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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 6/04/24 through 6/05/24 Event ID# EBTJ11. The following intakes were investigated NC00217401 and NC00216179. 1 of the 4 complaint allegations resulted in a deficiency. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity (G) Non-compliance began on 5/17/24. The facility came back into compliance effective 5/21/24.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to protect a	F 600	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 06/19/2024

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cognitively intact resident from verbal and physical abuse by a family member when Family Member #1 threw cold tea and water onto Resident #1, put her hands around Resident #1's throat, threatened to kill her and pushed Resident #1 onto the bed. This resulted in redness to Resident #1's neck. Resident #1 was sent to the Emergency Department (ED) for evaluation and returned the same day with a diagnosis of the strain of the neck muscle. Staff reported the resident appeared out of breath, nervous, and shocked following the incident. A reasonable person would have experienced feelings such as fear, anxiety, and humiliation. This was for 1 of 4 residents reviewed for abuse.

Findings included:

Resident #51 was admitted to the facility on 4/27/24 with a diagnosis of atrial fibrillation, chronic obstructive pulmonary disease, and chronic pain syndrome.

A review of Resident #1's admission Minimum Data Set (MDS) assessment dated 5/03/24 revealed she was cognitively intact.

A review of a nurse progress note written by Agency Nurse #1 completed for Resident #1 dated 5/17/24 at 8:15 PM revealed that Resident #1 walked out of the room to the hallway using her walker, stated Family Member #1 threw tea and water on her and choked her. Resident #1 was drenched in tea (cold tea) and water. Vital signs were taken and oxygen 2 liters given via nasal canula. The residents' skin was assessed, and redness was noted on her neck. Tylenol was given for general pain. The Nurse Practitioner was made aware and an order was received to

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be sent to ER (emergency room) for evaluation and treatment.

Agency Nurse #1 did not respond to attempts to contact her via telephone for an interview.

In an interview on 6/04/24 at 2:49 PM Nurse #1 revealed she had been working on Resident #1's discharge on 5/17/24 as she was scheduled to discharge home that day. Family Member #1 arrived and made multiple excuses for why she could not take Resident #1 home. Nurse #1 revealed that after talking with Family Member #1, she (Family Member #1) went to Resident #1's room, Nurse #1 believed to discuss the discharge with the resident and closed the door. Nurse #1 revealed she was with the Social Worker (SW) approximately 20-30 minutes later when they (Nurse #1 and the SW) saw Family Member #1 walking fast down the hall and noticed that her necklace was broken. When asked what happened to her necklace Family Member #1 began cursing, stated Resident #1 broke the necklace and she (Family Member #1) continued walking. Nurse #1 indicated she went to check on the resident and saw Resident #1 out of her room and overheard her telling Agency Nurse #1 that Family Member #1 tried to choke her. She indicated Resident #1 seemed out of breath so Nurse #1 provided her with oxygen and encouraged her to take deep breaths and calm down. Resident #1 indicated Family Member #1 had thrown tea (cold tea) and water on her, tried to choke her by putting her (Family Member #1's) hands around her throat, and then pushed her back onto her bed. Family Member #2 then pulled Family Member #1 off the resident. Nurse #1 revealed the resident's shirt and pants were wet, and there was liquid on the chair and floor in her

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room. Nurse #1 revealed she immediately reported the incident to the Director of Nursing (DON) who went to check on the resident. Nurse #1 reported that Resident #1 seemed shocked about what had happened and out of breath as she had waited all day to discharge home and Family Member #1 refused.

In an interview on 6/04/24 at 3:00 PM the SW revealed on 5/17/24 she had been working with the Family Member #1 from 11:30 AM till 4:00 PM arranging Resident #1's discharge. She indicated shortly afterwards she saw Family Member #1 in the hall and noticed her necklace was broken. When she asked what had happened, Family Member #1 began cursing Resident #1 and accused her (Resident #1) of breaking her necklace. The SW indicated Nurse #1 was with her and left to check on Resident #1. The SW reported after the incident, she and Nurse #1 encouraged Resident #1 to remain in the facility over the weekend so they could arrange a safe discharge on the following Monday. She indicated Resident #1 was nervous and shaken by the incident. The SW indicated while working with Family Member #1 she had no indication the incident would occur.

