STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey entry was conducted from 4/4/24 through 4/5/24. A surveyor returned on 4/9/24 to validate the plan of correction, investigate a new complaint intake, and obtain additional information. Additional information was obtained on 4/18/24. Therefore, the exit date was changed to 4/18/24. Event ID# 6T0K11. The following intakes were investigated NC00214862 and NC00215556. One of the two complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity J. The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 3/19/24 and was removed on 4/10/24. 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	F 600		5/2/24

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

Electronically Signed | 04/26/2024

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F 600	Continued From page 1 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interview of the staff and Police Officer #1, the facility failed to protect a cognitively impaired dependent resident (Resident #1) from sexual abuse by a cognitively intact resident (Resident #2). On 3/19/24 Resident #2 was found in Resident #1's room by Nursing Assistant #1. Resident #2 was observed fondling Resident #1's penis with skin to skin contact from his hand. Resident #1 was unable to stop the sexual abuse due to his limited ability to move and he was non-verbal/unable to call for help. Resident #1 was incapable of consenting to the sexual act and could not express an adverse psychosocial outcome. A reasonable person expects to be protected from abuse in their home environment and sexual abuse would cause emotional trauma. This deficient practice affected 1 of 3 residents reviewed for abuse. Immediate Jeopardy began on 3/19/24 when staff failed to protect Resident #1 from sexual abuse. Immediate jeopardy was removed on 4/10/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of a "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure staff education is completed and monitoring systems put into place are effective.	F 600	CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED: While completing routine room rounds, CNA noted resident number 2 in resident number 1 room. Resident number 2 was fondling resident number 1□s penis. Resident number 2 was immediately removed from resident number 1 room. Resident number 2 was immediately placed on 1:1 supervision. A full head to toe assessment completed on 3/19/2024 by a licensed nurse on resident number 1 with no issues or areas of concern noted. Resident number 1 was sent out to hospital for further evaluation on 3/19/2024 and he was discharged to another facility per family request. Abuse in-service to all staff was immediately initiated by Director of Health Services or designee on 3/19/2024 and Police and Adult Protective Services were notified. Resident number 2 discharged Against Medical Advice after spoken to by law enforcement on 3/20/2024. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE	

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F 600	Continued From page 2 Findings included: A. Resident #1 was admitted to the facility on 1/8/20 with the diagnoses of quadriplegia (paralysis of the body below the neck) after skull fracture, Traumatic Brain Injury (TBI), aphasia (loss of ability to understand or express speech). Resident #1's quarterly Minimum Data Set dated 1/15/24 indicated the resident was rarely/never understood. The resident had functional limitations in range of motion of his bilateral upper and lower extremities and was dependent on assistance with all activities of daily living. B. Resident #2's hospital discharge summary dated 2/20/24 documented the resident was homeless living in a shelter and had fallen due to advancing Parkinson's disease. The resident had significant risk for worsening of his medical and behavioral status and was at high risk for rehospitalization. Resident #2 was admitted to the facility on 2/20/24 with the diagnosis of Parkinson's disease. Resident #2's admission Minimum Data Set dated 2/27/24 documented he had an intact cognition and no behaviors. The resident used a walker and a wheelchair for ambulation and was independent with set up. A nurse's note at 9:00 pm on 03/09/24 documented Resident #2 informed the Interim Director of Nursing that he was taking a cab to visit his sister who had just come to town. The Interim Director of Nursing informed the resident that it was late, and he should wait until tomorrow	F 600	POTENTIAL TO BE AFFECTED: The unit managers on 3/19/2024 completed a full audit on all residents. Unit managers completed head to toe assessments on 26 residents that were most vulnerable for potential abuse with BIMS of 9 and below looking for signs and symptoms of abuse or any appearance of fear during their assessment. No areas of concern were noted. Unit managers completed 68 safe survey interviews with the residents with BIMS of 10 and above asking if they had experienced any abuse, including sexual, in this facility. No areas of concern were noted. SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFIENCIENT PRACTICE WILL NOT OCCUR: ON 3/19/2024, an abuse in- service initiated per Director of Health Services to ensure that all staff recognize, prevent and protect a residents right to be free from abuse. This in-service and review of facility abuse policy with all staff initiated a heightened awareness for residents who are most vulnerable and assure that our partners are doing all that is within our control to create a standard of intolerance and to prevent any occurrences of any form of patient abuse. This in-service was completed on 4/9/2024, any staff not completing this in-service by this date was removed from the schedule until completed. The Director of Health Services or designee is responsible for ensuring all staff in-serviced.	

