STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING ______ B. WING ______	C 05/06/2024

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PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		5/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/31/2024

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

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated at least annually. The findings included: Review of the EP plan read it was last updated on 3/2023. The skilled nursing facility is housed on the second floor of the local hospital. The reviewed EP plan contained signatures of the hospital Chief Nursing Officer, the hospital manager of Hospitality Services and the hospital Emergency Management Coordinator which were dated 3/2023. The policy stated the next review was to be done 3/2024.	E 004	The annual effectiveness review of the Physical Environment plans (Emergency Preparedness, Hazardous Materials, Security, Utilities, Fire and Life Safety, Safety Management, and Medical Equipment) was reviewed and approved by the Physical Environment Committee on 3/13/24 and by the Board of Trustees (BOT) at their 4/17/24 meeting. The Hazard Vulnerability Analysis which includes an analysis of hazardous materials, human events, technological events, and natural events was reviewed and approved by the Physical Environment Committee which is chaired by the President/Administrator and includes the skilled nursing unit (SNU) Director of Nursing (DON) as a committee member at the 1/29/24 meeting. On 5/1/24, on or about 2:15pm, the DON reviewed the emergency operations policy (EOP) and determined no changes were needed. On 5/17/24 the EOP was reviewed at the SNU Quality Assurance Process Improvement (QAPI) meeting. On 5/27/24, the EOP was reviewed and revised by the President/Administrator. The BOT approved the EOP via an email vote on 5/30/24.	

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E 004	Continued From page 2	E 004	The EOP applies to the SNU and ensures there is a plan to keep all residents safe during emergency situations. An annual review of this policy with revisions (as needed) ensures it remains current and that any changes in the facility, community, healthcare industry, etc. that might impact resident safety are taken into consideration and mitigated as much as possible. The SNU staff complete mandatory annual education regarding EOP to ensure their ongoing understanding of the policy and how/when to implement it when necessary. Furthermore, on 5/1/24, the DON audited SNU staff annual education transcripts to validate staff received the education and confirmed it was complete. On 5/22/24 an automatic annual reminder to review the EOP at the first QAPI meeting of the quarter has been placed on the individual calendars of SNU leadership (DON, clinical coordinator, Minimum Data Set (MDS) coordinator, and President/Administrator). The automatic reminder is set never to expire. The DON will ensure the EOP is on the agenda and reviewed at the SNU QAPI meeting on an annual basis in the first quarter each year. An annual reminder has been set on each of the SNU leader's calendars to ensure the review is completed. To ensure the EOP review occurs, on 5/30/24, the DON was added to the policy management software for the EOP policy	

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E 004	Continued From page 3	E 004	and will have a "required read" as a required writer to ensure the policy meets SNU requirements. This required input will be completed in January each year prior to the plan update. A "required read" will be scheduled for the DON annually after the document was approved (in April) to validate EOP policy was updated. This annual review of the EOP policy will be reported at the SNU QAPI meeting and documented in the minutes.	
E 013 SS=L	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 013		5/30/24

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E 013	Continued From page 4 this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by:	E 013		

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E 013

Continued From page 5

Based on staff interviews, police interview, resident interviews, and record review the facility failed to implement their emergency procedures on 4/9/24 when Nurse Aide (NA) #2 witnessed Resident #2 with a knife. Later that same day (4/9/24), in the presence of NA #1, Resident #2 threatened Resident #1 with the knife stating, "I'm gonna get you with it." Resident #1 stated she feared for her life, put her head under the covers, and "prayed he wasn't going to kill [her]." NA #1 and NA #2 did not disclose the information to administration and did not contact 911. The administration was not aware of the incident until 4/11/24 when Resident #1 reported the incident to Nurse #1 and who then informed administration. The knife remained in Resident #2's possession until police were contacted on 4/11/24 to confiscate the knife. The knife was described by the police as having a 4 inch handle with a 4 inch "flip blade" (a blade which was spring loaded and the blade was automatically engaged by pressing a button). This failure to immediately implement emergency procedures put all residents (34 residents) at high likelihood of suffering serious harm perpetrated by Resident #2.

Immediate Jeopardy began on 4/9/24 when the facility failed to implement their emergency procedures to protect all residents when NA #2 observed Resident #2 with a weapon. Immediate jeopardy was removed on 5/3/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of "F" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.

E 013

The Emergency Operations Policy (EOP) was implemented as soon as the safety incident was reported to the skilled nursing unit (SNU) leadership on 4/11/24.

In addition to the actions taken by 5/4/24 which are already reflected in this 2567 document the following actions have been taken:

The EOP applies to the SNU and ensures there is a plan to keep residents safe in an emergency. An annual review of this policy with revisions (as needed), will ensure it remains current and that any changes in the facility, community, health care industry, etc. that might impact resident safety are taken into consideration and mitigated as much as possible. A review of the EOP occurred on 5/1/24 by the DON and she determined no changes were needed. On 5/27/24 the President/Administrator reviewed the Emergency Operations Plan (EOP) and made minor revisions (i.e. hospital name, department names, electronic medical record name, etc.) and sent a revised copy to the Board of Trustees (BOT) via email for approval. The BOT approved the EOP via email on 5/30/24.

On 5/28/24, the DON reviewed the files of the one new hire and confirmed the new hire's file verifies understanding of the Emergency Operations Policy including how to call for help. This education was complete with this new hire on 5/20/24.

The SNU staff complete mandatory

E 013

Continued From page 6

The findings included:

Review of the emergency preparedness policy titled "Security Alert Response Policy" last reviewed 3/2023 revealed an active threat situation is "an individual displaying a weapon, having made threats, and shown intent to cause harm or act out in violence". A weapon is defined any firearm, knife, or other object that can cause bodily harm, injury or death. The policy further stated "Any staff person who encounters or suspects an active threat situation will: call 9-911 [911]or designate someone to call 9-911, notify the Patient Care Supervisor and help with tasks designated by the Patient Care supervisor.
Resident #2 was admitted to the facility on 4/28/23 with diagnoses that included stroke and antisocial personality disorder.

Resident #2's quarterly Minimum Data Set (MDS) assessment, dated 3/18/24 revealed he was assessed as cognitively intact, with no mood symptoms or behaviors. He was assessed as ambulating independently and utilized a manual wheelchair.

During an interview with NA #2 on 4/30/24 at 12:58 PM she stated on 4/9/24 Resident #2 showed her a knife in the hallway on 4/9/24. She reported it was a large black knife with a blue handle. NA #2 stated he was waving the knife around but did not open it. She reported he did not threaten her with the knife but was "showing it off." NA #2 stated she did not report the knife to administration because it wasn't any of her concern and it was "none of her business." NA #2 stated Resident #2 often bragged about his criminal history. She further stated he was verbally abusive to staff at times and would get

E 013

education regarding the EOP to ensure their ongoing understanding of the policy and how/when to implement it when necessary. On 5/1/24, the DON audited SNU staff annual education transcripts to validate staff received the education. On 5/28/24, the President/Administrator reviewed the education rosters to ensure 100% of the education was completed as planned. She confirmed 100% completion.

Team members are empowered and required to activate the EOP at the immediate onset of an actual or perceived threat. Residents have the right to be free of emotional or physical abuse. Residents are instructed, empowered, and required to report actual or perceived abuse or security threats to any team member.

Drills and actual events involving the EOP activation were conducted on May 3, 14, 21, 29, and 30, 2024. The DON will document the effectiveness of the EOP activations.

Effective 5/3/24, the DON began monitoring adherence to the corrective action measures. A spreadsheet is maintained to track confirmation that
- residents received the personal belongings (contraband) policy upon admission;
- new hires understand unit policies and procedures pertaining to abuse and emergencies;
- new hires received the emergency operations badge buddy; and

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"rowdy."

An initial report with the investigation report was submitted to the state agency on 4/18/24. The report indicated the facility became aware of the incident on 4/11/24 at 3:00 PM. The investigation included a timeline of events. On 4/9/24 Resident #2 entered the room of Resident #1, "brandished [waved] a knife" and threatened her. Resident #1 indicated that Nurse Aide (NA) #1 was in the room when Resident #2 threatened Resident #1 and she (NA #1) "turned her head and walked away."

An interview was conducted with Resident #1 on 4/30/24 at 11:28 AM. Resident #1 stated on 4/9/24 Resident #2 came in her room in a wheelchair and stood at her bedside while she was in bed. She revealed Resident #2 brandished a knife and threatened her stating, "I'm gonna get you with it." Resident #1 stated Resident #2 "popped the switchblade open" and waved the 4-inch blade in front of her face. She indicated she put her head under the covers and "prayed he wasn't going to kill me." She stated Resident #2 left the room while she had the covers over her head. She indicated she had a roommate at the time of the incident, but she could not recall where the roommate was at when the incident occurred. She added that her bed (Resident #1's) was the one closest to the door. She reported that NA #1 was in the room when Resident #2 came in on 4/9/24 but was unsure of her (NA #1's) exact location within the room when Resident #2 brandished the knife. Resident #1 stated she remained in her room after the incident because she was afraid of Resident #2. She stated she normally spent a great deal of time out of her room and participated in activities

E 013

- SNU staff completed mandatory abuse/neglect education.

Drills/actual events involving the EOP activation will be conducted twice a month for four months and logged. In order to monitor our performance and ensure solutions are sustained, effective 5/3/24, the DON documents the effectiveness of the EOP activations. The denominator will be the emergency plan activations and the numerator will be the number of times it was implemented according to policy. The DON will monitor compliance with implementing the corrective action measure listed above for 4 months. The ongoing monitoring data will be reported at the SNU Quality Assurance Process Improvement (QAPI) meetings and documented in the minutes.