In a telephone interview with Resident #1 on 6/04/24 at 1:59 PM she reported that 5/17/24 was the first time anything like that had happened and she did not want to talk about it anymore.

A review of the hospital discharge summary dated 5/17/24 at 6:55 PM documented Resident #1 was brought in from the nursing facility for evaluation of possible injuries from an assault by Family Member #1 who was supposed to take her home today. Family Member #1 was reportedly trying to

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choke Resident #1 and was pulled away quickly. She has been arrested. Resident #1 notes pain in the left paraspinal muscles (muscles that support the back) but no anterior neck pain. Resident #1 was diagnosed with left neck strain. No other injuries were noted on the exam. Resident #1 was discharged back to nursing. Resident #1 was noted to take acetaminophen for discomfort.

Review of the Police Report completed on 5/17/24 at 4:56 PM documented the police received a report of a Crime Incident of Assault-Physical the facility. The police investigation was still in process.

In an interview on 6/04/24 at 12:56 PM the Director of Nursing (DON) indicated that Family Member #1 arrived on 5/17/24 to discuss plans for Resident #1's discharge home. She revealed the SW had 24-hour care lined up, however Family Member #1 was stalling and decided to not follow through with the discharge plan. The DON revealed the SW reported to her the family was upset, and she sent Nurse #1 down to see Resident #1, who then reported the incident to her. The DON indicated staff remained with Resident #1 and when interviewed by the police, Resident #1, repeated the same story. Resident #1 stated she told Family Member #1 she wanted to go home, and Family Member #1 went crazy on her. Resident #1 reported Family Member #1 said she would kill her, put her hands around her neck and pushed her back onto her bed and if Family Member #2 had not pulled her away, she may have been hurt. The DON reported Resident #1 had light red marks underneath her chin and complained of some neck pain. They called the Medical Doctor and received the order to send to the ED for evaluation. Resident #1 returned from

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the ED that same day with no new orders, and to follow up with her own physician. During that time, Family Member #1 and Family Member #2 returned to the facility, were stopped from entering the facility and the police arrested Family Member #1. The DON revealed Resident #1 agreed to stay the weekend, to allow time to arrange a safe discharge and on the following Monday (5/20/24) she went home with a family friend and with 24-hour services in place.

In an interview on 6/04/24 at 12:53 PM the Administrator indicated she was not in the building on 5/17/24 when Resident #1 reported that Family Member #1 had thrown cold tea and water on her. She indicated the DON immediately notified the police. She reported Family Member #1 was arrested later that evening when she returned to the facility. The Administrator reported that they had no prior indication Family Member #1 would become physical with Resident #1.

The facility provided the following corrective action plan:

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

On 5/17/24 the resident notified the Charge Nurse that during a visit at the facility Family Member #1 threw a glass of tea and attempted to throw a glass of water on the resident then put her hands around the resident's neck and stated, "I will kill you". The resident stated Family Member #1 pushed the resident hard back onto the bed, hitting the resident's leg with her shoe. Family Member #2 intervened, and both the Family Member #1 and Family Member #2 left the

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facility. On 5/17/24 at approximately 4:45pm, the Social Worker and the Unit Manager reported to the Director of Nursing that an altercation had occurred between the resident and the Family Member #1. The Unit Manager completed a skin assessment on the resident which revealed red marks on both sides of her neck. The resident complained of neck pain.

On 5/17/24 At approximately 5:00 pm, the Unit Manager notified the physician of altercation and resident assessment with a new order to send the resident to the emergency department for evaluation. The staff stayed with the resident for emotional support.

On 5/17/24 at approximately 4:50 pm, the Director of Nursing notified the local police department of alleged family to resident abuse.
On 5/17/24 at approximately 5:25pm, the Director of Nursing notified Adult Protective Services (APS) of alleged family to resident abuse.
On 5/17/24 at approximately 5:45pm the local police arrived and interviewed the resident with the same findings as the facility. During this time, Family Member #1 arrived back at the facility and was intercepted by the receptionist and police.

On 5/17/24 at approximately 6:10 pm, the resident was transported to the Emergency Department.
On 5/17/24 at approximately 6:30 pm, all current staff were educated, and a sign with a picture of Family Member #1 and Family Member #2 was placed at the front screening desk and time clock that the Family Member #1 and Family Member #2 were not allowed to visit.

