STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. BUILDING _____ B. WING _____	C 04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING AND REHABILITATION CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

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F 000	INITIAL COMMENTS An onsite complaint investigation survey was conducted from 04/10/24 through 04/12/24. The corrective action plan was validated onsite on 04/29/24. Therefore, the exit date was changed to 04/29/24. Event ID# GMNY11. Intake NC00214425 was investigated. One (1) of 1 complaint allegation was substantiated resulting in a deficiency. Intake NC00214425 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity K CFR 483.12 at tag F607 at a scope and severity J The tags F600 and F607 constituted Substandard Quality of Care. A partial extended survey was conducted. Immediate jeopardy began on 12/27/23 and was removed on 3/02/24.	F 000		
F 600 SS=K	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-	F 600		

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

Electronically Signed | 05/10/2024

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F 600	Continued From page 1 §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 observations, record review, resident, physician, and staff interview the facility failed to protect a severely cognitively impaired resident from the right to be free from physical abuse (Resident #5). Resident #5 experienced physical abuse twice on 12/27/23 when before bingo Resident #4 placed her arm around the Resident #5's neck, and pulled her forward, and then on the same day, placed Resident #5 in a chokehold with her arm while she was seated in her wheelchair. Resident #5 was held in the chokehold position which caused the resident to gasp and her face to become red. In addition, the facility failed to protect a severely cognitively impaired resident from the right to be free from sexual abuse (Resident #3). Resident #3 experienced sexual abuse on 2/26/24 when Resident #2 touched and rubbed her pubic area. Based on the reasonable person concept, being placed in a chokehold and non-consensual sexual contact would cause a reasonable person to experience psychosocial harm, trauma and fear from physical or sexual abuse. Abuse occurred for 2 of 4 sampled residents reviewed for protection from abuse (Resident #5 and Resident #3). The findings included: 1. Resident #4 re-admitted to the facility on 10/26/22. Diagnoses included recurrent major depressive disorder, post-traumatic stress disorder (PTSD), and anxiety disorder.	F 600	Past noncompliance: no plan of correction required.	

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A 12/4/23 quarterly Minimum Data Set (MDS) assessment evaluated Resident #4 with adequate hearing and vision (with corrective lenses), clear speech, made herself understood, able to understand others, intact cognition, no behaviors, used a motorized wheelchair for mobility and independent or required supervision with activities of daily living (ADL).

Review of the care plan for Resident #4 revised 12/7/23 revealed she did not have a comprehensive person-centered behavior care plan. The care plan did document that Resident #4 required staff assistance with ADL due to her history of PTSD. Staff interventions included allowing rest breaks between tasks, encouraging participation in small tasks, and allowing adequate time to complete tasks.

A 12/27/23 skin audit conducted by the Director of Nursing (DON) recorded no injuries noted for Resident #4.

Resident #5 re-admitted to the facility on 6/24/22 and expired in the facility with hospice services on 3/18/24.

Diagnoses included dementia with agitation, anxiety disorder, mood affective disorder, psychosis, and major depressive disorder.

A care plan revised 3/7/23 recorded Resident #5 cursed at a resident and at staff. Interventions included referral for psych services as needed, provide psych medications as ordered, involve the Responsible Party (RP), if possible, redirect her when she is noted with agitation/aggression, and educate her that cursing others is not acceptable.

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A 11/21/23 quarterly MDS assessment evaluated Resident #5 with adequate hearing, impaired vision, clear speech, made self-understood, able to understand others, severely impaired cognition, no behaviors, no functional limitation in upper extremity range of motion (ROM), impaired function limitation in lower extremity ROM on both sides, wheelchair use for mobility and dependent on staff for ADL.

A 12/27/23 skin audit conducted by the DON recorded no injuries noted for Resident #5.

1a. Medical record review for Resident #4 and Resident #5 revealed there was no documentation in either medical record that Resident #4 placed her arms around the neck of Resident #5 on 12/27/23 and pulled the Resident forward.

An interview with the Activity Director (AD) and the Activity Assistant occurred on 4/11/24 at 5:37 PM. During the interview, the AD stated that on 12/27/23, she did not know the exact time, but sometime before bingo which was scheduled at 2:30 PM, she was in her office, which was adjacent to the dining room, and she heard Resident #5 talking loudly in the dining room and using profanity. Resident #4 told Resident #5 "nobody wants to hear that." During the interview, the Activity Assistant stated that before the 2:30 PM bingo activity, she was not sure of the exact time, she was in/out of the dining room setting up bingo, and she told Resident #5 to calm down. The Activity Assistant stated that Resident #5 got upset, continued using profanity and yelled at Resident #4 "b**** I will f*** you up." The Activity Assistant stated she called the AD to come and

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help her when she saw Resident #5 propel in her wheelchair towards Resident #4, Resident #4 put her arms around the neck/shoulders of Resident #5 and pulled her forward. The Activity Assistant stated she separated the Residents, directed Resident #4 to go to her room while the AD took Resident #5 to the Nurse. The Activity Assistant said she returned to setting up bingo and that she did not report to the administration that she had to separate the two Residents. The interview continued and the AD stated that the Activity Assistant asked for her help. The AD stated that when she came out of her office into the dining room, she saw the Activity Assistant "pulling the two residents apart." The AD said that the Activity Assistant told her what occurred, the AD took Resident #5 to her Nurse (Nurse #1), reported the incident to Nurse #1 and returned to the dining room for bingo. The AD stated that she did not report the incident to the administration, but rather took Resident #5 to her Nurse. Both the AD and the Activity Assistant stated they were unaware that a second incident occurred between Resident #4 and Resident #5 on the same day (12/27/23) in the hallway.

Nurse #1 was interviewed via phone on 4/12/24 at 3:35 PM. He stated that he was the assigned Nurse on the South Unit for the 7A - 3P shift on 12/27/23. He stated that close to the end of the shift on 12/27/23 he heard staff stating that Resident #5 said something to Resident #4 that got her upset and caused her to hit Resident #5. He stated that no one reported the incident to him directly. Nurse #1 said he was told that an incident report had been made, but he could not recall who told him that, so he did not make a report about the incident because he did not witness it and he was not asked to do any follow

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up. Nurse #1 said after he heard about the incident, he did recall seeing Resident #5 in her wheelchair at the end of the hall near her room, but that she did not mention what occurred. Nurse #1 said he was not made aware that there were two incidents between Resident #4 and Resident #5 that day. Nurse #1 stated that if staff had reported the incident directly to him, he would have contacted the DON and Administrator to get the police involved if a resident was assaulted and followed the facility's abuse policy. Nurse #1 described Resident #5 as confused intermittently and heard staff say she made racial comments and cursed staff/resident, but that he was not aware that Resident #5 ever physically hit another resident. Nurse #1 described that Resident #4 seemed like the sweetest person, but that she could be aggressive at times and made verbal threats of what she would do in different circumstances if she were provoked. He stated that he never reported the behavior of Resident #4 because these were comments that he heard in passing.

1b. A Resident Incident Report for Resident #4 completed by the DON recorded that on 12/27/23 at 1:45 PM, Resident #4 and Resident #5 were both in the dining room when Resident #5 began to harass the kitchen staff. The report recorded that when Resident #4 told Resident #5 to stop harassing the staff, Resident #5 turned to Resident #4 and cursed at her. At this, Resident #4 stated that she got upset and put Resident #5 in a "chokehold" because Resident #5 had been harassing her for weeks. The report recorded that staff heard the commotion, separated the Residents, and both Residents were assessed by the DON without injury. The report recorded that the Physician (MD), RP for Resident #5, law

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enforcement and Adult Protective Services (APS), were notified of the incident.

Review of a Facility Reported Incident, completed by the DON, dated 12/27/23 at 1:45 PM indicated Resident #4 put Resident #5 in a "headlock." The Summary of Facility Investigation recorded, Resident #4 and Resident #5 were both in the dining room when Resident #5 shouted to dietary staff that she was hungry. The DON recorded Resident #5 received a sandwich and juice but continued to shout for more food. Resident #4 asked Resident #5 to stop harassing the dietary staff at which time Resident #5 turned to Resident #4 and responded with expletives. The DON documented that Resident #4 stated that she became extremely frustrated because Resident #5 had been harassing her for weeks, and that this incident made her so angry that she rolled up behind Resident #5 and put her in a "headlock" from behind.

A police report dated 12/27/23 at 2:08 PM recorded that Resident #4 verbally threatened Resident #5 with bodily injury. Resident #5 alleged that Resident #4 threatened to choke her to death. Multiple attempts to interview the police officer were unsuccessful.

A Nursing General Note for Resident #5 dated 12/28/23 at 8:38 AM by the DON recorded that on 12/27/23 at approximately 1:45 PM, Resident #5 and Resident #4 were in the dining room. The DON recorded that Resident #4 reported that Resident #5 started harassing kitchen staff and when Resident #4 asked Resident #5 to stop harassing the kitchen staff, Resident #5 cursed at her. At this, the DON recorded that Resident #4 stated that she got upset and put Resident #5 in a

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"chokehold" because Resident #5 had been harassing her for weeks. The DON recorded that staff heard the commotion and separated the Residents. The RP for Resident #5 was made aware of the incident and the incident was recorded in the MD communication book.