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F 600	Continued From page 3 to visit. The resident stated, "I'm not waiting until tomorrow, she already called my cab and it's upfront waiting for me." The resident proceeded to the front door where he was observed getting into a van. The resident refused to sign out. The resident was in no apparent distress at the time of departure from the facility. The resident's emergency contact was called. The person answering the phone commented that they had the wrong number. Resident #2's Emergency Department record dated 3/10/24 documented he was seen for leg and foot pain. The resident had a positive drug screen for cocaine. The facility allowed him to return to the facility on 3/10/24 and he was discharged from the hospital. The Interim Director of Nursing documented in the nurses' notes on 3/19/24 Resident #2 was observed by staff with inappropriate touching of Resident #1's private part. The resident was immediately separated and placed on one-to-one supervision in a room by himself. Resident #2 was interviewed, and he informed the Interim Director of Nursing he touched Resident #1's private part. Resident #2 also indicated that this was the first time he "did anything like this here." On 4/4/24 at 2:12 pm an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated she was assigned to Residents #1 and #2 on 3/19/24 during the abuse incident. During rounds shortly after the evening shift change, NA #1 entered Resident #1's room and observed Resident #1 lying in his bed near the door and Resident #2 was in his wheelchair sitting by the side of Resident #1's bed with his back to the door. The	F 600	Department managers complete on-going routine room rounds. This room round screening form includes questioning alert and oriented residents if they have experienced any abuse or visualizing any signs of abuse from residents unable to respond. On 3/25/2024, the Licensed Nursing Home Administrator and Director of Health Services reviewed and updated facilities preadmission checklist to include Director of Health Services reviewing prior to admission, any potential admission with a history of homelessness, drug addiction and or behaviors. On 3/25/2024 the Admissions Director was notified of updated preadmission checklist. If any applicable items are found, this checklist is sent to the Director of Health Services for admission or denial. The Admissions Coordinator completes a sex offender registry check on all new admissions, anyone appearing on the sex offender registry is denied admission. On 3/25/2024 the Licensed Nursing Home Administrator notified the Director of Health Services to review facility activity report (this is a report within the facilities electronic records) Monday thru Friday, monitoring for, but not limited to behaviors, signs of aggression, wandering, and sexual deviations, etc. This review is discussed during morning clinical meeting, which includes the Director of Health Services, the Assistant Director, the Unit Managers, the Social	