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E 013	Continued From page 8 throughout the day. Resident #1 stated that she was scared, "He was gonna get me," and that she feared for her life. She stated she felt powerless to stop him from harming her if that was his plan. Resident #1 informed her family member of the incident on the phone. The family member told her (Resident #1) to report the incident to the facility or she (her family member) would report it. Resident #1 stated the first staff member she reported the incident to was Nurse #1 on 4/11/24. She stated the DON visited her room on 4/11/24 after she initially disclosed the incident to Nurse #1. An interview was conducted with Nurse #1 on 4/30/24 on 3:35 PM. She stated Resident #1 called her into her room on 4/11/24 and told her Resident #2 had threatened her with a knife. Nurse #1 stated Resident #1 indicated she was sharing this with her (Nurse #1) in case something happened with Resident #2 and the knife. Nurse #1 stated she went immediately and reported this to the DON. During an interview with Nurse Aide #1 on 4/30/24 at 1:07 PM she stated she provided care to Resident #1 on 4/9/24 and did not see a knife while she was in Resident #1's room. NA #1 stated she heard Resident #1 and Resident #2 talking about a knife. Resident #2 was in Resident #1's room. NA #1 stated she could not recall what specifically was said because she was trying to get her work done at the time. She stated she was in and out of Resident #1's room and explained the conversation about the knife occurred while she was in the hallway. She stated she thought they (Resident #1 and Resident #2) were joking around because Resident #2 frequently discussed his criminal	E 013		

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history and bragged a great deal about his past criminal history. NA #1 stated she "intentionally" did not look for the knife. She indicated she did not want to be involved.

A second interview was conducted with NA #1 with the DON present on 5/1/24 at 11:00 AM. NA #1 reported she never saw Resident #2 with the knife on 4/9/24. NA #1 stated she saw Resident #2 in the doorway of Resident #1's room (4/9/24) and heard him say something about having a knife. NA #1 indicated she did not hear a threat. During this interview NA #1 acknowledged that she was afraid of Resident #2 because he frequently bragged about his criminal history. She further stated she was not aware she should have reported to the administration Resident #2 had a knife. NA #1 stated she was not aware a knife was considered contraband (property by which in its own entity is a crime to possess such as illegal drugs, drug paraphernalia, switchblades, gun etc...) or a weapon.

An interview was conducted with the DON on 4/30/24 at 10:53 AM. She stated she spoke with Resident #1 on 4/11/24 at 2:30 PM who stated Resident #2 had threatened her [Resident #1] with a knife on 4/9/24 by coming in her room while she was in bed and waving it in front of her face. The DON stated she called the hospital police department (the facility was located on the second floor of a hospital) immediately for advice. She reported she was advised to contact the local police department for assistance with confiscating the knife. She reported she contacted the local police on 4/11/24 who responded and confiscated the knife from Resident #2. The DON did not call 911 but called the local police department.

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E 013	Continued From page 10 She stated she implemented the facility's emergency plan at that time. She indicated residents were escorted to their rooms and room doors were shut. The DON stated she had staff members relocated to the dayroom while she waited for the police and manned the nurse's station and call light system. She indicated at the time Resident #2 was in his private room with the door shut. The DON stated when the police officers came, Resident #1 did not want to press charges and the knife was secured in a locked nursing supervisor closet. She stated she saw the knife when it was confiscated on 4/11/24. She reported the blade was 4 inches long and the handle was 4 inches long. She stated she understood from when she talked to Resident #2 on 4/11/24 that he ordered the knife and had it delivered after he was admitted to the facility. She stated the police made her aware of two outstanding warrants for Resident #2 on 4/11/24. He was not arrested due to Resident #1 not wanting to press charges and he was receiving care in the facility. She stated afterwards, during a meeting with her staff, she discovered NA #1 had overhead Resident #1 and Resident #2 discussing the knife on 4/9/24. The DON further stated NA #2 had been shown the knife by Resident #2 on 4/9/24. The DON stated after the incident Resident #2 began threatening residents and staff. He was discharged on 4/18/24 to the local police due to him having two outstanding warrants. Review of the police report completed by Police Officer #1 dated 4/11/24 revealed a warrant check was conducted and Resident #2 was found to have two felony warrants. During a phone interview conducted with Police	E 013		

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Officer #2 on 5/6/24 at 2:16 PM she stated she came to the facility on 4/11/24 solely to confiscate the knife. She explained the resident, staff, and facility had elected not to press charges. She indicated the knife's blade was 4 inches long and the handle of the knife was blue and black. She stated the handle was 4 inches long. Police Officer #2 stated the knife had a flip blade.

A phone interview was conducted with Police Officer #1 on 5/2/24 at 10:42 AM. He stated he spoke with Resident #2 on 4/12/24 after the incident was disclosed and informed him that threatening behavior to residents and staff would not be tolerated. Police Officer #1 reported Resident #2 stated he would comply. He stated Resident #2 was not arrested on 4/11/24 because Resident #1 was not willing to cooperate with prosecution. He further explained Resident #2 was receiving medical care from the facility so he was not taken into custody for the outstanding warrants on 4/11/24.

Review of a notice of discharge for Resident #2 dated 4/18/24 revealed Resident #2 was discharged from the facility on 4/18/24 due to the safety of individuals in the facility being endangered. The notice of discharge revealed his discharge location was the local jail.

The Administrator was notified of immediate jeopardy on 5/1/24 at 1:15 PM.

The facility provided the following immediate jeopardy removal plan:

" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome

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as a result of the noncompliance:
The facility failed to implement emergency procedures when staff failed to report a resident who was in possession of a knife. The 34 residents admitted to the facility were at risk of suffering from harm perpetrated by Resident #2.
Incident
On 04/09/2024, NA #1 and NA #2 knew that Resident #2 was in possession of a knife. It wasn't until 04/11/2024 after Resident #1 reported to a nurse that Resident #2 threatened Resident #1 with a knife that NA #1 and NA #2 admitted to knowing about Resident #2's knife for approximately two days. NA #1 and NA #2 were fearful of retaliation from Resident #2 if they came forward with the information.
On 04/11/2024 at 2:30pm a nurse notified the Director of Nursing (DON) that Resident #1 reported that the "day before yesterday" (on 04/09/2024) Resident #2 entered her room, brandished a knife, and threatened her.
On 04/11/2024 at 3:11pm, the Director of Nursing (DON) notified company police that there was a resident (Resident #2) in possession of a knife, which posed a security threat. At 3:37pm the DON called the local police department for assistance with confiscating the knife. In an effort to ensure no other residents were abused, and while Resident #2 was resting in his room with the door shut, the DON cleared the Skilled Nursing Unit (SNU) hallways of residents and staff. Residents were escorted to their rooms and room doors were shut by staff. The residents were kept safe and told they should go and stay in their room while staff investigated the situation. In an effort to maintain a calm environment, we did not disclose the details to the other residents. Residents were kept calm and supported by staff by maintaining business as usual while staff was

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E 013	Continued From page 13 remaining vigilant in their surroundings. On 04/11/2024 at 3:40pm, in addition to moving residents into their rooms, the remaining staff were relocated to the day room. The DON stayed at the nursing station monitoring the patient call system. When the local police arrived, they instructed Resident #2 that having a weapon on hospital property (the SNU was located within a hospital) is not allowed and the knife was confiscated. The DON and local police asked Resident #2 if he had any concerns about his safety and he responded no. The DON instructed them to search Resident #2's room for any additional contraband and there was nothing additional found. Within less than twenty minutes of calling the local police department and after the knife was confiscated by police and the situation was under control, the DON announced via a unit overhead page that staff and residents were free to move about the unit. The DON rounded on residents and completed one-to-one interviews and determined no other residents had been harmed or in need of assistance. This is evidenced by no complaints or grievances from other residents at the time. Cognitively impaired residents did not demonstrate signs of physical harm (i.e. no injuries of unknown origin) or emotional anguish (i.e. no pursed lips, muscle tension, restlessness, or labored breathing). The residents (other than Resident #1) and staff reported no additional episodes of threatening behavior or abuse. On 04/16/2024 on our about 11:00am, the President/Administrator interviewed NA #1 and NA #2 who admitted to knowing Resident #2 was in possession of a knife on 04/9/2024. During their 04/16/2024 interview, both indicated they shared fear of retaliation because Resident #2	E 013		

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labeled them as a "snitch." Due to this fear, NA #1 and NA #2 refrained from reporting their knowledge and therefore, emergency procedures were not activated.

"   Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:
On 05/01/2024, the following actions were completed:
1. On or about 2:15pm, the DON reviewed the Emergency Operations Policy and determined no changes to policy were needed.

2. At 3:00pm, the DON reviewed the 2023 annual training transcripts for of all SNU team members to ensure they completed required emergency operations plan education. Results revealed 100% compliance of all SNU staff (nursing and nursing assistants, activity coordinator).

3. At 4:00pm, the SNU Clinical Coordinator provided education to SNU clinical team members (Licensed Nurses, Certified Nursing Assistants, Activity Coordinator) present on-site via on-site in-person training regarding emergency operations activation (including what to do when staff and/or patients experience potential or actual harm which could be related to an abuse situation). Staff are empowered to activate the emergency operations plan starting with calling 9-911. Nursing leadership should also be notified immediately.

4. Beginning at 5:00pm, the Nursing Supervisor educated team members in the following disciplines regarding emergency operations

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activation via in-person, face-to-face huddles (A huddle is a fixed time for gathering of team members to focus on care coordination, facilitate immediate face-to-face clarification of issues and discuss important topics. This process is designed to improve productivity, communication, and teamwork within clinical practice settings and is typically held at shift changes. It focuses on the daily action plan, and adjustments needed which improves efficiency and enhances teamwork by anticipating needs for the day. The goal of huddles is to increase individual team member accountability for patient safety and to help foster a culture of empowerment and collaboration) on the following units:

a. SNU licensed nurses
b. SNU certified nursing assistants
c. Therapy services
d. Environmental Services
e. Dietary
f. Facilities
g. Clinical outcomes

An emphasis was placed on the understanding of the serious nature and threat to the safety of residents by not implementing emergency procedures. Specific scenarios were discussed to ensure that staff did understand that in this case, a resident or staff member could have been stabbed or severely injured.