During an interview with Resident #4 on 4/11/24 at 10:30 AM, and a follow-up interview on 4/12/24 at 9:15 AM, she stated that on 12/27/23, she remembered that she and Resident #5 were in the dining room. Resident #4 said she recalled Resident #5 kept messing with staff in the kitchen saying she was hungry. Resident #4 said she told Resident #5 to leave the kitchen staff alone and to eat the food she had been given. At that time, Resident #5 turned to her, got in her face, and said "f*** you." Resident #4 said she got so tired of Resident #5 talking to her that way, so she knocked on the activity door, which was a room in the dining room, but then decided she would go find a staff member. Resident #4 stated that as Resident #5 was leaving the dining room Resident #4 stated, she rolled up behind her (Resident #5) in the hallway and stated, that's when "I blacked out and then the next thing I knew staff told me that I grabbed her around her neck and was pulling her hair." Resident #4 stated that staff had to tell her what she did when she "blacked out" because she did not remember that she grabbed Resident #5 around her neck and pulled her hair. She stated staff also told her that on the same day, 12/27/23, there was another incident between the two Residents that occurred before she grabbed Resident #5 around her neck. Resident #4 said the Activity Assistant told her that while the two Residents were in the dining room before bingo, the Activity Assistant had to separate them because Resident #4

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placed her arms around the neck of Resident #5 and pulled her forward. Resident #4 stated she did not recall putting her arms around the neck of Resident #5 and pulling her forward, but that Resident #5 must have continued to curse at her in order for her to physically assault Resident #5 twice. Resident #4 stated this was not her usual behavior, she stated "I don't put my hands on people, and I asked God to forgive me for what I did." She stated that she did not have a chance to apologize to Resident #5 before she passed away and that she felt bad about that, but that Resident #5 should not have gotten in her face and cursed at her. Resident #4 stated that she talked to a Mental Health Nurse Practitioner after these incidents, who adjusted her medications for depression, which has helped.

The Human Resources (HR) Director was interviewed on 4/11/24 at 1:20 PM and stated that on 12/27/23 she was in the DON's office sometime after lunch, she did not recall the exact time, when she heard Resident #4 say "I told you not to f*** with me no more." When she went into the hallway, she saw Resident #4 and Resident #5 in the hallway in front of the dining room. The HR Director described that Resident #4's arm was around the neck of Resident #5, in a "headlock", Resident #5's face was red, and she was "gasping". The HR Director stated she told Resident #4 to let go of Resident #5, but she did not, so the HR Director had to physically separate them. The HR Director stated that the DON came into the hallway after the incident, so she reported to the DON what happened and called the Administrator to report to him what occurred.

An interview on 4/11/24 at 5:30 PM occurred with the DON. She stated that she was notified on

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12/27/23 by the HR Director that at around 1:45 PM, the HR Director overheard commotion coming from the hallway near the dining room. The HR Director said she went to the hallway and saw Resident #4 holding Resident #5 in a "headlock." The HR Director said she separated the Residents, and Resident #5 was taken to her room. The DON stated she notified the Administrator, started an investigation, contacted law enforcement, and the RP for Resident #5. The DON said she assessed and interviewed both Residents. Resident #4 was assessed without injury and when she was interviewed, she explained "she was tired of Resident #5 picking on her and this is what she gets." The DON said that about an hour later, Resident #4 came to her office, very remorseful and said she should not have choked Resident #5 but reported her concerns regarding Resident #5 to staff instead. She said that "she just lost it." Resident #4 said that Resident #5 picked on her for weeks and she was tired of it. She stated that while the Residents were in the dining room, Resident #5 started banging on the kitchen door, asking for food. The kitchen staff gave her a sandwich and juice, but Resident #5 continued to yell out for more food. Resident #4 said she told Resident #5 to stop shouting and to eat the food she had. That's when Resident #5 cursed at her, so Resident #4 went up to Resident #5 and put her in a "headlock." The DON stated that Resident #5 was assessed without injury, but during the assessment, she was still upset and cursing, so the DON had to allow her time to calm down. When Resident #5 was interviewed, she said that Resident #4 tried to "choke" her, but that she was fine. The DON said that both Residents were monitored every 15 minutes for two hours and then hourly for the next 24 hours. During the

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interview, the DON was asked by the Surveyor if she was aware that on 12/27/23 sometime before bingo, the Activity Assistant separated Resident #4 from Resident #5 in the dining room when she put her arms around the neck of Resident #5 and pulled her forward. The DON stated that she was not notified by staff that both Residents were separated earlier that day on 12/27/23 due to another physical altercation that occurred in the dining room. She said that if she had been made aware of the first physical altercation that occurred between the two Residents in the dining room, she would have separated the Residents then which would have prevented the second incident from occurring later in the hallway.

The Administrator stated in an interview on 4/11/24 at 5:45 PM that he was notified on 12/27/23 that Resident #4 physically assaulted Resident #5 in the hallway after an argument occurred in the dining room. He stated that he told the staff to separate the Residents, assess them for injury, place the Residents on monitoring every 15 minutes for the first two hours and then hourly checks thereafter. He also informed staff to notify law enforcement, the MD, the RP for Resident #5, and APS. The Administrator stated that when he returned to work on 12/28/23, he spoke to Resident #4 about her behavior and advised her that she should have reported her previous concerns with Resident #5 to the DON, that her behavior was unacceptable and that he expected to see improvement. Resident #4 stated that she understood what she did wrong and that her behavior needed to improve. He stated that at the time of the incident, Resident #4 was being followed weekly by mental health services for depression and after the physical abuse toward Resident #5, she was referred for psych services.

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He said that he was not notified of a prior incident involving physical abuse by Resident #4 to Resident #5 on the same day. He stated that he expected residents to be protected from abuse and if he had been notified of the first incident of physical abuse by Resident #4 that occurred in the dining room, he would have strategized a plan to prevent further interactions between the two Residents and protected Resident #5 from further abuse.

A phone interview with the MD occurred on 4/11/24 at 9:06 AM. The MD stated that she was notified that Resident #4 physically assaulted Resident #5 on 12/27/23 and that she remembered the incident vaguely. The MD stated she recalled Resident #4, physically assaulting other residents was not her history and such an incident had not occurred before with Resident #4. The MD stated both Residents were separated, both Residents were assessed without injury and assessed for any contributing factors that attributed to the events of 12/27/23. The MD stated that Resident #4 was already followed by mental health services for a history of depression and when this occurred, she was referred for psych services. The MD stated that to her knowledge, Resident #4 had no further incidents of physical assault. The facility put ongoing monitoring into place for both Residents and the family of Resident #5 did not want to press charges. MD stated that the facility had a responsibility to protect all residents in the facility and due to the facility's high-risk population of residents with a mental health/behavior history, that made managing behaviors difficult. The MD stated that she was no longer the MD at the facility, but while she was the MD, the facility met the mental health needs of the residents by

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making mental health services readily available.

2. Resident #2 was admitted to the facility on 2/1/24 from a previous nursing home with diagnoses that included other sexual dysfunction not due to a substance or known physiological condition, dementia, mild with other behavioral disturbance, cerebrovascular accident with hemiplegia affecting the left non-dominant side, anxiety disorder, depression, and adjustment disorder with depressed mood.

The February 2024 Medication Administration Record (MAR) for Resident #2 recorded a Physician (MD) order for Fluoxetine Hydrochloride (Prozac) 20 milligrams (mg) to give one tablet once daily for depression. The medication start date was 2/1/24.

A 2/2/24 Psychotherapy Diagnostic Assessment written by the Licensed Clinical Social Worker (LCSW) recorded Resident #2 displayed inappropriate sexual behaviors as noted in a previous assessment completed by the Psych Mental Health Nurse Practitioner (PMHNP) in a previous nursing home. The assessment also noted that Resident #2 met the criteria for adjustment disorder due to impulsivity and inappropriate sexual behaviors.

A phone interview with the LCSW occurred on 4/15/24 at 11:08 AM. She stated that her initial visit with Resident #2 occurred on 2/2/24 for Psychotherapy Talk Services. She stated that he was referred to mental health services regarding his diagnoses of adjustment disorder and mild dementia with other behavioral disturbance. The LCSW said during her initial assessment on

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2/2/24, he did not seem oriented and appropriate for services due to some confusion. The LCSW said she reviewed the progress notes of his history from the psych services he received while he was a Resident at the previous nursing home. The LCSW said she saw in the notes that he was accused by two female residents of inappropriately touching them, presented with mild cognitive impairment during his stay at the previous nursing home and received Prozac 20 mg daily to assist with sexual behaviors by decreasing his libido (sexual desire). The LCSW said she communicated to the Administrator that Resident #2 had a history of inappropriate touching while he was a Resident at the previous nursing home and that the electronic psych records from the previous nursing home were faxed to the facility.