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F 600	Continued From page 4 door was open. Resident #1's disposable undergarment was open and hospital gown in place, his (Resident #1's) penis was exposed, and Resident #2 had Resident #1's penis in his hand and was fondling it with one hand. She indicated Resident #1 was not saying anything or using his hands to stop Resident #2 during the incident. Resident #1's eyes were open. NA #1 stated she asked Resident #2 what he was doing, and Resident #2 commented Resident #1 told him he would pay him $3 to touch him. NA #1 informed Resident #2 that Resident #1 "cannot speak and to get out of the room." Resident #2 was escorted out of the resident's room by NA #1 and placed on one-to-one supervision by another nursing assistant. NA #1 stated she had not known how long Resident #2 was in Resident #1's room or how long he (Resident #2) was touching his (Resident #1's) genitals. NA #1 further stated she was not familiar with Resident #2. He was a new admit for rehabilitation. NA #1 stated there appeared to be no harm to Resident #1 and she immediately reported the incident to the supervising nurse (Nurse #1). Resident #2 left the facility Against Medical Advice (AMA) after the incident the next day. Resident #1 was sent to the hospital for evaluation and transferred to another facility. NA #1 stated this was the first time she had observed Resident #1 in his room on her shift 3/19/24. Resident #2 was from another hall and not on her assignment. Their rooms were not close to each other, they resided on different halls (200 and 300). On 4/4/24 at 3:25 pm an interview was conducted with Nurse #1. Nurse #1 stated she was assigned to Resident #1 on 3/19/24 during the evening shift and was informed of the sexual abuse by NA #1. Nurse #1 stated she was	F 600	Worker, and the MDS coordinator. This review is used to update resident care plans and implement medically needed interventions. Direct care staff is trained during orientation of necessary documentation needed, including but not limited to progress notes, point of care documentation, care plan updates, etc. This documented information in turn flows to the facility activity report for review. MONITORING OF PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED: The Licensed Nursing Home Administrator is responsible for the plan of correction implementation. The QA coordinator and its members will be responsible for the ongoing monitoring of this process as follows: 1.The Licensed Nursing Home Administrator will review partner room round forms daily during stand-up meetings. Any noted issues will be immediately addressed and corrected. This will be reviewed Monday through Friday for 30 days, twice weekly for four weeks, and once monthly for three months. 2.The Director of Health Services will present the analysis of facility activity report daily during stand-up meeting, Director of Health Services, Assistant Director, Unit Managers, Social Worker, MDS nurses, Activities Director, Maintenance Director, Housekeeping	

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F 600	Continued From page 5 informed that Resident #2 was observed by NA #1 molesting/holding the penis of Resident #1. Resident #2 was immediately removed from Resident #1's room by NA #1 and Nurse #1 observed Resident #2 in his room alone with one-to-one supervision by the nursing assistant. Nurse #1 stated she immediately informed the Administrator, and an investigation began. Resident #1 was examined by Nurse #1, and no injury was observed. Resident #1 was sent to the Emergency Room and the family were notified. Resident #2 was a new admit and there was no prior behavior of this type. The Resident #1 was oriented to self and situation and was non-verbal. On 4/8/24 at 1:46 pm an interview was conducted with Police Officer #1 from the Special Crime Victims Unit by phone. The Officer stated Resident #2 (perpetrator) admitted to sexual abuse Resident #1 when interviewed by the responding Officer. Officer #1 stated she tried to interview Resident #1 (victim) at another facility on 4/8/24 by using yes and no questions raising his hand. Resident #1 had limited participation and was non-verbal. Police Officer #1 further stated since the sexual abuse was observed by facility staff and Resident #2 admitted to the crime, the case will be presented to the District Attorney for prosecution. The whereabouts of Resident #2 were currently unknown. Police Officer #1 indicated she had just completed her investigation on 4/8/24 and there was no report completed at this time. Resident #2's nurse's note completed by the Interim Director of Nursing dated 3/20/24 at 1:34 pm documented the resident left the facility	F 600	Director, Business Manager, Nurse Navigator, and Medical Records. Any noted issues will be immediately addressed and corrected. Any noted issues will be immediately addressed and corrected. This will be reviewed Monday through Friday for 30 days, twice weekly for four weeks, and once monthly for three months. On April 29, 2024, results of these reviews will be presented by the Licensed Nursing Home Administrator to the QA team. Findings will be presented to the QA team monthly until 3 months of sustained compliance is maintained and then quarterly thereafter. Date pf Compliance May 2, 2024	

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F 600	Continued From page 6	F 600		

against medical advice at 1pm. The resident signed the AMA paperwork to leave and was provided with his medication.