The following actions were completed on 05/02/2024:

1. To continue education efforts of team members that had not yet received education, at 6:50am, the DON facilitated a SNU team meeting and in-service and completed education regarding emergency operations activation (including what to do when staff and/or patients

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experience potential or actual harm which could be related to an abuse situation).

2. At 8:00am, the DON posted the process of activating the emergency operations plan that was discussed in the huddle/in-service at the SNU nurse's station desk phones so that information is readily available for staff in an emergency.

3. At 8:15am, the Manager of Clinical Outcomes created a badge buddy outlining the criteria for and steps to activate the emergency operations plan. A badge buddy is an employee badge-sized document that is attached to a staff member's badge. The purpose of a badge buddy is to have immediate access to information related to high-risk, low-volume processes. These were distributed to SNU staff and will continue to be distributed to Social Workers, Admissions, Case Management, Therapy Services, Dietary Services, Environmental Services Plant Engineering, and Nursing Supervision. Nursing Supervision will round and track to ensure staff receive the badge buddy prior to working on the floor.

4. At 8:30 AM, the Manager of Clinical Outcomes facilitated another in person, face-to-face in-service on the emergency operations activation (including what to do when staff and/or patients experience potential or actual harm which could be related to an abuse situation) in the facility's education room for Social Workers, Admissions, Case Management, Therapy Services, Dietary Services, Environmental Services, Plant Engineering and Nursing Supervision leaders and staff members.

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5. For Social Work, Admissions, Case Management, Therapy Services, Dietary Services, Environmental Services, Plant Engineering, and Nursing Supervision, education regarding emergency operations activation (including what to do when staff and/or patients experience potential or actual harm which could be related to an abuse situation) will be ongoing by unit leaders until 100% compliance is achieved and prior to staff working on the floor. The DON informed the leaders of Social Work, Admissions, Case Management, Therapy Services, Dietary Services, Environmental Services, Plant Engineering, and Nursing Supervision that they and all the staff must attend the outlined education on the emergency operations plan until 100% compliance is achieved and prior to staff working on the SNU.

6. At 2:50pm, during shift change, company police provided an in-person, face-to-face in-service to SNU staff (nurses, nurse assistants) that were present about abuse. The in-service covered domestic and workplace violence., the security management plan, responsibilities of leaders, team members duty to report, actual and potential security risks, activation of emergency response if situations of abuse/potential harm and 911 notifications. The DON or Manager of Clinical Outcomes will provide SNU staff that were not present education via daily huddles and one on one sessions. This information will be tracked by the DON, who will ensure 100% education of SNU staff is completed upon returning to work.

7. As part of onboarding new staff, standard, facility-wide orientation facilitated by the Human Resources Department includes education

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E 013	Continued From page 18 regarding the Emergency Operations Plan and reasonable suspicion of a crime examples. A computer-based learning module created by the facility's Professional Development Department about resident abuse and neglect remains a part of the SNU staff's annual education requirements. Additionally, the DON will be responsible for ensuring completion of a unit-specific orientation checklist that includes each new hire's verification of understanding of the emergency operations policy including how to call for help. Proof of completion of the SNU-specific orientation checklist will be kept in the employee's file. The DON updated the SNU orientation checklist to ensure new staff receive a badge buddy as part of orientation. Alleged Date of Immediate Jeopardy Removal: 05/03/2024 Onsite validation of the immediate jeopardy removal plan was completed on 5/6/24. Interviews confirmed all staff from all departments were educated on activating the emergency preparedness plan activation including what to do when residents experience potential or actual harm related to a threat of harm situation. Observations conducted on 5/6/24 revealed all staff were wearing a badge buddy which outlines the criteria for and steps to activate the emergency operations plan and is a badge-sized document that is attached to a staff member's badge. The DON verified she was responsible for ensuring new staff complete unit specific training that includes verification of staff's understanding of the emergency operations policy including how to call for help. The facility's date of 5/3/24 was validated.	E 013		

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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite from 4/30/24 through 5/2/24. Additional information was obtained remotely 5/3/24. Onsite validation of the immediate jeopardy removal plans was conducted on 5/6/24. Therefore, the exit date was 5/6/24. The following intakes were investigated: NC00213320 and NC0216218. Intake NC00216218 resulted in immediate jeopardy. 3 of the 3 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.73 at tag E0013 at a scope and severity (L) CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.12 at tag F607 at a scope and severity (L) The tags F600 and F607 constituted Substandard Quality of Care. Immediate Jeopardy began on 4/9/24. Immediate Jeopardy was removed on 5/3/24 for E0013 and F600 and on 5/4/24 for F607. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 600		5/28/24

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and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and interviews with police, resident, and staff, the facility failed to protect a resident's right to be free from resident-to-resident mental and verbal abuse. On 4/09/24 Resident #2 entered Resident #1's room and threatened her with a knife stating "I'm gonna get you with it." Resident #1 reported Resident #2 "popped the switchblade open and waved the 4 inch blade in front of [her] face." Resident #1 stated she feared for her life, put her head under the covers, and "prayed he wasn't going to kill [her]." This deficient practice affected 1 of 3 residents reviewed for abuse.

Immediate jeopardy began on 4/9/24 when the facility failed to protect Resident #1 from abuse perpetrated by Resident #2. Immediate jeopardy was removed on 5/3/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of "D" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.

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In addition to the actions taken by 5/4/24 which are already reflected in this 2567 document, the following actions have been taken:

On 5/3/24, the Director of Nursing (DON) modified the admission policy to support a comprehensive admission eligibility assessment beyond whether the facility could meet the resident's clinical needs and had a bed available. In evaluating potential candidates for skilled nursing unit (SNU) admission, the admission team (social worker, case manager, financial counselor) will utilize available information including previous hospitalizations, medical records, and behaviors to determine whether the patient will be an appropriate fit in the milieu. Considerations include but are not limited to age, room availability, clinical conditions, personal preferences, and the safety and needs of other residents on the unit. Upon admission, the Minimum Data Set (MDS) coordinator and/or Social Worker or designee will complete an

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Findings included:

Resident #2 was admitted to the facility on 4/28/23 with diagnoses that included stroke and antisocial personality disorder.

Resident #2's quarterly Minimum Data Set (MDS) assessment, dated 3/18/24 revealed he was assessed as cognitively intact, with no mood symptoms or behaviors. He was assessed as ambulating independently and utilized a manual wheelchair.

Resident #2's active care plan as of 4/9/24, last updated on 9/18/23, did not have a care plan related to behavioral issues.

Resident #1's annual MDS assessment dated 3/17/24 indicated her cognition was intact.

An observation conducted on 4/30/24 at 10:00 AM revealed the skilled nursing facility was on the second floor of the local hospital.

An investigation report with a timeline of events, submitted on 4/18/24, revealed on 4/9/24 Resident #2 entered the room of Resident #1, he (Resident #2) "brandished [waved] a knife" and threatened Resident #1. Resident #1 indicated that Nurse Aide (NA) #1 was in the room when Resident #2 threatened her (Resident #1) and she (NA #1) "turned her head and walked away."

Review of an incident report completed by the Director of Nursing (DON) dated 4/18/24 revealed Resident #2 entered Resident #1's room and brandished a knife on 4/9/24.

An interview was conducted with Resident #1 on

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admission assessment and create an individualized care plan that ensures a safe environment for residents. This is an interdisciplinary approach with the Medical Director, MDS Coordinator, DON, Social Worker, Case Manager, and Financial Counselor with the Medical Director having the final approval. This process has been updated to critically evaluate potential residents via a holistic approach including efforts to determine if a resident's known history of a crime would endanger other residents prior to accepting the resident for admission.

The education for the social workers, admission department, case management, therapy services, dietary services, environmental services, plant engineering, and nursing supervision was complete on 5/5/24.

The DON reviewed the files of the one new hire on 5/28/24 and confirmed the new hire's file verifies understanding of the EOP policy including how to call for help.

Additionally, the DON is responsible for ensuring completion of a unit-specific orientation checklist that includes each new hire's verification of understanding the abuse policy (definition of abuse, reportable situations, and who/how to report) and the emergency operations policy including how to call for help. Proof of completion of the SNU-specific orientation checklist is kept in the employee's file. The DON reviewed the

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4/30/24 at 11:28 AM. Resident #1 stated on 4/9/24 Resident #2 came in her room in a wheelchair and stood at her bedside while she was in bed. She revealed Resident #2 brandished a knife, and threatened her stating "I'm gonna get you with it." Resident #1 stated Resident #2 "popped the switchblade open" and waved the 4-inch blade in front of her face. She indicated she put her head under the covers and "prayed he wasn't going to kill me." She stated Resident #2 left the room while she had the covers over her head. She indicated she had a roommate at the time of the incident but she could not recall where the roommate was at when the incident occurred. She added that her bed (Resident #1's) was the one closest to the door. She reported that NA #1 was in the room when Resident #2 came in on 4/9/24 but was unsure of her (NA #1's) exact location within the room when Resident #2 brandished the knife. Resident #1 stated she remained in her room after the incident because she was afraid of Resident #2. She stated she normally spent a great deal of time out of her room and participated in activities throughout the day. Resident #1 stated that she was scared "he was gonna get me" and that she feared for her life. She stated she felt powerless to stop him from harming her if that was his plan.

During an interview with Nurse Aide #1 on 4/30/24 at 1:07 PM she stated she provided care to Resident #1 on 4/9/24 and did not see a knife while she was in Resident #1's room. NA #1 stated she heard Resident #1 and Resident #2 talking about a knife. NA #1 stated she could not recall what specifically was said because she was trying to get her work done at the time. She stated she was in and out of Resident #1's room and reported the conversation about the knife

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files of the new hires on 5/28/24 and confirmed the new hire's file verifies understanding of the emergency operations policy including how to call for help.