A 2/7/24 psychiatric initial consult progress note written by the Doctor of Nurse Practitioner, (DNP) recorded that Resident #2 was referred for mild dementia with other behavioral disturbance and other sexual dysfunction not due to a substance or known physiological condition. The DNP documented that she reviewed the prior psych records from the previous nursing home which indicated Resident #2 displayed inappropriate sexual behaviors when he was noted touching another female resident, but that he had not been noted to display any current sexual behaviors at the facility. The DNP documented that the Administrator informed her of a conversation he had with Resident #2 regarding his behaviors at the previous nursing home and advised that those types of behaviors were not allowed in the facility under any circumstances. The DNP recommended to continue Prozac 20 mg daily.

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The DNP was interviewed by phone on 4/12/24 at 8:07 AM. She stated that Resident #2 was admitted to the facility from the previous nursing home where he received psych services with the same provider group. The DNP said she had access to his prior psych records because the psych services were from the same provider group. She stated that when she reviewed his previous psych records she noted his history of inappropriate sexual behavior, which she spoke to the Administrator about on 2/7/24. The DNP said Resident #2 was placed on Prozac 20 mg when he exhibited inappropriate sexual behaviors at the previous nursing home. The DNP said she had a very candid conversation with Resident #2 on her first visit with him on 2/7/24, regarding his behavior at the previous nursing home and he was informed that inappropriate sexual behavior was not going to be tolerated at the facility.

A 2/9/24 admission Minimum Data Set assessed Resident #2 with adequate hearing, adequate vision, clear speech, understood by others, and understands others, intact cognition, no mood disorders, no behaviors, no functional limitation in upper/lower extremity range of motion (ROM), and he independently used a manual wheelchair for ambulation.

Review of the 2/21/24 care plan for Resident #2 revealed he did not have a behavior symptoms care plan.

During an interview on 4/12/24 at 3:00 PM, Resident #2 said a few days after he came to the facility, he told the Administrator and Director of Nursing (DON) about the time he touched "(named Resident)" at the previous nursing home. Resident #2 said "They asked me if I had

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touched anyone inappropriate at (the previous nursing home) and I told them I touched her breast, she said I could, but the Administrator told me not to do that here, I told him that I would try to be good here, he said I had to behave and that I could not touch anyone here."

During an interview with the Administrator and DON on 4/12/24 at 1:45 PM, the Administrator said the LCSW notified him after her first session with Resident #2 on 2/2/24 that she had access to the psych progress notes for Resident #2 from the previous nursing home since Resident #2 was seen by a Practitioner from the same provider group. Per the Administrator, the LCSW said when she reviewed the psych progress notes from the previous nursing home, she saw documentation that Resident #2 had poor, inappropriate behaviors at the previous nursing home that required one-to-one monitoring. The Administrator stated that the LCSW was not specific about the behaviors, and that he did not ask specifics, but that the Administrator and the DON went to Resident #2 and asked him what happened. The DON said when interviewed, Resident #2 said that he tried to "fist bump" two residents and accidentally contacted their shoulder, and then he said, "I did not touch anyone." The Administrator stated he advised Resident #2 of the expectation to have appropriate behavior while he was a Resident at the facility, Resident #2 expressed understanding. The Administrator stated that he did not request the psych notes from the previous nursing home at that time.

Resident #3 was re-admitted to the facility on 1/22/24 with diagnoses that included Alzheimer's disease, major depressive disorder, and

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dementia without behavioral disturbance.

A 1/29/24 quarterly MDS assessed Resident #3 with severely impaired cognition, dependent on staff for all activities of daily living (ADL) and used a wheelchair for ambulation.

Resident #1 was admitted to the facility on 5/31/23 and discharged home on 3/2/24.

A 12/5/23 quarterly MDS assessment indicated Resident #1's cognition was intact.

A 2/26/24 Facility Reported Investigation for resident abuse recorded that on 2/26/24 at 4:40 PM, staff notified nurse leadership of poor resident interaction that was witnessed by Resident #1. The Summary of Investigative Findings recorded that on 2/26/24, Resident #1 witnessed Resident #2 touch Resident #3 on the leg while the Residents were seated in the commons area of the West Unit. Resident #1 yelled for Resident #2 to stop touching the leg of Resident #3 which prompted staff to separate Resident #2 from Resident #3. Resident #2 was placed on one-to-one monitoring ongoing, Resident #3 was assessed without injury, and notifications were made to the Administrator, law enforcement, Adult Protective Services (APS), the Responsible Party (RP) for Resident #3, the Emergency Contact for Resident #2, and the MD. The Summary of Findings included a written statement from Resident #1 which recorded "I, (Name of Resident), saw the young man put his hands between a resident's legs, the resident was trying to move his hands, but he continued to rub her between her legs or crotch; I saw it and approached him telling him to stop because it was wrong."

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A 2/26/24 police report noted that law enforcement was notified at 5:03 PM on 2/26/24 that the listed suspect (name withheld) sexually assaulted the victim (name withheld) at the facility on 2/26/24 at approximately 5:00 PM. The North Carolina Offense Category was listed as adult sex offense/assault/sexual battery, and the classification was listed as forcible fondling. Attempts to interview law enforcement were unsuccessful.

A 2/28/24 11:34 AM Triage Note from the DON to DNP recorded that on 2/26/24, Resident #2 was caught fondling a female resident who was oriented to self only due to dementia, the Resident (Resident #2) was placed on one-to-one since then, he is on Prozac for depression, please advise. The DNP responded on 2/28/24 to the Triage Note from the DON that Resident #2 was not on Prozac for depression, but for his history of inappropriate sexual behavior, to refer to the DNP progress note of 2/7/24, increase Prozac to 40 mg daily and under no circumstances leave Resident #2 alone with Resident #3.

A 2/29/24 Resident Incident Report for Resident #3 recorded that on 2/26/24 at 5:00 PM, Resident #3 was seated in her wheelchair when Resident #1 screamed "get away from her" when she saw Resident #2 put his hands between the legs of Resident #3. The report recorded that Resident #3 began moving the hands of Resident #2, but Resident #2 continued rubbing the Resident's leg. The report described Resident #3 as alert to person only, the "Immediate Action Taken" as staff separated and monitored the two Residents, and the MD and RP for Resident #3 were notified.

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A 3/1/24 Resident Incident Report for Resident #2 recorded that on 2/27/24 at 5:38 PM, Resident #1 yelled "What are you doing" at Resident #2 and accused him of rubbing Resident #3 between her legs. The Resident Incident Report described Resident #2 as alert, oriented to person, place, and time. The "Immediate Action Taken" recorded Resident #2 was sent to the emergency room (ER) for a psych evaluation and returned to the facility before midnight with no new orders. The Administrator, MD and Emergency Contact for Resident #2 were notified of the incident.

During review of the 3/1/24 Resident Incident Report for Resident #2, with the Administrator on 4/10/24 at 12:30 PM, he stated that the date of 2/27/24 was an error and should have been 2/26/24.

The medical record for Resident #2 included progress notes from the previous nursing home faxed to the facility on 3/1/24 at 10:02 AM which included the following:
- A Triage Note dated 1/16/24 recorded Resident #2 inappropriately touched another resident's breast and the staff requested medication management.
- A Physician Assistant (PA) progress note dated 1/16/24, recorded the PA was asked to assess Resident #2 for sexual behavior issues due to complaints by staff of inappropriate gestures and touching. The progress note recorded a MD order was written for a psych referral and for Prozac 20 mg daily.
- A Psych Mental Health Nurse Practitioner (PMHNP) progress note dated 1/22/24, recorded Resident #2 was seen for an urgent Telehealth psych evaluation for the diagnoses of mild

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dementia, with other behavioral disturbance and other sexual dysfunction not due to a substance or known physiological condition after accusations from two female residents of inappropriately touching them. The progress note recorded that Resident #2 reported to the PMHNP when interviewed that he accidently touched a female resident. The progress note recorded that the Resident was placed on Prozac 20 mg daily after this incident to assist with sexual behaviors by reducing his libido.

A 3/1/24 psychotherapy progress note written by the LCSW recorded that staff reported that on 2/26/24, Resident #2 displayed inappropriate sexual behaviors. The progress note recorded that Resident #2 acknowledged during the 3/1/24 psychotherapy session that he inappropriately touched a resident, made hand motions towards his private area when asked where he touched the resident and stated that the resident said he could. The note also recorded that Resident #2 stated that he was being kept in his room, but that he did not want to stay there when he referred to the one-on-one support provided by the facility because of his inappropriate behavior. The progress note recorded that he expressed he understood that he should not ask other peers to be touched inappropriately as some residents may not have the cognition to consent appropriately. The progress note recorded Resident #2 received Prozac 40 mg daily to decrease libido and manage his sexual behaviors.

