the resident's right side. Resident #1 stood up and pushed her rollator into MA #1. MA #1 proceeded to block the resident's rollator movement with her right hand and her right foot. The medication aide was observed looking for a lost pill on the floor. Certified Nurse Aide (CNA) #2 was observed to walk to the area from the nursing station, stand behind MA #1 and to the right of Resident #1. MA #1 approached the left side of Resident #1 who was sitting on the couch and	L415	Resident #1 was seen by the Physician Assistant on 8/7/23 with no new orders. • Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents on the Memory Care unit, where Resident #1 resides, were assessed for skin condition changes with no negative findings on August 7th, 2023. • Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The accused staff member and the Director of Nursing at the time of the incident are no longer employed at the facility. Widespread, specific education on reportables and abuse was done on 8/7/23 with staff. On 8/8/23 specific education was conducted with management team during stand-up meeting on abuse reporting requirements and criteria, as well as a review of the incident on 8/4/23 and how the reporting criteria was not followed. On 8/8/23, an educational call was sent to all employees on payroll outlining abuse policies and reporting. • Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Audit 2 resident skin checks weekly for 4	

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L415	Continued From page 10 Resident #1 rolled the rollator into the back of MA #1. This action knocked MA #1's right shoe off. MA #1 was observed picking her shoe up off the floor, throwing the water toward Resident #1 with her left hand and hitting the resident at least 3 times with her shoe with her right hand. MA #1's back was toward the camera at this time. Then CNA #2 was noted to go to Resident #1, who stood up from the couch unassisted and left the area, using her rollator with CNA #2 walking by her side. A male resident (Resident #2) was noted standing at the nurse's station in the background. Resident #1 was interviewed on 09/07/23 at 4:41 PM. She stated she enjoyed some things at the facility and sometimes felt comfortable and safe. She stated she was happy to be at the facility and had been there 15 years. The resident stated she was not well-taken care of. The resident became irritable when she was asked more questions about her care and stated she wouldn't give more information or any improvement ideas for fear of tattling. Interviews with MA #1 were attempted on 09/07/23 at 12:15 PM, 09/07/23 at 1:53 PM and 09/08/23 at 8:58 AM with no return call. CNA #2 was interviewed via phone at 3:56 PM on 09/07/23, regarding the incident 08/04/23 with Resident #1. She stated she could not recall the exact time, but it was early in the 7PM-7AM shift and the resident was in the living room. CNA #2 said she had been sitting at the nurse's station and heard noises behind her. The CNA noted she turned around and saw MA #1 holding the top of the resident's rollator. MA #1 told CNA #2 that two pills were on the floor and CNA #2 walked over to the area to help find the medications. MA	L415	weeks, then 1 skin check weekly for 4 weeks. At that time, if there are no adverse findings in the audits, the information will be taken to the QAPI committee for recommendations on continuing/discontinuing monitoring to ensure solutions are sustained. Ad-Hoc QAPI was held on August 9th, 2023 to review the situation and complete a root cause analysis. The QAPI committee agrees with the plan of correction. • Include dates when corrective action will be completed. Completion date: 8/9/23	

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#1 found one pill. The CNA stated she heard noises again, and Resident #1 had used her rollator and was pushing it into the back of MA #1. CNA #2 said the MA turned around and hit the resident with her shoe. CNA #2 said she screamed, "Stop, stop, [MA #1's name], stop." NA #2 said she walked over to the couch area again and the resident was wet. NA #2 stated she was not sure if water was thrown on her by MA #1, as it all happened so fast. CNA #2 stated, she said to the resident "Walk with me to your room and we will get you dry." She let the resident walk at a slight distance from her so Resident #1 would not become more agitated. The CNA stated she offered to help Resident #1 as she was upset that she was wet, and the resident said she "wanted to know who did this?" The CNA stated she asked the Medication Aide later "Why did you do that" and told her "You should have walked away. That never should have happened." The CNA indicated MA #1 said "Yes, I should have." The Medication Aide told her "I know they will see me on camera, and I know they will fire me." CNA #2 said she called the Nursing Supervisor, who called the former Director of Nursing (DON). CNA #2 noted the former DON called her that evening 08/04/23 and she told her exactly what she had seen that the Medication Aide had picked up her shoe and used it to slap the resident a few times. CNA #2 stated this explanation was what she told the former DON on Friday night 08/04/23. The CNA said another resident, Resident #2, saw it and was upset as well. The CNA said 2 other residents were there in the living room on the memory care unit, but they did not say anything. The CNA said when the Nursing Supervisor came back to the unit on 08/04/23, the former DON had told the supervisor to have the Medication Aide leave the unit and the supervisor was to stay on

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the unit for the rest of the shift.

Resident #2 who was observed on the 08/04/23 video at the nurse's station and had verbalized concern to the Nursing Supervisor with MA #1 following the abuse incident. He was interviewed on 09/08/23 at 4:51 PM, in his room on the memory care unit. He stated he had been there for 1 year, denied any concerns with staff or care and reflected "Everything was great."