The admission policy that was reviewed and revised on 5/3/24 by the DON applies to residents on the SNU and ensures a comprehensive assessment is conducted on potential residents. In order to ensure existing residents understood their rights to be free abuse, neglect, misappropriation of resident property, and exploitation including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to to treat the resident's medical symptoms, on 5/1/24, an ad hoc resident council meeting was facilitated by nursing leadership to educate the residents on their rights to be free from physical and mental abuse. There was a discussion about the different types of abuse and when and how to report abuse. Residents were also educated on the personal belongings policy including the list of contraband items and that this same policy will be provided to each new resident upon admission.

On 5/5/24, the SNU admission packet was updated by the DON to include the list of contraband items that include but are not limited to weapons (firearms, knives, explosives); lighters and other smokeless tobacco, illicit substances, and drug paraphernalia which are strictly

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occurred while she was in the hallway. She stated she thought they (Resident #1 and Resident #2) were joking around because Resident #2 frequently discussed his criminal history and bragged a great deal about his past criminal history. NA #1 stated she "intentionally" did not look for the knife. She indicated she did not want to be involved.

A second interview was conducted with NA #1 with the DON present on 5/1/24 at 11:00 AM. NA #1 reported she never saw Resident #2 with the knife on 4/9/24. NA #1 stated she saw Resident #2 in the doorway of Resident #1's room (4/9/24) and heard him say something about having a knife. She reported she (NA #1) heard Resident #2 say he believed she (NA #1) and NA #2 had reported him for having the knife after it was confiscated by the police on 4/11/24 and he stated he (Resident #2) was going to get them (NA #1 and NA #2). During this interview NA #1 acknowledged that she was afraid of Resident #2 because he frequently bragged about his criminal history. She reported after the knife was discovered on 4/11/24 he yelled out "who is the snitch" and "snitches get stitches".

An interview was conducted with the DON on 4/30/24 at 10:53 AM. She reported Resident #1 pulled her into her (Resident #1's) room on 4/11/24 and told her Resident #2 had pulled a knife on her on 4/9/24. The DON stated Resident #1 was afraid to leave her room because Resident #2 had threatened her with the knife. The DON stated she saw the knife on 4/11/24 and it was 8 inches long. She reported the blade was 4 inches long and the handle was 4 inches long. She stated she understood from when she talked to Resident #2 on 4/11/24 he

F 600

prohibited. On 5/5/24 the same list was was given to each resident and emailed to every resident's family member(s)/power of attorney by the DON. A flier outlining what constitutes contraband was placed at the entrances (elevators) to the unit and in the visitor restroom on the SNU.

On 4/29/24 the DON created the standardized admission evaluation tool that is used by the DON or designee for each referral for admission to the SNU. This objective tool fosters a comprehensive admission eligibility assessment that takes historical behaviors, personal preferences, and milieu compatibility into consideration. The tool is in a spreadsheet format. In order to monitor our performance and ensure solutions are sustained, the DON is documenting the use of this tool in evaluating potential admissions to the unit. The numerator is the number of times the document is used to evaluate admissions and the denominator is the number of admissions to the unit. The DON or designee will complete the tool for each referral for the next four months.

For at least four months, reports of potential abuse are reviewed by the SNU leadership team (DON, President/Administrator, and Medical Director) to evaluate the effectiveness of the admission evaluation process, EOP implementation, and timeliness of reporting requirements including but not limited to Adult Protective Services. The ongoing monitoring data will be reported

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ordered the knife and had it delivered after he was admitted to the facility. She stated after she was made aware of the knife she contacted the hospital police who advised her to contact the local police department. She contacted the local police department 4/11/24 and asked them to confiscate the knife. The DON stated when the police officers came on 4/11/24 Resident #1 did not want to press charges so Resident #2 was not arrested and the knife was secured in a locked nursing supervisor closet. The DON stated Resident #2 was discharged on 4/18/24 to the local police due to him having two outstanding warrants. She stated it was her understanding that he was taken to the local jail on 4/18/24. The DON reported Resident #2 had some issues since his admission. She reported there had been an incident with him inviting a suspected prostitute to visit and he continued to have contact with people who were suspected to be in the "drug community". The DON reported Resident #1 and Resident #2 had an incident in the past in which Resident #2 swung to strike Resident #1 and missed on 2/27/24. She (Resident #1) grabbed his (Resident #2's) glasses and the staff had a difficult time getting him to remove his hands from the handrail in the hallway. The residents were separated, and the incident appeared to be handled.

Review of the police report completed by Police Officer #1 dated 4/11/24 revealed a warrant check was conducted and Resident #2 was found to have two felony warrants.

During a phone interview conducted with Police Officer #2 on 5/6/24 at 2:16 PM she stated she came to the facility on 4/11/24 solely to confiscate the knife. She explained the resident, staff, and

Plan of correction (F 600): at the SNU Quality Assurance and Process Improvement (QAPI) meetings and documented in the minutes.

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facility had elected not to press charges. She indicated the knife's blade was 4 inches long and the handle of the knife was blue and black. She stated the handle was 4 inches long. Police Officer #2 stated the knife had a flip blade (a blade which was spring loaded and the blade was automatically engaged by pressing a button).

A phone interview was conducted with Police Officer #1 on 5/2/24 at 10:42 AM. He stated he spoke with Resident #2 on 4/12/24 after the incident was disclosed and informed him that threatening behavior to residents and staff would not be tolerated. Police Officer #1 reported Resident #2 stated he would comply. He stated Resident #2 was not arrested on 4/11/24 because Resident #1 was not willing to cooperate with prosecution. He further explained Resident #2 was receiving medical care from the facility so he was not taken into custody for the outstanding warrants on 4/11/24.

Review of a notice of discharge for Resident #2 dated 4/18/24 revealed Resident #2 was discharged from the facility on 4/18/24 due the safety of individuals in the facility being endangered. The notice of discharge revealed his discharge location was the local jail.

The facility and hospital were part of the same entity and had a shared medical record. The medical record revealed as of 5/6/24 Resident #2 was in a local hospital awaiting placement after transfer from the jail due to concerns related to his medical health.

During an interview with the DON on 4/30/24 at 3:15 PM she stated the facility tried to protect the other residents while simultaneously protecting

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Resident #2's rights.

A follow-up interview was conducted with the DON on 5/6/24 at 10:00 AM. She reported the hospital was having a difficult time with placement. The DON stated Resident #2 would not be allowed back at the facility.

Attempts to interview Resident #2 were unsuccessful.

The Administrator was notified of immediate jeopardy on 5/1/24 at 1:15 PM.

The facility provided the following immediate jeopardy removal plan:

- Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
The facility did not protect Resident #1's right to be free from mental and verbal abuse perpetrated by Resident #2.

Incident
On 04/11/2024 at 2:30pm a nurse notified the Director of Nursing (DON) that Resident #1 reported that "day before yesterday" (on 04/09/2024) Resident #2 entered her room, brandished a knife, and threatened her.

On 04/11/2024 at 3:11pm, the Director of Nursing (DON) notified company police that there was a resident (Resident #2) in possession of a knife, which posed a security threat. The DON then called the local police department for assistance with confiscating the knife at 3:37pm. In an effort to ensure no other residents were abused, and while Resident #2 was resting in his room with the

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door shut, the DON cleared the Skilled Nursing Unit (SNU) hallways of residents and staff. Residents were escorted to their rooms and room doors were shut by staff. The residents were kept safe and told they should go and stay in their room while staff investigated the situation. In an effort to maintain a calm environment, we did not disclose the details to the other residents. Residents were kept calm and supported by staff by maintaining business as usual.

In addition, staff were relocated to the day room at 3:40pm. The DON stayed at the nursing station monitoring the patient call system. The DON instructed the local police to search Resident #2's room for any additional contraband. The local police instructed Resident #2 that having a weapon on hospital property (the SNU was located within a hospital) is not allowed. The DON and local police asked Resident #2 if he had any concerns about his safety and he responded no.

Within less than twenty minutes, after the knife was confiscated, the DON announced via a unit overhead page that staff and residents were free to move about the unit. The Social Worker reported to the unit and was briefed on the situation by the DON. The DON directed the Social Worker to round first on Resident #1. After providing emotional support and offering resources such as Chaplain services, counseling, physician consultation etc. to Resident #1, (who declined) the Social Worker rounded on the other Residents to assess exposure to or impact of the abuse situation. This was achieved by individually interviewing residents and asking if there were any questions, concerns or needs.

The DON presented to Resident #1's room on

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04/11/2024 to assess the situation. The DON discussed the situation that happened on 04/09/2024 when Resident #2 entered her room with a knife. Resident #1 explained in her normal demeanor what happened and admitted that she was fearful of retaliation and did not come out of her room for a couple of days. The DON determined there was no need for further interventions for Resident #1 on 04/11/2024.

In addition, the DON rounded on residents and implemented a two-team member approach to providing care to Resident #2, or when entering his room. At the time, the DON determined via one-to-one interviews, no other residents had been harmed or in need of assistance. This is evidenced by no complaints or grievances from other residents at the time. The DON debriefed with the oncoming nursing supervisor who then instructed the security officer who works every day from 5:00pm to 3:00am to complete extra rounding on the SNU.

The DON was onsite monitoring the situation and handed off to the nursing supervisor at 4:40pm on 94/11/2024 instructing them to supervise Resident #2 closely. The DON consulted the Medical Director and a Behavioral Health consult was ordered for Resident #2. The DON debriefed the team and instructed the team to place this patient on close supervision and call the local police department immediately at the onset of any threatening behaviors from Resident #2. The Minimum Data Set (MDS) Coordinator modified Resident #2's care plan to include interventions to include interventions that would reduce or eliminate inappropriate or threatening behaviors. The DON notified the dietary services to place Resident #2 on a "safe tray" that utilizes

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plastic utensils, Styrofoam tray and no plastic bags.