On 4/4/24 at 1:50 pm an interview was conducted with the Interim Director of Nursing (DON). The Interim DON stated on 3/19/24 Resident #2 was observed to inappropriately touch Resident #1's privates and admitted to touching Resident #1s penis when asked. Resident #2 left the facility against medical advice again on 3/20/24 shortly after the police questioned him. The resident signed the AMA paperwork and was provided with his medication.

Resident #1's Nurse Practitioner (NP) progress note dated 3/20/24 at 6:03 pm documented a staff member observed Resident #2 touch Resident #1 inappropriately on his private part. Resident #1 had a cognitive deficit, was non-verbal and could not consent to Resident #2 touching him at his private part. Resident #2 was immediately placed on 1:1 supervision in a room by himself. Resident #1 was assessed and there was no evidence of physical harm noted. Resident #1 had a flat affect (facial expression) and was non-verbal. Resident #1 had a head-to-toe assessment, including skin check, and had no evidence of physical harm. The resident's representative and physician was notified. The physician requested Resident #1 be sent out to Emergency Room for evaluation.

On 4/4/24 and 4/5/24 attempts were made to contact Resident #1's representative but were unsuccessful.

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F 600	Continued From page 7	F 600		

On 4/4/24 at 1:40 pm an interview was conducted with the Administrator and Director of Nursing (DON). The Administrator stated Resident #1 was inappropriately touched in his genitals by Resident #2 on 3/19/24. The incident was considered abuse and was reported as required. Resident #2 was removed and placed on one-to-one supervision. Resident #1 was assessed for any injury, and none was found. Resident #1 went to hospital and had not returned to this facility; he was transferred to another facility at his responsible party's request. Resident #1 had limited ability to communicate with yes or no by raised hand from direct questions. Resident #1 had impaired cognition and was the victim of sexual assault/touching by Resident #2 who was alert and oriented. Resident #1 was unable to provide a statement. Resident #2 admitted to touching Resident #1's penis. Resident #2 had a sexual offender registry check which was negative. Resident #2 had no prior behavior other than the incident on 3/19/24. The police, resident's representative, and Adult Protective Services were notified. The responding police officer interviewed Resident #2 on 3/20/24 and he admitted to the abuse behavior and left the facility AMA shortly after. Since Resident #1 was not alert and was abused, the police referred the case to the Special Victims Unit (Police Officer #1).

The Administrator was notified of immediate jeopardy on 4/5/24 at 1:54 pm.

The facility provided the following credible allegation of immediate jeopardy removal with a completion date of 4/10/24:

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F 600	Continued From page 8	F 600		

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

While completing routine room rounds, CNA (Certified Nursing Assistant) noted Resident #2 in Resident #1's room. Resident #2 was fondling Resident # 1's penis. Resident #2 was immediately removed from Resident #1's room. Resident #2 was immediately placed on 1:1 supervision. A full head to toe assessment was completed on 3/19/2024 by a licensed nurse on Resident #1 with no issues or areas of concern noted. Resident #1 was sent out to hospital for further evaluation on 3/19/2024 and he was discharged to another facility per family request. Abuse in-service to all staff was immediately initiated by Director of Health Services or designee on 3/19/2024 and Police and Adult Protective Services were notified. Resident #2 discharged Against Medical Advice after spoken to by law enforcement on 3/20/2024.

The unit managers on 3/19/2024 completed a full audit on all residents. Unit managers completed head to toe assessments on 26 residents that were most vulnerable for potential abuse with BIMS (Brief Interview for Mental Status) of 9 and below looking for signs and symptoms of abuse or any appearance of fear during their assessment. No areas of concern were noted. Unit managers completed 68 safe survey interviews with the residents with BIMS of 10 and above asking if they had experienced any abuse, including sexual, in this facility. No areas of concern were noted.

Specify the action the entity will take to alter the process or system failure to prevent a serious

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F 600	Continued From page 9	F 600		

adverse outcome from occurring or recurring, and when the action will be complete.