Resident #2 was interviewed on 4/10/24 at 1:00 PM. He stated that he was recently admitted to the facility and that since his admission, staff spoke to him about touching a resident. Resident

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#2 said he touched a resident on her "vagina" while she was clothed. When asked to show the surveyor where he touched the Resident, he touched the center of his pubic area and said, "I touched her here, I asked her if I could touch her, and she said yes." He said they were in the TV area watching TV near the nurse's station when he touched Resident #3. Then he said, "But then "(named Resident #1)" yelled at me to stop, I told her what is it to you, nobody is touching you, but she told on me, so I am supposed to be going to court so Mecklenburg can get guardianship of me. A 66-year-old with a guardian, what do I need a guardian for? Now I have a sitter with me all the time. It's like I am a chap." When asked if anything like this happened before he said "yeah, I had a sitter while I was at a (previous nursing home), I touched a lady there, I asked her too and she said I could, but then I got in trouble and had to be watched."

Resident #3 was interviewed on 4/10/24 at 1:19 PM and did not recall the sexual abuse that occurred on 2/26/24.

The Medication Aide (MA) was interviewed on 4/10/24 at 4:22 PM and stated she was the assigned MA on 2/26/24 on the West Unit. The MA said she saw Resident #2 and Resident #3 seated in their wheelchairs next to each other in the common area watching TV, but the Residents were not interacting with each other. Then "sometime" after 3 PM, she was passing medications when she heard Resident #1 say "something like" he is going closer to her, he is touching her, but then she saw a Nurse respond and the Nurse removed Resident #2 immediately. The MA said that the police were called, interviewed Resident #2 and Resident #3,

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Resident #2 was placed on one-to-one monitoring and that she had not seen the two Residents near each other since. The MA said she was not aware of any other inappropriate incidents with Resident #2 and other residents.

Nurse #2 stated in a phone interview on 4/10/24 at 8:39 PM that she was the assigned Nurse on the 3P - 11P shift, on the West Unit the day the incident happened. She said she was the assigned Nurse for the first time for Resident #2 and Resident #3. Nurse #2 said she was standing at the medication cart around dinner time when Resident #2 and Resident #3 were both in their wheelchairs next to each other watching TV. Then she heard another Resident yell "get your hands off her." When the Resident yelled out, she saw Resident #2 physically move his body backwards away from Resident #3. Nurse #2 stated that Resident #2 could move around the facility independently in his wheelchair, so she moved Resident #3 to the other side of the sofa, away from Resident #2 and asked staff to watch the Residents while she went to notify the DON. Nurse #2 said she left the unit and told the DON what was going on, the DON came to the unit, and removed Resident #2 from the West Unit. Nurse #2 stated she was present when the DON interviewed Resident #2. When he was asked what happened Resident #2 said "I touched her." Nurse #2 described Resident #3 as having periods of confusion and Resident #2 as alert and oriented. Nurse #2 said she called medic to transport Resident #2 to the ER for a psych eval, but that he returned to the facility on the next shift with no new orders. Nurse #2 said she was not aware of any other inappropriate incidents with Resident #2 and other residents.

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During a phone interview on 4/11/24 at 1:00 PM with the family of Resident #3, the family member stated that after the facility told her that Resident #3 was sexually assaulted, she spoke to her, but the Resident did not remember what happened. The family member stated that Resident #3 would be upset if she knew she was assaulted like that.

The DNP was interviewed by phone on 4/12/24 at 8:07 AM and stated that when she was notified via triage that Resident #2 touched Resident #3 inappropriately, she discussed with facility staff to increase the Prozac for Resident #2 to 40 mg daily, monitor his behaviors and notify her if the behaviors increased. She stated that the facility placed Resident #2 on one-to-one monitoring. The DNP said during her next visit with him after the sexual abuse, he acknowledged what he did to Resident #3. The DNP said she expected the facility to do what they could to keep residents safe, especially since the facility housed a high-risk population. She said the facility staff needed to keep Resident #2 in close monitoring and redirect his sexual behavior if it occurred.

During a phone interview on 4/15/24 at 11:08 AM, the LCSW said she was asked to assess Resident #2 again after staff reported that he touched Resident #3 inappropriately on 2/26/24. The LCSW said during this session he had limited communication and did not engage in the session. The LCSW said she followed up again because the Administrator said the facility staff were getting a different level of communication from Resident #2. The LCSW said that during her session on 3/1/24, Resident #2 shared that he was being kept in his room because he inappropriately touched a peer (Resident #3) after she said, "I could," but that he did not want to stay

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in his room. Resident #2 motioned towards his private area to indicate that's where he touched the peer (Resident #3). The LCSW said she completed a cognitive assessment during the 3/1/24 session and he demonstrated no cognitive impairment. During the session he verbalized that he should not ask other peers/staff to touch them inappropriately.

A phone interview with the Medical Director (MD) occurred on 4/11/24 at 9:06 AM and she stated that she was no longer the MD at the facility, as of the first week of March 2024. The MD stated that she was notified that Resident #2 touched Resident #3 inappropriately, the facility separated the Residents immediately, and both residents were assessed without injury. Resident #2 was placed on one-to-one monitoring to ensure he did not have access to Resident #3 or any other female residents and monitored closely. Resident #2 was referred for psych eval/services with medication adjustments, and the family of Resident #3 was contacted to see what next steps they wanted to take. The MD said that the police were contacted and came to the facility to interview staff/residents. The MD said she did not feel comfortable speaking to whether Resident #2 was a danger to himself/others, but that he needed some staff assistance, had some confusion at times, due to his diagnosis of mild dementia, but that Resident #2 was also aware of his actions. The MD said that the facility had a responsibility to protect all residents in the facility due to the facility's high-risk population of residents with a mental health/behavior history which could be difficult to manage. The MD said she felt the facility met the mental health needs of the residents and made mental health services readily available.

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During an interview with the Administrator and DON on 4/10/24 at 12:30 PM and a follow up interview on 4/12/24 at 1:45 PM, the DON stated she investigated the sexual abuse that occurred on 2/26/24 towards Resident #3. The DON stated Resident #1 said she observed Resident #2 put his hands on the private area of Resident #3 and shouted to him "stop, what you are doing, why are you doing that?" Resident #2 stopped touching Resident #3 and the staff separated the two Residents. The DON stated she obtained a written statement from Resident #1, whom she described as alert and oriented, immediately assessed Resident #3 which resulted in no injury, sent Resident #2 to the ER for a psych evaluation, notified the Administrator of the sexual abuse, the police, APS, the MD, and the family of both Residents. The DON stated she interviewed other staff/residents but there were no other witnesses to the incident. She stated that Resident #2 was placed on one-to-one monitoring as instructed by the Administrator. The DON stated she was not aware that Resident #2 exhibited sexual behavior in a previous nursing home. The interview continued as the Administrator stated he received a phone call from the DON on 2/26/24 who reported that Resident #2 touched Resident #3 inappropriately, but that he did not remember if the DON explained to him how Resident #2 touched Resident #3. The Administrator said he told the DON to put Resident #2 on one-to-one monitoring until the Administrator arrived the next morning. The Administrator said that the police were called, they responded and interviewed Resident #1, Resident #2, and Resident #3, but that criminal charges could only be filed by Resident #3 or by the family. The Administrator stated he spoke to

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the family of Resident #3 and advised the family of the right to file charges. The Administrator stated when the police said they could not arrest Resident #2 on 2/26/24, the facility transferred Resident #2 to the ER for a psych evaluation, but he returned to the facility with no new orders. The Administrator stated that Resident #2 received Prozac 20 mg daily for depression when he was admitted to the facility. He stated that when the facility notified the DNP of the sexual abuse that occurred on 2/26/24, she increased the Prozac to 40 mg daily for inappropriate sexual behavior. The Administrator stated he interviewed Resident #1 on 2/27/24 and she told him that Resident #2 touched Resident #3 on her leg and when he interviewed other staff/residents, there were no other witnesses or previous reports of sexual behavior by Resident #2. The Administrator stated after the incident of 2/26/24, he reviewed the medical record for Resident #2 and found no record of sexual behavior.

The Administrator was notified of immediate jeopardy on 4/11/24 at 4:45 PM.

The facility provided a corrective action plan with a completion date of 03/02/24.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
1. On 12/27/23 during the 7a - 3p shift, the Activity Director reported to nursing that Resident #4 placed both arms around the neck/shoulder area of Resident #5, a confused resident, and pulled Resident #5 towards her when she was approached by Resident #5 in the dining room after a verbal altercation between the two

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F 600	Continued From page 26 Residents On 12/27/23 during the 7a - 3p shift, the Activity Director reported to nursing that Resident #4 placed both arms around the neck/shoulder area of Resident #5, a confused resident, and pulled Resident #5 towards her when she was approached by Resident #5 in the dining room after a verbal altercation between the two Residents. On 12/27/2023, at approximately 1:45pm, Resident # 4 was sitting in the facility's dining room in her wheelchair when a staff member brought Resident #5 into the dining room. Resident # 5 proceeded to shout that she was hungry to get the attention of the kitchen staff. A sandwich and juice were brought to the resident, but the resident continued to shout out after the kitchen staff went back into the kitchen and closed the door. Resident #4 then asked Resident #5 to "stop harassing the kitchen staff and eat the food that was brought to her". On hearing what Resident #4 stated, Resident #5 turned around and uttered expletives to Resident #4. Resident #4 explained that when she heard the expletives, she was extremely frustrated because Resident #5 has been harassing her for weeks and this incident made her get so angry that she rolled up to Resident #5 and put her in a headlock from behind. Staff members outside the dining room heard the commotion and ran in to separate the two residents. The residents were separated by the Human Resources (HR) Manager on 12/27/23. Resident #5 was examined by the Director of Nursing for any injuries. No injuries were noted, and the resident was taken to her room while Resident #4 was allowed to remain in the dining room. The facility's Nurse Practitioner was informed of the incident on 12/27/2023. On 12/27/2023 Law Enforcement	F 600		

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and Adult Protective Services (APS) was notified. Resident #4 is her own Responsible Party. Resident #5's Responsible Party was notified. Resident # 4 was placed on Q15mins (every 15 minutes) checks for 2hrs (hours) and then Q1hr for the next 24 hrs on 12/27/2023. No aggressive behavior was observed during the observation period. Resident #4's next psych visit was 1/9/2024. No changes were made to the medications. Progress notes state that the resident will have follow up in one month.