A phone interview was done with the Nursing Supervisor on 09/7/23 at 12:53 PM regarding the incident from 08/04/23. She stated she received two calls that evening, one from CNA #2 and the other from Medication Aide #1. It was reported to her that Resident #1 had been having behaviors and someone had spilled water on her. She went to the Memory Care Unit where Resident #1 resided, and the resident was upset that someone had poured water on her. The supervisor asked her why Resident #1 was wet, and MA #1 said the resident did not want to take her medication and was holding the water and fighting. The MA denied pouring the water on the resident and stated the resident probably spilled the water on herself. MA #1 denied pouring the water on Resident #1 and said she probably spilled it on herself. The Nursing Supervisor noted when she saw Resident #1 was wet, she asked her if she could help her change her clothes, which she did and then gave her a snack. The Nursing Supervisor noted she stayed with the resident and offered to help her get dressed, as she was afraid, and the resident asked her to stay with her. The Nursing Supervisor stated after she assisted Resident #1 to change her clothes and had completed a full body assessment, she called the Director of Nursing. CNA #2 asked her to have the Director

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of Nursing run the camera to review the incident, as there was suspected abuse and Resident #1 was wet. The former DON told her that she would talk with the Medication Aide and the CNA. The Nursing Supervisor said she knew the former DON had spoken with them. She said the former DON called her back and told her to complete a head-to-toe assessment. The Nursing Supervisor stated she had completed a full body assessment immediately following the incident 08/04/23 and no bruising or injury was reported. The Supervisor informed the former DON she had and there were no injuries. The former DON asked the supervisor to write a statement on paper. The Supervisor said she emailed the former DON the statement that 7PM-7AM shift. The Nursing Supervisor stated the former DON had asked if other residents were concerned. She said she had reported to the former DON, that Resident #2 was upset. When he saw the Medication Aide, he told the supervisor to get that woman out of here. She said she asked him to go back to his room and he smiled. The Supervisor said she spoke with Resident #2 later and sat with him and he did not recall what happened. She said he was not able to verbalize why he was upset. The Nursing Supervisor said she had no idea abuse had happened at that time. The Nursing Supervisor asked if she was able to see the camera. She indicated she could not review camera footage, but it was shown to her the next week by management on 08/08/23. The Nursing Supervisor said she wrote her statement before viewing the video. The Nursing Supervisor stated that she worked the rest of the shift on the Memory Care Unit and observed the residents.

A phone interview with the former Director of Nursing (DON) was done on 09/07/23 at 2:12 PM

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regarding the 08/04/23 incident with Resident #1. She revealed she was notified on Friday evening, 08/04/23 by the Nursing Supervisor. She was told to look at the cameras and the former DON stated she did not have access, that her camera access had never worked remotely. The Nursing Supervisor had reported that she was not sure if the Medication Aide had poured water or spilled it on her. The former DON had spoken with CNA #2 that was also on the unit, regarding the water plus was told by CNA #2 to pull the camera footage as she was not sure. The CNA had told her the MA's shoe had come off. The former DON said she asked CNA #2 about the shoe and if MA #1 hit the resident with the shoe and was told "I don't know, everything happened so fast." The former DON said she called the Medication Aide, and she told her she did not hit the resident and did not know how the water got on her. The former DON stated she removed the MA from the memory care unit and texted the Regional Director of Clinical Services (RDCS), as the Administrator was not available. The former DON said the RDCS was busy, so she texted the Regional Director of Operations (RDO) that she may have a reportable and asked her to call. The former DON stated she had told the Nursing Supervisor to do a reportable. The RDO returned the call and told the DON the incident was not reportable and not to do one. The former DON said she had reported the incident and focused on the water as a reportable, but no one had confirmed anything about the shoe. She stated she had no one to help her access the camera that night. The former DON said she called the Independent Living Director on Sunday 08/06/23 to pull the camera information, regarding the water being spilled or poured, as the Independent Living Director covered in the Administrator's absence. The former DON revealed the

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L415	Continued From page 15 Independent Living Director said she could not pull camera footage on Sunday but would 08/07/23. The camera footage was pulled 08/07/23 by the Independent Living Director first thing Monday per the former DON. The former DON said she had a statement in her office 08/07/23 from NA #2. The former DON stated 08/04/23 NA #2 had said she did not see anything and then wrote on her statement that MA #1 had slapped Resident #1 with her shoe. The former DON stated she texted the Administrator, RDO and RDCS and they all viewed the video on Monday. The former DON said there was no way that they would have told her the MA slapped someone with a shoe and she would have ignored it. The former DON stated that no one in their right mind would ignore that, and her biggest mistake was believing what she was told. If she knew about the resident being hit with a shoe, the former DON said she would have gone on-site and removed the MA from the building and completed the state reportable. A phone interview was done with the RDO on 09/07/23 at 2:46 PM regarding the incident on 08/04/23. The RDO said the former DON had called her on the evening of 08/04/23 and told her that the MA had bent down to pick up Resident #1's shoes and spilled water. She stated she did not know about the abuse allegation until 08/07/23. The RDO said she was not told anything about a reportable incident. She stated on 08/07/23 she was sent a video clip to her phone. The RDO was asked who had access to the camera videos and stated the former DON would be able to view the event remotely via laptop. The RDO stated she would have expected the event to be reported within 2 hours and be told truthful information about the abuse.	L415		

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Record review from 08/05/23 at 4:54 PM indicated Resident #1 had no signs of abnormal bleeding or bruising due to blood thinner therapy.