On 3/19/2024, an abuse in-service was initiated per Director of Health Services to ensure that all staff recognize, prevent and protect a resident's right to be free from abuse. This inservice and review of facility abuse policy with all staff initiated a heightened awareness for residents who are most vulnerable and assure that our partners are doing all that is within our control to create a standard of intolerance and to prevent any occurrences of any form of patient abuse. This in-service was completed on 4/9/24, any staff not completing this in-service by this date was removed from the schedule until completed. The Director of Health Services or designee is responsible for ensuring all staff inserviced.

Department managers complete on-going routine room rounds. This room round screening form includes questioning alert and oriented residents if they have experienced any abuse or visualizing any signs of abuse from residents unable to respond.

On 3/25/2024, the Licensed Nursing Home Administrator and Director of Health Services reviewed and updated facilities preadmission checklist to include Director of Health Services reviewing prior to admission, any potential admission with a history of homelessness, drug addiction and or behaviors. On 3/25/2024 the Admissions Director was notified of updated preadmission checklist. If any applicable items are found, this checklist is sent to the Director of Health Services for admission or denial. The Admissions Coordinator completes a sex

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offender registry check on all new admissions, anyone appearing on the sex offender registry is denied admission.

On 3/25/2024 the Licensed Nursing Home Administrator notified the Director of Health Services to review facility activity report (this is a report within the facilities electronic records) Monday thru Friday, monitoring for, but not limited to behaviors, signs of aggression, wandering, and sexual deviations, etc. This review is discussed during morning clinical meeting, which includes the Director of Health Services, the Assistant Director, the Unit Managers, the Social Worker, and the MDS coordinator. This review is used to update resident care plans and implement medically needed interventions. Direct care staff is trained during orientation of necessary documentation needed, including but not limited to progress notes, point of care documentation, care plan updates, etc. This documented information in turn flows to the facility activity report for review.
Date of Immediate Jeopardy removal: 4/10/24

Validation of the credible allegation was completed on 4/9/24:

On 4/9/24 at 9:40 AM a tour of the facility was done. During this time there were no residents observed with outward signs of physical abuse. Multiple residents and staff were interviewed during this time. Residents reported they had not been abused or mistreated. Alert residents recalled that facility staff had interviewed them in recent weeks about abuse as per the facility's action plan. Some of the staff reported they had received in-service training per the facility's action plan. These staff members were able to express

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F 600	Continued From page 11	F 600		

points covered in the abuse in-service material. Two of the interviewed facility staff, who were working on 4/9/24 reported they had not received abuse training since 3/19/24. A review of in-service training records revealed these two staff members' names did not appear on the facility's in-service sign in sheets for abuse training that had occurred between 3/19/24 and 3/25/24.

The Director of Nursing was interviewed on 4/9/24 at 11:15 AM and reported she had not been the Director of Nursing (DON) at the time of the abuse in-services for staff. An Interim DON had completed the in-service training, and she could not find the list of current employees which the Interim DON had used to ensure all the staff had been in-serviced. The DON stated that she would confirm which employees were current at the facility and compare to the abuse in-service sign in sheets during onsite 4/9/24.

During a follow up interview with the DON on 4/9/24 at 3:00 PM, the DON provided an updated list of current employees and reported that she had identified four more employees who had been working since 3/25/24 who had not been in-serviced. On 4/9/24 the DON in-serviced the two staff members identified by the surveyor and the additional four employees she had identified. The DON did this by providing in-person training or calling them on the phone on 4/9/24. This completed the facility's in-service training for all current working employees.