2. On 2/26/24 Resident # 1 observed Resident # 2 touch Resident #3 in her private area in the common area of west unit nursing station while all were sitting in the area congregating watching television. Resident # 1 announced for Resident # 2 to abstain from touching Resident # 3 and yelled which prompted staff response to separate Resident # 2 from Resident # 3. Resident # 2 was placed on 1 on 1 monitoring until further investigation. Resident # 3 was assessed for injuries by Nurse #1 immediately following incident on 2/26/2024 with no noted injuries. Law enforcement was notified on 2/26/2024. Adult Protective Services (APS) was notified of the occurrence on 2/26/2024. Resident # 3's responsible party was notified of occurrence on 2/26/2024. Resident # 2's emergency contact was also notified of the occurrence on 2/26/2024. Resident #2 was transferred to the hospital on 2/26/24 for a psych evaluation and returned to the facility. Resident #2 had a history of sexual aggression prior to admission, he was followed by the same psych provider in the previous facility, the provider notified the facility after admission that Resident #2 had a history of behaviors, and his medical record history was available for review. The medical records information sent

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from referring hospitals for all referrals will be reviewed for history of behaviors or utilization of anti-psychotic medications prior to admission by the Director of Nursing and/or Administrator. The medical records will be inclusive of but not limited to psychiatric notes, behavioral documentation, history and physical, and nursing and/or physician practitioner progress notes. On 2/27/2024 the Administrator educated the Admissions Director of review process for all new referral's approval process.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
1.Abuse questionnaires were completed by the facility's Social Worker on all residents with Brief Interview for Mental Status (BIMS) score of 9 and above with no adverse responses. Questionnaires were completed on 12/27/2023. Director of Nursing/Wound Nurse and/or Floor Nurse completed skin assessment for all residents with a BIM score below 9 as of 12/28/2023. Director of Nursing, Administrative Nurses and Social Worker reviewed the electronic medical records and care plans to identify current residents with behaviors of aggression as of 12/28/2023.

2. On 2/27/24 the Social Worker Assistant interviewed all residents with a BIM's score of 9 or above. The questions included with Social Worker Assistant's interviews with residents were the following: 1. Have you had inappropriate interactions with others that was uncomfortable? i.e. personal space was crossed with another resident. If so, describe specifically your encounter in detail. 2. Have you observed poor interactions from residents on your unit toward

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others, if so, describe your observation. Based on resident interviews there were no other reported incidents of abuse from any residents. Director of Nursing completed skin assessments for residents with a BIMs score of 9 or lower as of 2/29/2024. All staff during investigation period 2/27/2024 through 3/01/2024 were asked questions Social Worker and/or Administrator which included: 1. Have you observed poor interactions from Resident # 2 towards others, if so, describe the observation. 2. If not, how would you describe Resident # 2 in one word. Based on staff interviews there were no other reported incidents of abuse from Resident # 2.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
1. On 12/27/2023 the Director of Nursing educated 100% of facility staff on the facility abuse policy to include residents right to be free from abuse to include sexual, physical, mental, verbal and misappropriation of property and well as signs of abuse and reporting of abuse or potential abuse education was completed on 12/27/2023. Staff will not be permitted to work until education is completed. The Director of Nursing will verify completion of education. Education will be included for new hires during orientation.

As of 12/28/2023 The Director of Nursing, Administrator and the Interdisciplinary Team to include Social Worker, Unit Managers, Activity Director and Medical Director when available will review all progress notes to identify residents with aggressive behaviors during morning meeting Monday thru Friday. Education for this process was provided to the IDT team as of 12/28/2023.

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The Physician will be notified of behaviors by Director of Nursing and/or Unit managers, the Physician's recommendations will be implemented by Unit Managers, care plan will be updated by Care Plan Nurse with new interventions, new interventions will be placed in the resident care guide Nurse Managers, staff will follow the stop and watch process which is staff observation of behavior changes with residents in the facility's electronic system to alert the licensed nurse of any changes in behaviors or increased aggressive behaviors. As off 3/01/2024 care plan nurses were reeducated on the intervention process behaviors and care guide updates by the administrator. DON/Administrator reeducated all staff of the stop and watch process as of 3/01/2024. License nurses will request from the Physician a Psych referral if resident is not currently being treated by Psych services. The Administrator/DON will inform psych services for any resident changes in residents already under psych services for any needed changes. The facility's Ambassadors (Social Worker, Activities, Nurse Managers, Human Resources, and any other assigned employees to be determined by the Administrator) will observe behaviors during rounds and report any observed aggressive behaviors to the Administrator or the Director of Nursing. Administrator re-educated the ambassadors of observing and reporting residents with behaviors as of 3/01/2024. The Responsible Party will be made aware of resident's aggressive behaviors as soon as possible and updated with new interventions by the licensed nurse as of 3/01/2024.

2. As of 3/1/2024 all staff have been re-educated on the facility abuse policy by the Director of Nursing and/or Administrator. Education included

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but not limited to the various types of abuse such as physical, mental, sexual, neglect, misappropriation of property, and involuntary seclusion. All new hires in orientation receive information on the abuse policy by Human Resources with a signed acknowledgement of understanding. Any staff not scheduled during investigation period (2/27/2024-3/1/2024 or PRN (as needed) were explained the policy before next scheduled shift by Human Resources.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
1. The Director of Nursing/Unit Managers will audit 100% progress notes and incident reports during clinical meetings beginning on 12/29/23. Auditing will be completed 5 x per week for 4 weeks then weekly for 4 weeks starting on 12/29/2023. The Director of Nursing will report all findings of audits to the Quality Assurance Performance Improvement committee to include Administrator, Director of Nursing, Activity Director, Unit Managers, Human Resources and Medical Director when available monthly until substantial compliance is obtained. Facility completed Ad Hoc QAPI on 12/27/23 to review investigation.

2. On 2/26/24, the Administrator reviewed the schedule to ensure that facility has an individual assigned by staffing coordinator as 1 on 1 supervision with Resident # 2, during 1st and 2nd shift and when out of bed at night as resident is unable to ambulate on his on. Resident # 2's wheelchair is removed from room at night for safety and when in bed. Resident # 2 is not in hallways or other resident areas unsupervised. Any behaviors identified during the 1:1

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supervision will be documented and reported to the facility administrator and director of health service to ensure monitoring of resident. Auditing will be completed 5 x per week for 4 weeks then weekly for 4 weeks starting on 2/29/2024. The Director of Nursing will report all findings of audits to the Quality Assurance Performance Improvement committee to include Administrator, Director of Nursing, Activity Director, Unit Managers, Human Resources and Medical Director when available monthly until substantial compliance is obtained.

On 2/27/2024 Facility completed AdHoc QAPI to review investigation and current action plan to ensure all components were done and followed. The facility administrator and director of health services is responsible for continued compliance.

The IJ removal date: 03/02/2024

On 4/29/24 the facility's credible allegation of immediate jeopardy removal date of 3/2/24 was validated. The validation was evidenced by interviews with staff and residents, record review, and review of in-service agendas and staff attendance records. In-service agendas and staff attendance records revealed staff were in-serviced on the facility's Abuse, Prevention, Intervention, Reporting, and Investigation policy, effective November 2016, One on One Monitoring and updating the care guide. Interviews conducted with staff from all shifts and all disciplines, and interviews conducted with residents indicated knowledge of the in-services provided. Review of QA records, monitoring tools and audits revealed ongoing monitoring systems were in place by the facility.

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F 607 SS=J	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 by: Based on a resident interview, staff interviews and record review, the facility failed to report an incidence of physical abuse to facility administration to protect a resident from further physical abuse. Resident #5 experienced physical	F 607	Past noncompliance: no plan of correction required.	

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abuse twice on 12/27/23. Both incidents occurred on 12/27/23 before 2:30 PM. Resident #4 first physically assaulted Resident #5 in the dining room. This occurrence of physical abuse was not reported to the facility administration. As a result, Resident #4 physically assaulted Resident #5 again in the hallway. The deficient practice occurred for 1 of 4 sampled residents reviewed for abuse (Resident #5).