The Skin Evaluation dated 08/07/23 indicated Resident #1 had no bruising.

The Physician Assistant (PA) Progress note dated 08/07/23 indicated Resident #1 was alert, confused and had intermittent increased agitation and behaviors at times. The resident denied any pain.

The PA was interviewed on 09/07/23 at 1:28 PM. She stated she was made aware of the abuse incident for Resident #1 on 08/07/23. She noted she examined her with the former DON present and did not notice any bruising or changes in her mental status. The PA said the resident had random bruising on her legs chronically, and on her arms occasionally with the anticoagulant therapy. The PA relayed the resident was not able to verbalize anything about the incident. The PA stated she had no concerns related to abuse or care at the facility.

Record review indicated a police report was completed on 08/07/23 by Police Officer (PO) #1 for abuse-simple assault of Resident #1. The former DON had contacted the Police department regarding the incident.

A phone interview was conducted 09/08/23 at 9:14 am with Police Officer #1 and he verified the police report was done for resident abuse. He noted the investigation continued, charges had been filed and a warrant issued for MA #1.

Review of the Investigative Report submitted by the facility to Department of Health and Human

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Services (DHHS) on 08/07/23 for abuse of Resident #1 reported that she was alert, oriented to self and her mental status was at baseline following the incident. It was documented that there was no evidence of mental anguish. She was examined by the Medical Provider on 08/07/23, no changes were noted and there were no new orders.

The Administrator was interviewed on 09/07/23 at 9:45 AM. She stated an incident occurred on 08/04/23 with Resident #1 when a staff member willfully hit a resident with her shoe. The Administrator stated an investigation was started on 08/07/23 and she would send the video of the incident.

0n 09/07/23 at 3:15 PM. The Administrator noted that the resident had the right to refuse her medications, and restriction of Resident #1's movement with the walker was not permitted. She also acknowledged the staff's physical abuse with restricting her movement, hitting the resident with her shoe and water being spilled on the resident.

The Administrator was interviewed on 09/07/23 at 3:03 PM. She was asked for a timeline regarding the 08/04/23 incident. She stated she heard about the event mid-morning on 08/07/23 when she received the video, as she had been off 08/04/23-08/07/23. She said the former DON had access from home to view the camera, and the video could have been seen via phone or computer. The Administrator stated the family and police department were notified on 08/07/23 by the former DON. The Administrator reviewed the actions that had been taken to ensure staff were aware of types of abuse, prevention, staff mental health care, abuse reporting and dementia

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care. Education and monitoring had been completed with all staff and audits had been done since 8-8-23. The Administrator stated education was completed with all staff on payroll on 08/08/23 and information about the event was reported during an ad hoc Quality Assessment and Performance Improvement meeting on 08/09/23. Documented attendance roster sheets were provided for education for types of abuse, abuse prevention, reporting and dementia care.

The facility provided the following corrective action plan with a completion date of 08/09/23 for Abuse.

" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

To ensure resident safety, the accused employee was immediately removed from Resident #1's assignment and the RN supervisor and CNA provided medicine administration and direct patient care. A full skin assessment was completed on Resident #1 on 8/7/23, with indications of latent bruising on the left upper extremity. Resident #1 was seen by the Physician Assistant on 8/7/23 with no new orders.

" Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

All residents on the Memory Care unit, where Resident #1 resides, were assessed for skin condition changes with no negative findings on August 7, 2023.

" Address what measures will be put into place or systemic changes made to ensure that the

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L415	Continued From page 19 deficient practice will not recur; The accused staff member and the Director of Nursing at the time of the incident are no longer employed at the facility. Widespread, specific education on reportables and abuse was done on 8/7/23 with staff. On 8/8/23 specific education was conducted with management team during stand-up meeting on abuse reporting requirements and criteria, as well as a review of the incident on 8/4/23 and how the reporting criteria was not followed. On 8/8/23, an educational call was sent to all employees on payroll outlining abuse policies and reporting. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Audit 2 resident skin checks weekly for 4 weeks, then 1 skin check weekly for 4 weeks. At that time, if there are no adverse findings in the audits, the information will be taken to the QAPI committee for recommendations on continuing/discontinuing monitoring to ensure solutions are sustained. Ad-Hoc QAPI was held on August 9, 2023, to review the situation and complete a root cause analysis. The QAPI committee agrees with the plan of correction. " Include dates when corrective action will be completed. Completion date: 8/9/23 Validation of the corrective action plan was done on 09/07/23. The initial report was sent in on 08/07/23. Records reviewed showed that	L415		

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L415	Continued From page 20 residents on the memory care unit did have a skin assessment completed. Education rosters for abuse and dementia care of all staff were reviewed. Interviews with staff confirmed they received education on types of abuse, prevention and reporting and dementia care. Record review confirmed monitoring was done. Based on the validation of the corrective action plan the facility was in compliance on August 10, 2023.	L415		