During interviews with staff on 3/9/24, staff were interviewed regarding whether they had witnessed abuse. Staff reported they had not witnessed any type of abuse. Staff were

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F 600	Continued From page 12 knowledgeable regarding what they should do if they did witness abuse. Review of records revealed documentation that Resident #2 was placed on one-on-one supervision from 3/19/24 until his discharge from the facility on 3/20/24. On 4/9/24 the facility presented documentation of audits they had completed per their action plan. The facility also presented an updated preadmission checklist noting that prior to admitting a resident with homelessness, drug addiction, and/or behaviors that the Admissions' Coordinator must consult with the DON per their action plan. There was a signed acknowledgement by the Director of Admissions noting that she understood this new policy. Interview with the DON on 4/9/24 at 3:00 PM revealed that since 3/25/24 there had been no residents requesting admission who were homeless or had drug and/or behavioral problems. On 4/9/24 it was confirmed that Immediate Jeopardy had been removed as of 4/10/24 due to staff education being completed on 4/9/24 prior to the survey's exit. .	F 600		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including	F 867		5/2/24

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adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after

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implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects

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F 867	Continued From page 15 conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification/complaint investigation survey dated 7/13/22 in order to achieve and sustain compliance. This was for a recited deficiency from a complaint investigation survey on 4/9/24. The deficiency was in the area of abuse. The continued failure during federal surveys of record showed a pattern of the facility's inability to	F 867	Corrective Action for those residents found to have been affected Resident #1 identified in the 2567 is discharged to another facility per request of family. Resident #2 identified in the 2567 is discharged Against Medical Advice. The Administrator will complete the electronic education in Relias training Quality	

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F 867	Continued From page 16 sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: F600: Based on record review and interview of the staff and Police Officer #1, the facility failed to protect a cognitively impaired dependent resident (Resident #1) from sexual abuse by a cognitively intact resident (Resident #2). On 3/19/24 Resident #2 was found in Resident #1's room by Nursing Assistant #1. Resident #2 was observed fondling Resident #1's penis with skin to skin contact from his hand. Resident #1 was unable to stop the sexual abuse due to his limited ability to move and he was non-verbal/unable to call for help. Resident #1 was incapable of consenting to the sexual act and could not express an adverse psychosocial outcome. A reasonable person expects to be protected from abuse in their home environment and sexual abuse would cause emotional trauma. This deficient practice affected 1 of 3 residents reviewed for abuse. During a previous survey on 7/13/22 the facility failed to protect a resident's right to be free from mistreatment for 1 of 1 resident investigated for staff to resident abuse. The resident sustained a scratch on her face and nose from the altercation with the staff and was crying stating that the altercation made her feel scared and anxious. On 4/18/24 at 9:50 am an interview was conducted with the Administrator. The Administrator stated the abuse deficient practice on 3/19/24 was an unusual circumstance and not the same as the prior abuse deficient practice (7/13/22). The staff addressed the situation as	F 867	Assurance/ Performance improvement developing and sustaining a quality culture by 5/2/2024. How the facility will identify other residents having the potential to be affected All residents have the potential to be affected by this practice. Systemic changes made to ensure that deficient practice will not reoccur: The Administrator and Director of Health Services initiated reeducation 4/18/2024 on the QAPI process for all staff on the QAA/QAPI Committee with emphasis on identifying areas that may lead to deficiency practice. Education to be completed on 5/2/2024. Administrator will lead Quality Assurance and Performance improvement meetings with emphasis and focus on ensuring that any areas of non-compliance are addressed to prevent further deficient practices related to residents right to be free from abuse. Monitoring of performance to make sure that solutions are sustained The Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis and focus on the area that has led to repeated deficiencies and/or citations. This will ensure that the facility has identified areas of non-compliance and have addressed to prevent further deficient practices related to resident□s	

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F 867	Continued From page 17 best they could under the circumstances.	F 867	right to be free from abuse. At least one member of the regional team that includes the senior nurse consultant, clinical reimbursement consultant, or area vice president will attend QAPI meetings times 3 months, and then quarterly times 3 quarters to ensure that any area leading to deficient practice identified during clinical and compliance rounds are acted upon by the facility according to the QAPI process. The administrator will report to the QAPI committee any areas of non-compliance times 3 months and then quarterly times 3 months for recommendations as needed. Date when the corrective action will be completed 5/2/2024	