The findings included:

The facility's policy, Abuse Prevention, Intervention, Reporting and Investigation, effective November 2016, recorded in part, "The facility will ensure the protection, prompt reporting, and interventions in response to alleged, suspected, or witnessed abuse of any resident. It is the responsibility of employees to promptly report to facility management any incident or suspected incident of abuse from other residents, staff, family, or visitors. Residents are to be protected during incident investigations by ensuring the administrator is immediately informed. A resident who is allegedly mistreated by another resident is removed from contact with that resident during the investigation. It is the facility policy that residents will be protected from alleged offender(s)."

Resident #5 re-admitted to the facility on 6/24/22. Diagnoses included dementia with agitation, anxiety disorder, mood affective disorder, psychosis, and major depressive disorder.

Resident #4 re-admitted to the facility on 10/26/22. Resident #4 was her own responsible party (RP). Diagnoses included recurrent major depressive disorder, post-traumatic stress

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disorder, and anxiety disorder.

Review of a Facility Reported Incident completed by the Director of Nursing (DON) and dated 12/27/23 at 1:45 PM indicated Resident #4 and Resident #5 were both in the dining room when Resident #5 shouted to dietary staff that she was hungry. Resident #5 received a sandwich and juice but continued to shout for more food. Resident #4 asked Resident #5 to stop harassing the dietary staff at which time Resident #5 turned to Resident #4 and responded with expletives. Resident #4 stated that she became extremely frustrated because Resident #5 had been harassing her for weeks, and that this incident made her so angry that she rolled up behind Resident #5 in the hallway and put her in a "headlock" from behind.

A Resident Incident Report for Resident #5 completed by the DON recorded that on 12/27/23 at 1:45 PM, Resident #4 and Resident #5 were both in the dining room when Resident #5 began to harass the kitchen staff. When Resident #4 told Resident #5 to stop harassing the staff, Resident #5 turned to Resident #4 and cursed at her. At this, Resident #4 stated that she got upset and put Resident #5 in a "chokehold" in the hallway, witnessed by the Human Resources (HR) Director, because Resident #5 had been harassing her for weeks. The Resident Incident Report documented that Resident #5 was assessed by the DON without injury. The Resident Incident Report did not record that a second incident of physical abuse by Resident #4 against Resident #5 also occurred on 12/27/23 before 2:30 PM.

A Nursing General Note dated 12/28/23 at 8:38

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AM by the DON recorded that on 12/27/23 at approximately 1:45 PM, Resident #5 and Resident #4 were in the dining room. Resident #4 reported that Resident #5 started harassing kitchen staff and when Resident #4 asked Resident #5 to stop harassing the kitchen staff, Resident #5 cursed at her. At this, Resident #4 stated that she got upset and put Resident #5 in a chokehold because Resident #5 had been harassing her for weeks. Staff heard the commotion and separated the Residents. The Nursing General Note recorded that Resident #5 was assessed without injury. The Nursing General Note dated 12/28/23 did not record that a second incident of physical abuse by Resident #4 against Resident #5 also occurred on 12/27/23 before 2:30 PM.

During an interview with Resident #4 on 4/11/24 at 10:30 AM, and a follow-up interview on 4/12/24 at 9:15 AM, she stated that on 12/27/23, she remembered that she and Resident #5 were in the dining room "sometime before bingo" which was scheduled for 2:30 PM, when Resident #5 kept messing with staff in the kitchen saying she was hungry. Resident #4 said she told Resident #5 to leave the kitchen staff alone and to eat the food she had been given. At that time, Resident #5 turned to her, got in her face, and said "f*** you." Resident #4 said she got so tired of Resident #5 talking to her that way, so she knocked on the activity door, which was an office inside the dining room, but then decided she would go find a staff member. Resident #4 stated that as Resident #5 was leaving the dining room Resident #4 stated, she rolled up behind her (Resident #5) in the hallway and stated, that's when "I blacked out and then the next thing I knew staff told me that I grabbed her around her

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neck and was pulling her hair." Resident #4 stated that staff had to tell her what she did when she "blacked out" because she did not remember that she grabbed Resident #5 around her neck and pulled her hair. She stated staff also told her that on the same day, 12/27/23, there was another incident between the two Residents that occurred before she grabbed Resident #5 around her neck. Resident #4 said the activity assistant told her that while the two Residents were in the dining room before bingo, the activity assistant had to separate them because Resident #4 placed her arms around the neck of Resident #5 and pulled her forward. Resident #4 stated she did not recall putting her arms around the neck of Resident #5 and pulling her forward, but that Resident #5 must have continued to curse at her in order for her to physically assault Resident #5 twice. Resident #4 stated this was not her usual behavior, she stated "I don't put my hands on people, and I asked God to forgive me for what I did." She stated that she did not have a chance to apologize to Resident #5 before she passed away and that she felt bad about that, but that Resident #5 should not have gotten in her face and cursed at her. Resident #4 stated that she talked to a mental health nurse practitioner after these incidents, who adjusted her medications for depression, which has helped.

An interview with the Activity Director (AD) and the Activity Assistant occurred on 4/11/24 at 5:37 PM. During the interview, the AD stated that on 12/27/23, she did not know the exact time, but sometime before bingo which was scheduled at 2:30 PM, she was in her office, which was a room inside the dining room, and she heard Resident #5 talking loudly in the dining room and using profanity. Resident #4 told Resident #5 "nobody

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wants to hear that." During the interview, the Activity Assistant stated that before the 2:30 PM bingo activity, she was not sure of the exact time, she was in/out of the dining room setting up bingo, and she told Resident #5 to calm down. The Activity Assistant stated that Resident #5 got upset, continued using profanity and yelled at Resident #4 "b**** I will f*** you up." The Activity Assistant stated she called the AD to come and help her when she saw Resident #5 propel in her wheelchair towards Resident #4, Resident #4 put her arms around the neck/shoulders of Resident #5 and pulled her forward. The Activity Assistant stated she separated the Residents, directed Resident #4 to go to her room while the AD took Resident #5 to her room. The Activity Assistant said she returned to setting up bingo and that she did not report to administration that she had to separate the two Residents. The interview continued and the AD stated that the Activity Assistant asked for her help. The AD stated that when she came out of her office into the dining room, she saw the Activity Assistant "pulling the two residents apart." The AD said that the Activity Assistant told her what occurred, the AD took Resident #5 to her nurse (Nurse #1), reported the incident to Nurse #1 and returned to the dining room for bingo. The AD stated that she did not report the incident to the administration, but rather took Resident #5 to her Nurse.

Nurse #1 was interviewed via phone on 4/12/24 at 3:35 PM. He stated that he was the assigned Nurse on the South Unit for the 7A - 3P shift on 12/27/23. He stated that close to the end of the shift on 12/27/23 he heard staff stating that Resident #5 said something to Resident #4 that got her upset and caused her to hit Resident #5. Nurse #1 said he was told that an incident report

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had been made, but he could not recall who told him that, so he did not make a report about the incident because he did not witness it and he was not asked to do any follow up. Nurse #1 said after he heard about the incident, he did recall seeing Resident #5 in her wheelchair at the end of the hall near her room, but that she did not mention what occurred. Nurse #1 said he was not made aware that there were two incidents between Resident #4 and Resident #5 that day. Nurse #1 stated that if staff had reported the first incident directly to him, he would have contacted the DON and administrator to get the police involved if a resident was assaulted and followed the facility's abuse policy to protect Resident #5 from further physical abuse.

The Human Resources (HR) Director was interviewed on 4/11/24 at 1:20 PM and stated that on 12/27/23 she was in the DON's office sometime after lunch, she did not recall the exact time, when she heard Resident #4 say "I told you not to f*** with me no more." When she went into the hallway, she saw Resident #4 and Resident #5 in the hallway in front of the dining room. The HR Director described that Resident #4's arm was around the neck of Resident #5, in a "headlock", Resident #5's face was red, and she was "gasping". The HR Director stated she told Resident #4 to let go of Resident #5, but she did not, so the HR Director had to physically separate them. The HR Director stated that the DON came into the hallway after the incident, so she reported to the DON what happened and called the administrator to report to him what occurred. The HR Director stated that she was not aware of a second incident of physical abuse by Resident #4 towards Resident #5 that occurred in the dining room.

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An interview on 4/11/24 at 5:30 PM occurred with the DON. She stated that she was notified on 12/27/23 by the HR Director that at around 1:45 PM, the HR Director overheard commotion coming from the hallway near the dining room. The HR Director said she went to the hallway and saw Resident #4 holding Resident #5 in a "headlock." The HR Director said she separated the Residents, and Resident #5 was taken to her room. The DON stated she notified the administrator and started an investigation. The DON said that both Residents were monitored every 15 minutes for two hours and then hourly for the next 24 hours. During the interview, the DON was asked by the surveyor if she was aware that on 12/27/23 sometime before bingo, the activity assistant separated Resident #4 from Resident #5 in the dining room when she put her arms around the neck of Resident #5 and pulled her forward. The DON stated that she was not notified by staff that both Residents were separated earlier that day on 12/27/23 due to another physical altercation that occurred in the dining room before bingo. She said that if she had been made aware of the first physical altercation that occurred between the two Residents in the dining room, she would have separated the Residents then which would have prevented the second incident from occurring later in the hallway.