On 04/12/2024, the DON called the SNU to check on all residents and staff, which reported non-disruptive and "good behavior" from Resident #2 and there were no issues at 2:00am.

The DON investigated the incident on 04/12/2024 by interviewing team members and the alert and oriented residents to assess for other incidents. The DON asked the alert and oriented residents if any other resident or staff have hurt them or made them feel unsafe. The DON assessed that cognitively impaired residents did not demonstrate signs of physical harm (i.e. no injuries of unknown origin) or emotional anguish (i.e. no pursed lips, muscle tension, restlessness, or labored breathing). The residents (other than Resident #1) and staff reported no additional episodes of threatening behavior or abuse.

1. On the following dates and times, the Director of Nursing (DON) facilitated a leadership meeting with legal department, case management, risk management, company police and manager of Clinical Outcomes to establish next steps, including the clinical appropriateness of resident discharge and associated Centers for Medicare and Medicaid Services (CMS) regulations.
-On 04/12/2024 at 11:00am: The team discussed the risks vs benefits of Resident # 2 remaining a resident at current facility.
-On 04/16/2024 at 10:30am: The team discussed discharge disposition options.
-On 04/17/2024 at 4:00pm: The team allocated appropriate durable medical equipment (DME) and medications to facilitate a safe discharge plan.

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-On 04/18/2024 at 9:30am, the above referenced team members finalized the discharge plan.

2. On 04/18/2024 at 10:07am, the DON completed the Nursing Home Notice of Transfer/Discharge that was signed by the facility President/Administrator and given to Resident #2. The attending provider completed a discharge summary and wrote a discharge order for Resident #2 at 10:15am. At 11:45am, the patient received Durable Medical Equipment (DME) and medications and was safely discharged from the facility.

3. On 04/18/2024 at 2:00pm, the DON discussed the context of Resident #2's discharge, including the facility policy, CMS guidelines, and importance of resident and staff safety with SNU staff via a staff meeting. Staff that were not present received this education from the DON, Clinical Coordinator or Nursing Supervisor, via one-on-one discussions upon arrival to their next shift.

4. The DON self-reported the resident abuse safety incident to the NC Department of Health and Human Services via fax on 4/18/2024 at approximately 4:30pm. No other agency was notified. The ombudsman was notified on 04/17/2024 at 11:41pm.

5. On 04/19/2024, the DON told Resident #1 that Resident #2 was discharged. The DON commended Resident #1 for discussing the incident and requested immediate reporting to the nurses or leadership if there is any situation or concerns in the future. The DON reassessed Resident #1 for mental suffering, found the resident to not be in distress and offered support

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including emotional support, pet therapy, chaplain services and counseling. Resident #1 stated that she also had a conversation with the Social Worker about available resources such as counseling, but Resident # 1 declined all available resources.

- Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 05/01/2024, the following actions were completed:
1. At 3:00pm, the DON reviewed the 2023 annual training transcripts for of all SNU team members to ensure they completed required resident abuse/neglect education. Results revealed 100% compliance of all SNU staff (nursing and nursing assistants, activity coordinator).

2. At 4:00pm, the SNU Clinical Coordinator provided education to SNU clinical team members (Licensed Nurses, Certified Nursing Assistants, Activity Coordinator) present on-site via on-site in-person training:
a. Emergency Operations activation (including what to do when staff and/or patients experience potential or actual harm which could be related to an abuse situation)
b. Reasonable suspicion of a crime examples (which could result in abuse)
Resident abuse - the definition of abuse, what needs to be reported and who/how to report.

3.Beginning at 5:00pm, the Nursing Supervisor educated team members in the following disciplines of the above educational topics via in-person, face-to-face huddles (A huddle is a

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fixed time for gathering of team members to focus on care coordination, facilitate immediate face-to-face clarification of issues and discuss important topics. This process is designed to improve productivity, communication, and teamwork within clinical practice settings and is typically held at shift changes. It focuses on the daily action plan, and adjustments needed which improves efficiency and enhances teamwork by anticipating needs for the day. The goal of huddles is to increase individual team member accountability for patient safety and to help foster a culture of empowerment and collaboration) on the following units:
a. SNU licensed nurses
b. SNU certified nursing assistants
c. Therapy services
d. Environmental Services
e. Dietary
f. Facilities
g. Clinical outcomes

The following actions were completed on 05/02/2024:
1. To continue education efforts of team members that had not yet received education, at 6:50am, the DON facilitated a SNU team meeting and in-service and completed education regarding the same topics outlined above in #2.

2. At 8:30 AM, the Manager of Clinical Outcomes facilitated another in person, face-to-face in-service on the abuse topic as outlined in # 2 above in the facility's education room for Social Workers, Admissions, Case Management, Therapy Services, Dietary Services, Environmental Services, Plant Engineering and Nursing Supervision leaders and staff members.

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3. For disciplines listed above, education regarding the same topics as above will be ongoing by unit leaders until 100% compliance is achieved and prior to staff working on the floor. The DON informed the leaders of Social Workers, Admissions, Case Management, Therapy Services, Dietary Services, Environmental Services Plant Engineering, and Nursing Supervision that they and all the staff must attend the outlined education on abuse until 100% compliance is achieved and prior to staff working on the SNU.

4. At 1:00pm, the Resident Council was provided education to residents on how to report safety concerns. The Clinical Outcomes Manager and the Unit Clinical Coordinator explained to the residents the importance of reporting any safety concerns, what constitutes a safety concern, how to report, when to report (immediately), and how they can report to staff members or leaders.

5. At 2:50pm, during shift change, company police provided an in-person, face-to-face in-service to SNU staff (nurses, nurse assistants) that were present about abuse. The in-service covered domestic and workplace violence, the security management plan, responsibilities of leaders, team members duty to report, actual and potential security risks, activation of emergency response if situations of abuse/potential harm and 911 notifications. The DON or Manager of Clinical Outcomes will provide SNU staff that were not present education via daily huddles and one on one sessions. This information will be tracked by the DON, who will ensure 100% education of SNU staff is completed upon returning to work.

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F 600	Continued From page 34 6. As part of onboarding new staff, standard, facility-wide orientation facilitated by the Human Resources Department includes education regarding the Emergency Operations Plan and reasonable suspicion of a crime examples. A computer-based learning module created by the facility's Professional Development Department about resident abuse and neglect remains a part of the SNU staff's annual education requirements. Additionally, the DON will be responsible for ensuring completion of a unit-specific orientation checklist that includes each new hire's verification of understanding the abuse policy (definition of abuse, reportable situations, and who/how to report) and the emergency operations policy including how to call for help. Proof of completion of the SNU-specific orientation checklist will be kept in the employee's file. Alleged Immediate Jeopardy Removal Date: 05/03/2024 Onsite validation of the immediate jeopardy removal plan was completed on 5/6/24. Interviews confirmed all staff from all departments were educated on abuse, the definition of abuse, what events require activating the emergency preparedness plan including what to do when residents experience potential or actual harm related to an abuse situation, and what constitutes reasonable suspicion of a crime as a result of abuse. Additionally, all nursing staff were educated by the company police on multiple topics that included actual and potential security risks to include situations of abuse. The DON verified she was responsible for ensuring new staff complete unit specific training that includes verification of staff's understanding of the abuse policy. Interviews with residents revealed they were educated on how to report safety concerns	F 600		

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F 600	Continued From page 35 and what constitutes a safety concern. The facility's immediate jeopardy removal date of 5/3/24 was validated.	F 600		
F 607 SS=L	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 record review and interviews with	F 607	In addition to the actions taken by 5/4/24	5/28/24

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police, resident, and staff, Nurse Aide (NA) #1 failed to immediately report an incident of abuse to administration after Resident #2 threatened Resident #1 with a knife on 4/9/24. The administration was not aware of the incident until 4/11/24 when Resident #1 reported the incident to Nurse #1 and who then informed administration. The knife remained in Resident #2's possession until police were contacted on 4/11/24 to confiscate the knife. This resulted in a failure to immediately implement protective measures. Resident #2 had access to all facility residents which placed all residents (34 residents) at high likelihood of suffering harm from further abuse perpetrated by Resident #2. The facility also failed to notify the state agency of the abuse within the required timeframe and they did not report the abuse to Adult Protective Services (APS). This was for 1 of 3 residents investigated for abuse (Resident #1).

Immediate Jeopardy began on 4/9/24 when the facility failed to implement measures to protect all residents from abuse after Resident #2 threatened Resident #1 with a knife. Immediate jeopardy was removed on 5/4/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of "F" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.

Findings included:

Review of the facility policy entitled "Abuse, Neglect and/or Theft of Patient Property In [company name] Health Facilities, Prevention and

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which are already reflected in this 2567 document, the following actions have been taken:

On 5/5/24, the DON reviewed orientation materials for skilled nursing unit (SNU) team members. As part of onboarding new staff, standard, facility-wide orientation facilitated by the Human Resources department includes education regarding timely abuse reporting and failure to do so will result in staff putting residents at further risk. A computer-based learning module created by the facility's Professional Development department about resident abuse and neglect remains a part of the SNU staff's annual education requirements. Additionally, the DON will be responsible for ensuring completion of a unit-specific orientation checklist that includes each new hires' verification of understanding the abuse policy (definition of abuse, reportable situations, and who/how to report and that failure to do so will result in staff putting residents at risk of further abuse) and proof of completion of the SNU specific orientation checklist will be kept in the employee's file.

On 5/6/24, the SNU social worker reported the incident to Adult Protective Services.