The Administrator stated in an interview on 4/11/24 at 5:45 PM that he was notified on 12/27/23 by the DON that Resident #4 physically assaulted Resident #5 in the hallway after an argument occurred in the dining room. He stated he did not recall the exact time he was notified. He stated that he told the staff to separate the

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Residents, assess them for injury, place the Residents on monitoring every 15 minutes for the first two hours and then hourly checks thereafter. When asked by the Surveyor if he was aware that two incidents of physical abuse occurred on 12/27/23 between the two Residents, he said that he was not notified of a prior incident involving physical abuse by Resident #4 to Resident #5 on the same day. He stated that he was only aware of the physical abuse by Resident #4 that occurred in the hallway. He stated that he expected residents to be protected from abuse and if he had been notified of the first incident of physical abuse by Resident #4 that occurred in the dining room, he would have strategized a plan to prevent further interactions between the two residents and protected Resident #5 from further abuse that occurred in the hallway.

The Administrator and the DON were notified of immediate jeopardy on 4/12/24 at 2:05 PM.

The facility provided the following corrective action plan with a completion date of 12/29/23.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
On 12/27/23 during the 7a - 3p shift, the Activity Director reported to nursing that Resident #4 placed both arms around the neck/shoulder area of Resident #5, a confused resident, and pulled Resident #5 towards her when she was approached by Resident #5 in the dining room after a verbal altercation between the two Residents. This resident-to-resident altercation was not reported to the administration, and therefore protection was not put into place or implemented.

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On 12/27/2023, at approximately 1:45pm, Resident # 4 was sitting in the facility's dining room in her wheelchair when a staff member brought Resident #5 into the dining room. Resident # 5 proceeded to shout that she was hungry to get the attention of the kitchen staff. A sandwich and juice were brought to the resident, but the resident continued to shout out after the kitchen staff went back into the kitchen and closed the door. Resident #4 then asked Resident #5 to "stop harassing the kitchen staff and eat the food that was brought to her". On hearing what Resident #4 stated, Resident #5 turned around and uttered expletives to Resident #4. Resident #4 explained that when she heard the expletives, she was extremely frustrated because Resident #5 has been harassing her for weeks and this incident made her get so angry that she rolled up to Resident #5 and put her in a headlock from behind. Staff members outside the dining room heard the commotion and ran in to separate the two residents. The residents were separated by the Human Resources (HR) Manager. Resident #5 was examined by the Director of Nursing for any injuries. No injuries were noted, and the resident was taken to her room while Resident #4 was allowed to remain in the dining room. The facility's Nurse Practitioner was informed of the incident on 12/27/2023. Law Enforcement was notified on 12/27/2023 and Adult Protective Services (APS) was notified on 12/27/2023. Resident #4 is her own Responsible Party. Resident #5's Responsible Party was notified. Resident # 4 was placed on Q15mins every 15 minutes) checks for 2hrs (hours) and then Q1hr for the next 24 hrs on 12/27/2023. No aggressive behavior was observed during the observation period. Resident #4's next psych visit

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was 1/9/2024. No changes were made to the medications. Progress notes states that the resident will have follow up in one month.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
On 12/27/2023 abuse questionnaires were completed by the facility's Social Worker on all residents with Brief Interview for Mental Status (BIMS) score of 9 and above with no adverse responses to determine if any other residents had any unidentified allegations of abuse that had not been reported. The questions included with Social Worker Assistant's interviews with residents were the following: 1. Have you had inappropriate interactions with others that was uncomfortable? i.e. personal space was crossed with another resident. If so, describe specifically your encounter in detail. 2. Have you observed poor interactions from residents on your unit toward others, if so, describe your observation. Based on resident interviews there were no other reported incidents of abuse from any residents.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing educated current facility staff on the facility abuse policy. Education was completed on 12/27/2023. Education included but not limited to the various types of abuse such as physical, mental, sexual, neglect, misappropriation of property, and involuntary seclusion. Education is also inclusive of the procedure for reporting any observed or suspected events of abuse. Education also included the importance of protecting residents following an allegation of abuse. Staff will not be permitted to work until

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education is completed. The Director of Nursing will verify completion of education. Education will be included in new hires orientation by Human Resources as of 12/28/2023. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing/Unit Managers will audit progress notes and incident reports during clinical meetings beginning on 12/27/23 to ensure any behaviors or altercations between residents were reported to administrator and/or Director of Nursing. Auditing will be completed 5 x per week for 4 weeks then weekly for 4 weeks starting on 12/27/2023. The Director of Nursing will report all findings of audits to the Quality Assurance Performance Improvement committee monthly until substantial compliance is obtained. Facility completed AdHoc QAPI to review investigation and current action plan to ensure all components were done and followed on 12/27/2023.

IJ removal date: 12/29/2023

On 4/29/24 the facility's credible allegation of immediate jeopardy removal date of 12/29/23 was validated. The validation was evidenced by interviews with staff and residents, record review, and review of in-service agendas and staff attendance records. In-service agendas and staff attendance records revealed staff were in-serviced on the facility's Abuse, Prevention, Intervention, Reporting, and Investigation policy, effective November 2016, One on One Monitoring and updating the care guide. Interviews conducted with staff from all shifts and all disciplines, and interviews conducted with residents indicated knowledge of the in-services provided. Review of QA records, monitoring tools and audits revealed ongoing monitoring systems

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F 607	Continued From page 45 were in place by the facility.	F 607		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		5/9/24

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F 656	Continued From page 46 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive person-centered individualized care plan for a resident with behaviors for 1 of 3 sampled residents (Resident #4). The findings included: Resident #4 re-admitted to the facility on 10/26/22 with diagnoses that included recurrent major depressive disorder, post- traumatic stress disorder, and anxiety disorder, among others. A review of the 8/4/23 care plan for Resident #4 revealed it did not include a behavior symptoms care plan. A 12/4/23 quarterly Minimum Data Set (MDS) assessment evaluated Resident #4 with adequate hearing and vision (with corrective lenses), clear speech, made self-understood, able to understand others, intact cognition, and no behavior symptoms. A Nursing General Note dated 12/28/23 at 8:38 AM written by the Director of Nursing (DON) recorded that on 12/27/23 at approximately 1:45	F 656	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.¿¿ The facility MDS coordinator completed a review of resident #4 care plan and added a behavior symptom care plan. This was completed 4/15/2024. How the facility will identify other residents potentially affected by the same deficient practice ¿ The Regional MDS nurse completed a review of all residents with physical behaviors directed towards others coded in section E of the MDS over the last 60 days to ensure there were correlating behavior symptom care plans. There were no other residents affected. This was completed 5/8/2024.	

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F 656	Continued From page 47 PM, Resident #5 and Resident #4 were in the dining room. Resident #4 reported that Resident #5 started harassing kitchen staff and when Resident #4 asked Resident #5 to stop harassing the kitchen staff, Resident #5 cursed at her. At this, Resident #4 stated that she got upset and put Resident #5 in a chokehold because Resident #5 had been harassing her for weeks. A 1/4/24 quarterly MDS assessment evaluated Resident #4 with adequate hearing and vision (with corrective lenses), clear speech, makes self-understood, able to understand others, intact cognition, and physical behavior symptoms directed towards others for 1 to 3 days of the assessment period. A review of the care plan on 4/10/24 revealed Resident #4 did not have a behavior symptom care plan. A phone interview on 4/18/24 at 2:30 PM with the Social Services Director (SSD) revealed she was not the SSD at the facility in December 2023, but that her department was responsible for completing the cognition section of the MDS and behavior care plans. She stated that if a resident displayed a new behavior symptom that occurred more than once, a care plan for behavior symptoms should be developed to monitor the resident and to see if the resident continued to exhibit the behavior. During a phone interview on 4/18/24 at 1:22 PM with the MDS Nurse, she reviewed the medical record for Resident #4. The MDS Nurse stated that the 12/4/23 quarterly MDS assessed Resident #3 without behaviors symptoms, but the 1/4/24 quarterly MDS assessed Resident #4 with	F 656	¿What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.¿¿ Regional MDS Nurse re-educated Social Worker and MDS Nurse on Care Plan process for behavior symptoms on residents with documented/coded physical behaviors directed towards others. This was completed as of 5/8/2024.Regional MDS Nurse will educate all new hires to the MDS department upon hire after 5/9/2024. The Regional MDS Nurse will review 5 random, resident care plans, weekly for 4 weeks, then 5 resident care plans bi-weekly for 3 months, to ensure appropriate behavior symptom care plans for residents with documented/coded physical behaviors towards others are active and in place. How the facility will monitor its performance to ensure the deficient practice does not recur:¿ MDS Nurse will report findings to the Quality Assurance Performance Improvement (QAPI) committee for any needed improvement. QAPI committee will review Monthly and make any necessary recommendations immediately for six months.	