The Abuse, Neglect, and/or Theft of Patient Property Policy applies to all current and future SNU residents. In order to ensure existing residents (as of 5/1/24) understood their rights to be free from

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Investigation" dated 8/2023 revealed staff are to report suspected incidents of patient abuse, neglect and theft to their leader. The policy stated senior nursing leadership, the Director of Nursing (DON), was responsible for notifying law enforcement. It further revealed that protection and emotional support will be provided to the resident.

An initial report with the investigation report was submitted to the state agency on 4/18/24. The report indicated the facility became aware of the incident on 4/11/24 at 3:00 PM. The investigation included a timeline of events. On 4/9/24 Resident #2 entered the room of Resident #1, "brandished [waved] a knife" and threatened her. Resident #1 indicated that Nurse Aide (NA) #1 was in the room when Resident #2 threatened Resident #1 and she (NA #1) "turned her head and walked away." On 4/17/24 the hospital legal team gave permission to contact the State agency. The Director of Nursing (DON) contacted the State agency by phone on 4/18/24 at 8:30 AM.

An interview was conducted with Resident #1 on 4/30/24 at 11:28 AM. (Resident #1's annual Minimum Data Set (MDS) assessment dated 3/17/24 indicated her cognition was intact.) Resident #1 stated NA #1 was in her room on 4/9/24 when Resident #2 threatened her with a knife. She was unsure of her (NA #1's) exact location within the room when the incident happened. Resident #1 stated she remained in her room after the incident because she was afraid of Resident #2. She stated she normally spent a great deal of time out of her room and participated in activities throughout the day. Resident #1 stated that she was scared "he was gonna get me" and that she feared for her life.

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abuse, neglect, misappropriation of resident property, and exploitation including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms, on 5/1/24 an ad hoc resident council meeting was facilitated by the nursing leadership to educate the residents on their rights to be free from physical and mental abuse. There was a discussion about the different types of abuse and when and how to report abuse. Residents were also educated on the personal belongings policy including the list of contraband items and that this same policy will be provided to each new resident upon admission.

On 5/5/24, the SNU admission packet was updated by the DON to include the list of contraband items that include but are not limited to weapons (firearms, knives, explosives), lighters and other smoking materials or smokeless tobacco, illicit substances, and drug paraphernalia which are strictly prohibited. On 5/5/24, the list of contraband items was given to each resident and emailed to every resident's family member(s) and/or power of attorney by the DON. A flier outlining what constitutes contraband was placed at the entrances (elevators) to the unit and in the visitor restroom on the SNU.

Effective 5/3/24, the DON is monitoring adherence to the corrective action measures. The DON or designee is maintaining a spreadsheet to track

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She stated she felt powerless to stop him from harming her if that was his plan. Resident #1 informed her family member of the incident on the phone. The family member told her (Resident #1) to report the incident to the facility or she (her family member) would report it. Resident #1 stated the first staff member she reported the incident to was Nurse #1 on 4/11/24. She stated the DON visited her room on 4/11/24 after she initially disclosed the incident to Nurse #1.

An interview was conducted with Nurse #1 on 4/30/24 on 3:35 PM. She stated Resident #1 called her into her room on 4/11/24 and told her Resident #2 had threatened her with a knife. Nurse #1 stated Resident #1 indicated she was sharing this with her (Nurse #1) in case something happened with Resident #2 and the knife. Nurse #1 stated she went immediately and reported this to the DON.

During an interview with Nurse Aide #1 on 4/30/24 at 1:07 PM she stated she provided care to Resident #1 on 4/9/24 and did not see a knife while she was in Resident #1's room. NA #1 stated she heard Resident #1 and Resident #2 talking about a knife. NA #1 stated she could not recall what specifically was said because she was trying to get her work done at the time. She stated she was in and out of Resident #1's room and reported the conversation about the knife occurred while she was in the hallway. She stated she thought they (Resident #1 and Resident #2) were joking around because Resident #2 frequently discussed his criminal history and bragged a great deal about his past criminal history. NA #1 stated she "intentionally" did not look for the knife. She indicated she did not want to be involved.

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confirmation that residents receive the personal belongings (contraband) policy upon admission. In order to monitor our performance and ensure solutions are sustained, the DON is monitoring compliance. The numerator is the number of new residents who receive a copy of the policy and the denominator is a total number of admissions.

Additionally, to validate that new hires understand unit policies and procedures pertaining to abuse, neglect, and exploitation of residents, misappropriation of resident property, and implementation of the emergency operations policy (EOP), the DON will validate that the new hire checklist is completed. The numerator is the number of new hires who have completed the new hire checklist and understand their responsibilities related to prohibiting and preventing abuse, neglect and exploitation of residents and misappropriation of resident property, and implementation of the EOP including timely reporting. The denominator is the number of new hires.

Finally, SNU staff will complete annual mandatory abuse/neglect education. The numerator is the number of SNU staff completing annual abuse/neglect education and the denominator is the total number of SNU staff. This process is ongoing.

Effective 5/4/24, all reports of potential abuse are reviewed by the leadership team (DON, President/Administrator, and

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A second interview was conducted with NA #1 with the DON present on 5/1/24 at 11:00 AM. NA #1 reported she never saw Resident #2 with the knife on 4/9/24. NA #1 stated she saw Resident #2 in the doorway of Resident #1's room (4/9/24) and heard him say something about having a knife. She reported she (NA #1) heard Resident #2 say he believed she (NA #1) and NA #2 had reported him for having the knife after it was confiscated by the police on 4/11/24 and he stated he (Resident #2) was going to get them (NA #1 and NA #2). During this interview NA #1 acknowledged that she was afraid of Resident #2 because he frequently bragged about his criminal history. She reported after the knife was discovered on 4/11/24 he yelled out frequently "who is the snitch" and "snitches get stitches".

An interview was conducted with the DON on 4/30/24 at 10:53 AM. She stated she spoke with Resident #1 on 4/11/24 who stated Resident #2 had threatened her (Resident #1) with a knife on 4/9/24. The DON stated she called the hospital police department (the facility was located on the second floor of a hospital) immediately for advice. She reported she was advised to contact the local police department for assistance with confiscating the knife. She reported she contacted the local police on 4/11/24 who responded and confiscated the knife from Resident #2. The DON stated the knife was placed in a personal belonging bag and locked in the nursing supervisor closet. She reported she spoke with the hospital leadership, the facility's legal team and the hospital police force on 4/12/24 about discharging Resident #2 and how to best honor Resident #2's rights. The DON stated Resident #2 was discharged on 4/18/24 to the local police due to him having two

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medical director) to evaluate effectiveness of the admission evaluation process, EOP implementation, and timeliness of reporting requirements including but not limited to Adult Protective Services.

On 5/28/24, the DON reviewed the file of the one new hire and confirmed that the new hire's file verifies completion of the Emergency Operations Policy education as of 5/20/24. This education included how to call for help.

This ongoing data will be reported at the SNU Quality Assurance and Process Improvement (QAPI) meeting and documented in the minutes.

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outstanding warrants. She stated it was her understanding that he was taken to the local jail.

Review of the police report completed by Police Officer #1 dated 4/11/24 revealed a warrant check was conducted and Resident #2 was found to have two felony warrants.

During a phone interview conducted with Police Officer #2 on 5/6/24 at 2:16 PM she stated she came to the facility on 4/11/24 solely to confiscate the knife. She explained the resident, staff, and facility had elected not to press charges. She indicated the knife's blade was 4 inches long and the handle of the knife was blue and black. She stated the handle was 4 inches long. Police Officer #2 stated the knife had a flip blade (a blade which was spring loaded and the blade was automatically engaged by pressing a button).

A phone interview was conducted with Police Officer #1 on 5/2/24 at 10:42 AM. He stated he spoke with Resident #2 on 4/12/24 after the incident was disclosed and informed him that threatening behavior to residents and staff would not be tolerated. Police Officer #1 reported Resident #2 stated he would comply. He stated Resident #2 was not arrested on 4/11/24 because Resident #1 was not willing to cooperate with prosecution. He further explained Resident #2 was receiving medical care from the facility so he was not taken into custody for the outstanding warrants on 4/11/24.

Review of a notice of discharge for Resident #2 dated 4/18/24 revealed Resident #2 was discharged from the facility on 4/18/24 due the safety of individuals in the facility being endangered. The notice of discharge revealed

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his discharge location was the local jail.

The facility and hospital were part of the same entity and had a shared medical record. The medical record revealed as of 5/6/24 Resident #2 was in a local hospital awaiting placement after transfer from the jail due to concerns related to his health.

A follow up interview was conducted with the DON on 5/6/24 at 9:30 AM and she stated she was unaware she needed to make a report to adult protective services. She reported staff were to report allegations of abuse to their immediate supervisor as soon as possible. The DON stated NA #1 should have reported her knowledge of the knife and the incident between Resident #1 and Resident #2 to her supervisor. She stated NA #1 stated she did not want to be considered a "snitch". The DON reported this put all other residents at risk. She stated when she was notified on 4/11/24 by Nurse #1 she immediately contacted the hospital police for guidance and implemented protective measures.

An interview was conducted with the facility Administrator on 4/30/24 at 3:33 PM. She stated they did not report the incident to the State agency until 4/18/24 because they were unsure if the incident was reportable. She stated there were conversations with the hospital legal team to ensure Resident #2's rights were respected. The Administrator indicated they were unaware they were to report this incident to APS.

The Administrator was notified of immediate jeopardy on 5/1/24 at 1:15 PM.

The facility provided the following immediate

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jeopardy removal plan:

- Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
The facility did not implement its abuse policy and therefore protective measures were not immediately implemented and this placed all residents at risk of suffering serious harm from abuse perpetrated by Resident #2.

Incident
On 04/9/2024, NA #1 witnessed Resident #2 abuse Resident #1, and NA #1 did not follow the abuse policy by immediately reporting to leadership or law enforcement. The failure to immediately report resulted in protective measures not being implemented for facility residents.