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F 656	Continued From page 48	F 656	Compliance Date:¿ 5/9/2024	

physical behavior symptoms directed towards others, due to the 12/28/23 Nursing General Note that documented physical behavior symptoms. The MDS Nurse stated that the care plan for Resident #4 did not have a behavior symptoms care plan until she added it on 4/15/24 at the direction of the Administrator. The MDS Nurse stated that the behavior symptoms care plan for Resident #4 should have been developed by Social Worker (SW #1) at the time she displayed behavior symptoms on 12/27/23.

During a phone interview on 4/19/24 at 9:03 AM, SW #1 stated that she ended her employment at the facility on 1/12/24. She stated that she was notified of a new behavior for Resident #4 on 12/27/23 and witnessed an interview with Resident #4 regarding physically assaulting Resident #5. SW #1 said when interviewed, Resident #4 stated that "Resident #5 was going off at the mouth" and because of that, Resident #4 said she put Resident #5 in a chokehold. SW #1 stated she educated Resident #4 that her behavior was inappropriate, and that she knew that she could not put her hands on residents. Resident #4 expressed understanding. SW #1 stated that she was responsible for the completion of the behavior section of the MDS and for developing behavior symptom care plans. SW #1 stated that she did not develop a behavior symptom care plan for Resident #4 regarding physical abuse directed toward others, because it was an oversight and that the care plan should have been developed.

During an interview on 4/12/24 at 1:45 PM with the Administrator and the DON, they both stated that a behavior symptoms care plan should have been developed for Resident #4 related to her

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F 656	Continued From page 49 physical behavior that occurred twice with Resident #5 on 12/27/23. The administrator stated that at the time of the incident, developing a behavior symptoms care plan was not discussed with the interdisciplinary team or considered.	F 656		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and	F 838		5/9/24

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F 838	Continued From page 50 (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to have an accurate facility assessment that recorded the current Medical Director and changes to administrative personnel. This failure occurred for a facility census of 99 residents. The findings included:	F 838	Facility failed to have an accurate facility assessment that recorded the current Medical Director and changes to administrative personnel for a facility census of 99. An accurate assessment with changes in Medical Director and administrative personnel was completed on 04/19/2024 by the Administrator.	

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F 838	Continued From page 51 The facility assessment was reviewed and recorded the last update and review by the facility's quality assurance, performance, and improvement (QAPI) committee occurred in January 2024. Page one of the facility assessment recorded the name of the former Medical Director. Pages 14 and 15 recorded the facility's Staffing Plan and the number of staff available to meet resident needs. The facility's Staffing Plan recorded that the Assistant Director of Health Services (Assistant to the Director of Nursing (DON)) provided 0.5 full-time equivalent hours and the Staff Development Coordinator (SDC) provided 0.5 full-time equivalent hours. During an interview on 4/10/24 at 1:30 PM the DON stated that she started her role at the facility at the end of May 2023 and that since she started, she did not have an assistant and the facility did not currently have a SDC. The DON stated that the unit managers reported directly to her and that she was responsible for providing staff education unless otherwise delegated. The DON stated that she was responsible for managing the nursing department, unit managers and that she educated staff. The Administrator was interviewed by phone on 4/18/24 at 2:02 PM. He stated that he updated the facility assessment in January 2024 and at the time the facility's Medical Director was not the current Medical Director. He stated that the current Medical Director started at the facility on 4/1/24. The Administrator stated that at the time he updated the facility assessment in January 2024, the DON did not have an assistant and the facility did not have a SDC. He stated that at the time, he included in the facility assessment a	F 838	The facility assessment has been reviewed by the Administrator to ensure the facility-wide assessment documents what resources are necessary to care for the residents competently during both day-to-day operations and emergencies. This review was completed on 04/19/2024. On 5/8/2024 the Regional Director of Operations re-educated the Administrator on reviewing and updating the facility assessment at least annually and whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment. The Administrator will review the assessment monthly for 6 months, then quarterly for 2 years to ensure that the facility-wide assessment documents what resources are necessary to care for the residents competently during both day-to-day operations and emergencies as of 5/8/2024. Data obtained during the audit will be analyzed for patterns and trends and reported to QAPI by the Administrator quarterly for 1 year. At that time the QAPI committee will evaluate the effectiveness of the plan to determine if continued monitoring is needed to maintain compliance. Date of compliance: 05/9/2024	

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F 838	Continued From page 52 budget for these positions, an anticipation of what the facility could afford, but that he did not have anyone in those roles at the time the facility assessment was updated in January 2024. He stated that the Unit Managers reported directly to the DON and that either the DON, the Administrator or a designee provided staff education. He stated that he was aware that the facility assessment should reflect a current facility status, but that he included these roles as part of his anticipated budget. He stated that the facility assessment did not reflect these changes due to prioritizing other responsibilities. He stated that the changes to the facility assessment would likely occur during the next quarterly QAPI meeting scheduled for April 2024.	F 838		
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 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	F 867		5/9/24

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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 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

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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 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

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F 867	Continued From page 55 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 observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey of 08/13/21, the complaint investigation survey of 09/29/22 and the current complaint investigation survey of 4/29/24. This failure occurred for three repeat deficiencies originally cited in the areas of freedom from abuse and neglect, develop and implement abuse and neglect policies, and comprehensive resident centered care plans that was subsequently recited on the current complaint investigation survey of 4/29/24. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F600: Based on observations, record review,	F 867	As of 5/8/2024, the Regional Director of Operations educated the Administrator on the QAPI process to review prior survey citations and monitor for those deficiencies. All prior identified deficiencies can be affected by this deficient practice, so the Administrator has reviewed annual and complaint surveys for the prior 3 years to review all areas of repeat deficient practice. As of 05/7/2024, the Regional Director of Operations has re-educated the Administrator on the facility QAPI procedures for monitoring areas of identified deficient practice and removing monitoring of areas. Regional Director of Operations will review QAPI minutes monthly to ensure improvement and	

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F 867	Continued From page 56 resident, physician, and staff interview the facility failed to protect a severely cognitively impaired resident from the right to be free from physical abuse (Resident #5). Resident #5 experienced physical abuse twice on 12/27/23 before bingo when Resident #4 placed her arm around the Resident's neck, and pulled her forward, and then on the same day, placed Resident #5 in a chokehold with her arm. Resident #5 was held in that position which caused the resident to gasp and her face to become red. The facility failed to protect a severely cognitively impaired resident from the right to be free from sexual abuse (Resident #3). Resident #3 experienced sexual abuse on 2/26/24 when Resident #2 touched and rubbed her pubic area. Based on the reasonable person concept, being placed in a chokehold and non-consensual sexual contact would cause a reasonable person to experience psychosocial harm, trauma and fear from physical or sexual abuse. Abuse occurred for 2 of 4 sampled residents reviewed for protection from abuse. During the complaint investigation survey of 09/29/22, the facility failed protect four residents from verbal and physical abuse when the same resident shook a resident, pushed a resident to the ground, grabbed a resident by the wrist causing a bruise, punched another resident in the chest and caused a resident to be fearful when the resident was threatened verbally with physical harm. F607: Based on a resident interview, staff interviews and record review, the facility failed to report an incidence of physical abuse to facility administration to protect a resident from further physical abuse. Resident #5 experienced physical abuse twice on 12/27/23. Both incidents occurred	F 867	monitoring of areas of deficient practices to include F600 abuse and F607 abuse reporting. The administrator will review the plan of corrections during weekly AdHoc QAPI meetings to ensure no future repeats of prior tags for a period of 8 weeks and then monthly for 12 months during the monthly QAPI meeting. The Administrator will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly of findings that need correction. The QAPI committee will make any adjustments necessary to the current plan if needed. Date of compliance: 05/09/2024	

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F 867	Continued From page 57	F 867		

on 12/27/23 before 2:30 PM. Resident #4 first physically assaulted Resident #5 in the dining room. This occurrence of physical abuse was not reported to the facility administration. As a result, Resident #4 physically assaulted Resident #5 again in the hallway. The deficient practice occurred for 2 of 4 sampled residents reviewed for abuse (Resident #5).

During the complaint investigation survey of 09/29/22, the facility failed to implement their abuse policy to report an allegation of verbal abuse to the state agency.

F656: Based on record review and staff interviews the facility failed to develop a comprehensive person-centered individualized care plan for a resident with behaviors for 1 of 3 sampled residents (Resident #4).

During a recertification and complaint investigation survey of 8/13/21, the facility failed to develop care plans for three residents in the areas of Pre-Admission Screening and Resident Review, pressure ulcers and smoking.

The Administrator stated in a phone interview on 4/18/24 at 2:09 PM that the facility's QAPI committee met quarterly with the department managers, the Medical Director, and the pharmacist to review corporate directives and the outcome of prior surveys. He stated the continued non-compliance in the areas of abuse and care plans was attributed to staff turnover, and staff communication. He stated that the current facility staff were not the same staff in the facility during the surveys of 2021 and 2022 and that although staff education was included in orientation regarding abuse and care plans, the facility would

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F 867	Continued From page 58 need to engage in staff education on abuse and care plans outside of resident incidents that occurred.	F 867		