On 04/11/2024 at 3:11pm, the Director of Nursing (DON) notified company police that there was a resident (Resident #2) in possession of a knife, which posed a security threat. The DON then called the local police department for assistance with confiscating the knife at 3:37pm. In an effort to ensure no other residents were abused, and while Resident #2 was resting in his room with the door shut, the DON cleared the Skilled Nursing Unit (SNU) hallways of residents and staff. Residents were escorted to their rooms and room doors were shut by staff. The residents were kept safe and told they should go and stay in their room while staff investigated the situation. In an effort to maintain a calm environment, we did not disclose the details to the other residents. Residents were kept calm and supported by staff by maintaining business as usual.

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In addition, staff were relocated to the day room at 3:40pm. The DON stayed at the nursing station monitoring the patient call system. The DON instructed the local police to search Resident #2's room for any additional contraband. The local police instructed Resident #2 that having a weapon on hospital property (the SNU was located within a hospital) is not allowed. The DON and local police asked Resident #2 if he had any concerns about his safety and he responded no.

Within less than twenty minutes, after the knife was confiscated, the DON announced via a unit overhead page that staff and residents were free to move about the unit. The Social Worker reported to the unit and was briefed on the situation by the DON. The DON directed the Social Worker to round first on Resident #1. After providing emotional support and offering resources such as Chaplain services, counseling, physician consultation etc. to Resident #1, (who declined) the Social Worker rounded on the other Residents to assess exposure to or impact of the abuse situation. This was achieved by individually interviewing residents and asking if there were any questions, concerns or needs.

The DON presented to Resident #1's room on 04/11/2024 to assess the situation. The DON discussed the situation that happened on 04/9/2024 when Resident #2 entered her room with a knife. Resident #1 explained in her normal demeanor what happened and admitted that she was fearful of retaliation and did not come out of her room for a couple of days. The DON determined there was no need for further interventions for Resident #1 on 04/11/2024.

In addition, the DON rounded on residents and

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implemented a two-team member approach to providing care to Resident #2, or when entering his room. At the time, the DON determined via one-to-one interviews, no other residents had been harmed or in need of assistance. This is evidenced by no complaints or grievances from other residents at the time. The DON debriefed with the oncoming nursing supervisor who then instructed the security officer who works every day from 5:00pm to 3:00am to complete extra rounding on the SNU.

The DON was onsite monitoring the situation and handed off to the nursing supervisor at 4:40pm on 04/11/2024 instructing them to supervise Resident #2 closely. The DON consulted the Medical Director and a Behavioral Health consult was ordered for Resident #2. The DON debriefed the team and instructed the team to place this patient on close supervision and call the local police department immediately at the onset of any threatening behaviors from Resident #2. The Minimum Data Set (MDS) Coordinator modified Resident #2's care plan to include interventions to include interventions that would reduce or eliminate inappropriate or threatening behaviors. The DON notified the dietary services to place Resident #2 on a "safe tray" that utilizes plastic utensils, Styrofoam tray and no plastic bags.

On 04/12/2024, the DON called the SNU to check on all residents and staff, which reported non-disruptive and "good behavior" from Resident #2 and there were no issues at 2:00am.

The DON investigated the incident on 04/12/2024 by interviewing team members and the alert and oriented residents to assess for other incidents.

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The DON asked the alert and oriented residents if any other resident or staff have hurt them or made them feel unsafe. The DON assessed that cognitively impaired residents did not demonstrate signs of physical harm (i.e. no injuries of unknown origin) or emotional anguish (i.e. no pursed lips, muscle tension, restlessness, or labored breathing). The residents (other than Resident #1) and staff reported no additional episodes of threatening behavior or abuse.

1. On the following dates and times, the Director of Nursing (DON) facilitated a leadership meeting with legal department, case management, risk management, company police and manager of Clinical Outcomes to establish next steps, including the clinical appropriateness of resident discharge and associated Centers for Medicare and Medicaid Services (CMS) regulations.
-On 04/12/2024 at 11:00am: The team discussed the risks vs benefits of Resident # 2 remaining a resident at current facility.
-On 04/16/2024 at 10:30am: The team discussed discharge disposition options.
-On 04/17/2024 at 4:00pm: The team allocated appropriate durable medical equipment (DME) and medications to facilitate a safe discharge plan.
-On 04/18/2024 at 9:30am, the above referenced team members finalized the discharge plan.

2. On 04/18/2024 at 10:07am, the DON completed the Nursing Home Notice of Transfer/Discharge that was signed by the facility President/Administrator and given to Resident #2. The attending provider completed a discharge summary and wrote a discharge order for Resident #2 at 10:15am. At 11:45am, the patient received Durable Medical Equipment (DME) and

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medications and was safely discharged from the facility.

3. On 04/18/2024 at 2:00pm, the DON discussed the context of Resident #2's discharge, including the facility policy, CMS guidelines, and importance of resident and staff safety with SNU staff via a staff meeting. Staff that were not present received this education from the DON, Clinical Coordinator or Nursing Supervisor, via one-on-one discussions upon arrival to their next shift.

4. The DON self-reported the resident abuse safety incident to the NC Department of Health and Human Services via fax on 4/18/2024 at approximately 4:30pm. No other agency was notified. The ombudsman was notified on 04/17/2024 at 11:41pm.

5. On 04/19/2024, the DON told Resident #1 that Resident #2 was discharged. The DON commended Resident #1 for discussing the incident and requested immediate reporting to the nurses or leadership if there is any situation or concerns in the future. The DON reassessed Resident #1 for mental suffering, found the resident to not be in distress and offered support including emotional support, pet therapy, chaplain services and counseling. Resident #1 stated that she also had a conversation with the Social Worker about available resources such as counseling, but Resident # 1 declined all available resources.

Review of other abuse allegations:
On 05/03/2024 at 3:00 pm, the Administrator and the DON reviewed the one other abuse allegation since September of 2022, the staff member who

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was the alleged threat was immediately suspended pending investigation. Protective measures were implemented immediately. The investigation was substantiated, and the staff member was terminated. All reports were filed with DHHS timely.

- Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:
On 05/01/2024, the following actions were completed:
1. At 3:00pm, the DON reviewed the 2023 annual training transcripts for of all SNU team members to ensure they completed required resident abuse/neglect education. Results revealed 100% compliance of all SNU staff (nursing and nursing assistants, activity coordinator).

2. At 4:00pm, the SNU Clinical Coordinator provided education to SNU clinical team members (Licensed Nurses, Certified Nursing Assistants, Activity Coordinator) present on-site via on-site in-person training:
a. Emergency Operations activation (who to report to, when to report, and the importance of implementing protective measures).
b. Reasonable suspicion of a crime examples (which could result in abuse)
Resident abuse - the definition of abuse, what needs to be reported and who/how to report.
c. By failing to immediately report safety concerns or abuse, staff are putting residents at risk of further abuse.

3. Beginning at 5:00pm, the Nursing Supervisor educated team members in the following disciplines of the above educational topics via

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in-person, face-to-face huddles (A huddle is a fixed time for gathering of team members to focus on care coordination, facilitate immediate face-to-face clarification of issues and discuss important topics. This process is designed to improve productivity, communication, and teamwork within clinical practice settings and is typically held at shift changes. It focuses on the daily action plan, and adjustments needed which improves efficiency and enhances teamwork by anticipating needs for the day. The goal of huddles is to increase individual team member accountability for patient safety and to help foster a culture of empowerment and collaboration) on the following units:
a. SNU licensed nurses
b. SNU certified nursing assistants
c. Therapy services
d. Environmental Services
e. Dietary
f. Facilities
g. Clinical outcomes

The following actions were completed on 05/2/2024:
1. To continue education efforts of team members that had not yet received education, at 6:50am, the DON facilitated a SNU team meeting and in-service and completed education regarding the same topics outlined above in #2.

2. At 8:30 AM, the Manager of Clinical Outcomes facilitated another in person, face-to-face in-service on the abuse topic as outlined in # 2 above in the facility's education room for Social Workers, Admissions, Case Management, Therapy Services, Dietary Services, Environmental Services, Plant Engineering and Nursing Supervision leaders and staff members.

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3. For disciplines listed above, education regarding the same topics as above will be ongoing by unit leaders until 100% compliance is achieved and prior to staff working on the floor. The DON informed the leaders of Social Workers, Admissions, Case Management, Therapy Services, Dietary Services, Environmental Services Plant Engineering, and Nursing Supervision that they and all the staff must attend the outlined education on abuse until 100% compliance is achieved and prior to staff working on the SNU.

4. At 1:00pm, the Resident Council was provided education to residents on how to report safety concerns. The Clinical Outcomes Manager and the Unit Clinical Coordinator explained to the residents the importance of reporting any safety concerns, what constitutes a safety concern, how to report, when to report (immediately), and how they can report to staff members or leaders.

5. At 2:50pm, during shift change, company police provided an in-person, face-to-face in-service to SNU staff (nurses, nurse assistants) that were present about abuse. The in-service covered domestic and workplace violence, the security management plan, responsibilities of leaders, team members duty to report, actual and potential security risks, activation of emergency response if situations of abuse/potential harm and 911 notifications. The DON or Manager of Clinical Outcomes will provide SNU staff that were not present education via daily huddles and one on one sessions. This information will be tracked by the DON, who will ensure 100% education of SNU staff is completed upon returning to work.

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6. As part of onboarding new staff, standard, facility-wide orientation facilitated by the Human Resources Department includes education regarding timely abuse reporting and failure to do so will result in staff putting residents at risk of further abuse. A computer-based learning module created by the facility's Professional Development Department about resident abuse and neglect remains a part of the SNU staff's annual education requirements. Additionally, the DON will be responsible for ensuring completion of a unit-specific orientation checklist that includes each new hire's verification of understanding the abuse policy (definition of abuse, reportable situations, and who/how to report and that failure to do so will result in staff putting residents at risk of further abuse) and Proof of completion of the SNU-specific orientation checklist will be kept in the employee's file.

Alleged Immediate Jeopardy Removal Date: 05/04/2024

Onsite validation of the immediate jeopardy removal plan was completed on 5/6/24. Interviews confirmed all staff from all departments were educated on abuse, the definition of abuse, reportable situations, who/how to report to, and that a failure to report will result in staff putting residents at risk for further abuse. Additionally the staff were educated on what events require activation of the emergency preparedness plan including what to do when residents experience potential or actual harm related to an abuse situation and what constitutes reasonable suspicion of a crime as a result of abuse. Additionally, all nursing staff were educated by

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F 607	Continued From page 51 the company police on multiple topics that included actual and potential security risks to include situations of abuse and the duty to report. The DON verified she was responsible for ensuring new staff complete unit specific training that includes verification of staff's understanding of the abuse policy to include reporting and protection of residents. Interviews with residents revealed they were educated on how to report safety concerns and what constitutes a safety concern. The facility's date of 5/4/24 was validated.	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	F 656		5/30/24

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F 656	Continued From page 52 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 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 and implement an individualized person-centered care plan in the areas of gastroesophageal reflux disease (GERD), hypertension, diabetes mellitus, falls, incontinence, pain, opioid pain medication, mood, and depression for 1 of 3 residents reviewed for comprehensive care plans (Resident #1). Findings included: Resident #1 was admitted to the facility on 2/3/23 with diagnoses that included GERD, hypertension and diabetes mellitus. Resident #1's annual Minimum Data Set (MDS)	F 656	The facility implemented a new electronic medical record (EMR) system on 5/4/24. Care plan data was cut over into the new EMR in the first week following go-live. On 5/5/24, the Director of Nursing (DON) initiated a care plan for each resident (including Resident #1) into the new EMR. By 5/8/24, the Minimum Data Set (MDS) coordinator completed comprehensive care plans in the new EMR for all admitted patients. On 5/8/24, the unit census was reviewed by the DON and MDS Coordinator who validated that 100% residents had a current, individualized person-centered	

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assessment dated 3/17/24 revealed she was cognitively intact. She was assessed with little interest or pleasure in doing things and feeling down/depressed/hopeless on 2 to 6 days. Resident #1 was always incontinent of bladder and bowel. She received routine and PRN (as needed) pain medications and antidepressant medication.

Review of Resident #1's active care plan, last updated 2/21/23, revealed focus areas for GERD, hypertension, diabetes mellitus, incontinence, chronic pain, opioid pain management, mood and depression. These focus areas each had goals identified, but no corresponding interventions. An additional focus area was in place for falls. This focus area had no identified goal and no corresponding interventions.

During an interview on 5/2/24 at 3:15 PM the MDS Nurse stated Resident #1's care plan should have been completed with interventions and goals for each focus area listed. She stated she was recently hired at the facility in the last month.

An interview was conducted with the Director of Nursing (DON) on 5/2/24 at 3:30 PM. She stated the previous MDS coordinator resigned in December 2023. She stated the facility had a difficult time recruiting a replacement. She reported she had developed a plan with the new MDS Nurse to get the MDS assessments and care plans up to date. The DON stated the MDS assessments had been completed but the care plans had not been completed.

During an interview with the Administrator on 5/6/24 at 10:00 AM she indicated due to the

F 656

care plan and corresponding interventions in place.

The "team conference" component of the long-term care (LTC) specific module of the facility's EMR will be utilized to document high-volume or high-risk plan of care updates. Using this new resource, the MDS coordinator or designee will make updates to the resident's care plan in real-time in the LTC module of the EMR. Additionally, the facility maintains a contract with the third party company utilized during the vacancy of the MDS coordinator role. This company can be engaged in the event of prolonged vacancies (i.e. turnover, FMLA, etc.) in our MDS role.

Effective 6/1/24, the DON will conduct a weekly chart audit for four months to ensure that a team conference note is documented for each resident each week. In order to monitor our performance and ensure solutions are sustained, the DON will monitor compliance. The numerator is the number of compliant medical records and the denominator is the number of medical records audited.

If a plan of care change in noted in the team conference note, then the DON will conduct an audit of the MDS navigator section corresponding to the change to ensure the care plan is updated appropriately. The numerator is number of updated care plans and the denominator is the number of team conference notes reflecting a need for an update to the care

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F 656	Continued From page 54 resignation of the previous MDS coordinator she was aware the care plans had not completed timely.	F 656	plan. This ongoing monitoring data will be reported at the SNU Quality Assurance and Process Improvement (QAPI) meetings and documented in the meeting minutes.	
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 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	F 867		5/31/24

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F 867	Continued From page 55 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 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	F 867		

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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 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

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F 867	Continued From page 57 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee previously put in place following the recertification survey of 2/17/23. This was for 1 repeat deficiency in the area of developing and implementing comprehensive care plans (F656). The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: The tag is cross-referenced to: F656: Based on record review and staff interviews, the facility failed to develop and implement an individualized person-centered care plan in the areas of gastroesophageal reflux disease (GERD), hypertension, diabetes mellitus, falls, incontinence, pain, opioid pain medication, mood, and depression for 1 of 3 residents reviewed for comprehensive care plans (Resident #1). During the recertification survey of 2/17/23 the facility was cited for not having a care plan in place related to antidepressant medication for a resident who was receiving antidepressant medication. An interview with the Director of Nursing (DON)	F 867	As a result of the recertification survey on 2/17/23, a corrective action plan was initiated to include the following: the Minimum Data Set (MDS) coordinator running a weekly report from the electronic medical record (EMR)to capture any newly prescribed medications; weekly resident huddles with secure spreadsheet tracking; the DON was added to all care plan meeting invites; the DON created a standardized care plan meeting note template to capture all required elements; the MDS coordinator coordinated a shared calendar that listed the names and dates of all upcoming assessment deadlines; the DON spot-checked the calendar with EMR documentation to validate updated care plans. The new processes were tracked and validated by the DON, and the MDS reported at the quarterly Quality Assurance Process Improvement (QAPI) meetings. The MDS Coordinator's last day of employment was 12/23/23. On 3/13/24, the third party MDS nurses assumed responsibility for the MDS data and care plans. On 3/13/24, a revised Corrective Action Plan (CAP) was initiated by the DON with the MDS third party nurses to ensure all current residents had up-to-date MDS assessments. On 3/14/24 the internal, voluntary CAP was discussed by the DON at the quarterly skilled nursing	

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was conducted on 5/6/24 at 9:00 AM. She reported she led the quality improvement tasks in the facility and the facility attempted to correct any on-going issues that were identified. The DON further stated the facility had some turnover in the role of Minimum Data Set Coordinator which may have contributed to the repeat citation.

F 867

unit (SNU) QAPI meeting. On 3/18/24, the third party MDS nurses reported to the DON that care plan data was missing. The DON instructed the third party MDS nurses to ensure the residents in the facility on that date had updated care plans documented within 3 weeks. The DON audited the MDS EMR, "Point Click Care," (PCC) to verify that care plans had been opened on every resident. Due to difficulty navigating and accessibility within PCC, the DON was able to verify that care plans had been opened but was not able to visualize implementation of the interventions.

On 5/5/24, the DON initiated a care plan for each resident admitted in the SNU on that date into the new EMR. By 5/8/24, the MDS coordinator completed comprehensive care plans in the new EMR for admitted residents. On 5/8/24, the DON and MDS coordinator validated that 100% of residents had a current, individualized, person-centered care plan and corresponding interventions in place.

The DON began giving a SNU QAPI report at the monthly Clinical Excellence meetings beginning on 4/23/24. On 5/31/24, the President/Administrator added the SNU QAPI report to the annual Medical Staff meeting agenda.

QAPI meetings have been occurring quarterly per regulatory requirements. The DON adjusted the QAPI meeting schedule to monthly and established a standard agenda template which covers all

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F 867	Continued From page 59	F 867	components of the QAPI/QAA improvement activities outlined below as per CFR (s) 483.75 (c)(d)(e)(g)(2)(i)(ii). Monthly, effective 6/1/24, the DON will conduct a patient-centered, nursing-focused QAPI meeting encompassing the following disciplines: unit nursing leadership, MDS coordinator, social work, and activities coordinator. The following standard agenda items will be discussed: MDS/care plan status, grievances, regulatory reporting and/or plan of correction implementation, and active unit quality or process improvement projects with corresponding data review. Quarterly, the DON will continue to conduct a comprehensive QAPI meeting with all QAPI stakeholders including those listed above plus the medical director, facility administration, pharmacy, infection prevention and control (IPC), therapy, and clinical outcomes. Progress regarding the standard agenda items for the monthly QAPI meeting will be evaluated in addition to reports shared on the following quarterly standing agenda items: facilities, regulatory quality reports (e.g. MDS and Centers for Medicare and Medicaid Services star ratings), pharmacy reports, IPC reports, and unit education needs. The DON adjusted the QAPI meeting schedule to monthly and established a standard agenda which covers all the components of QAPI/QAA improvement activities as per CFR (s) 483.75 (c)(d)(e)(g)(2)(i)(ii). The more frequent QAPI meetings allocate more time for leaders to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING ______ B. WING ______	C 05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 60	F 867	support the revised QAPI approach. In order to monitor performance and ensure solutions are sustained, effective 6/1/24, the DON will monitor compliance by conducting a weekly chart audit for 4 months to ensure that a team conference note and care plan update, as appropriate, is documented for each resident each week. The numerator will be the number of compliant medical records (e.g. conference note and updated care plan, as appropriate) and the denominator will be the number of medical records audited. If a plan of care change is noted in the team conference note, then the DON will conduct an audit of the MDS navigator section corresponding to the change to ensure the care plan is updated appropriately. This ongoing monitoring data will be reported at the QAPI meetings and documented in the minutes.	