On 5/17/24 at approximately 11:45pm, the

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F 600	Continued From page 7 resident returned from the hospital with a diagnosis of strain of neck muscle, and alleged assault. There were no new orders received. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 5/17/24, skin checks were initiated on all residents who are unable to report signs/symptoms of abuse by the hall nurse. A skin check assessment tool will be utilized with documentation in the electronic medical record. The skin checks were completed by 5/20/24 with no identified areas of concern. On 5/17/24, the Social Worker interviewed all alert and oriented residents regarding abuse. Questionnaires included: Do you know what abuse means? Are there any instances that you felt you were abused in any way that has not been addressed to include verbal abuse and/or abuse by family or visitors? Do you know who to report abuse to? Do you feel safe here? There were no additional concerns identified during resident interviews. Residents were educated on abuse to include domestic abuse and how to report abuse by the Social Worker during the interviews. The interviews were completed by 5/20/24. On 5/17/24, the Director of Nursing initiated questionnaires with all nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist regarding:	F 600		

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Do you know of any resident that you have witnessed or that has reported abuse to you that has not been addressed to include abuse by resident family and/or visitor? If yes: Please explain. The Administrator and/or DON will address all concerns identified during the questionnaires to include but not limited to assessment of the resident and reporting concerns per facility guidelines. The questionnaires were completed by 5/20/24. After 5/20/24, any staff that had not worked or who had not completed the questionnaire will complete it upon the next scheduled shift.

On 5/17/24, the Director of Nursing initiated an audit of all resident progress notes for the past 30 days. This audit is to identify any concerns related to abuse to include but not limited to verbal abuse and/or abuse by family or visitors. The DON will address all concerns identified during the audit to include assessment of the resident and reporting concerns per facility protocol. Audit was completed by 5/20/24.

" Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 5/17/24 the facility posted a picture of Family Member #1 and Family Member #2 at the front screening desk and time clock to ensure they are not permitted in the facility.

On 5/17/24 the DON initiated in-services with all nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk,

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Maintenance Director, Social Worker (SW), and receptionist regarding Abuse to include the definition of, domestic, verbal, and physical abuse, immediately removing/protecting resident from abuse and reporting abuse to the Administrator and/or DON. In-service was completed by 5/20/24. After 5/20/24, any staff who had not completed the in-service will complete it prior to the next scheduled work shift. Proactively the facility mailed in-services to any staff who had not worked or completed the in-service with instructions to read, sign and return to the Administrator and/or DON prior to the next scheduled work shift. All newly hired staff will be in service during orientation regarding Abuse.

On 5/20/24 Abuse Quizzes was initiated by the Unit Managers and Social Workers with all nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist. The quizzes included questions regarding (1) What to do first if you witness a resident being abused to include abuse by a family member or visitor? (2) If you witness abuse, when do you report it? (3) Who do you report abuse to? (4) if a family member is verbally or physically abusive to a resident, what do you do? (5) Who is the abuse officer/coordinator? The purpose of the abuse quizzes is to ensure that all staff display successful knowledge and understanding of abuse to include domestic abuse, intervening when abuse is witnessed or suspected and reporting abuse. The abuse quizzes were completed by 5/20/24. After

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F 600	Continued From page 10 5/20/24, any remaining staff that had not worked and not received the quizzes will complete it upon next scheduled shift. On 5/20/24, the Social Worker and Activities Director held an impromptu Resident Council Meeting with alert and oriented residents to review the definition of abuse to include domestic abuse, signs, and symptoms of abuse, what to do in an abusive situation and reporting abuse. The Social Worker educated any alert and oriented resident who did not attend the meeting 1:1. The education was completed by 5/20/24. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The IDT team to include the Administrator, DON, ADON, Unit Managers, and Social Worker, will review resident progress notes utilizing the Concerns Audit tool 5 times a week x 4 weeks during the IDT meeting. This audit is to identify any concerns related to abuse to include but not limited to verbal abuse and/or abuse by family or visitors. The Administrator and DON will address all concerns identified during the audit to determine if further actions are needed. The Social Worker will interview 10 alert and oriented residents regarding abuse weekly x 4 weeks utilizing the abuse questionnaire. Questionnaires included: Do you know what abuse means? Are there any instances that you felt you were abused in any way that has not been addressed to include verbal abuse and/or abuse by family or visitors? Do you know who to report abuse to? Do you feel safe here? The Social Worker will address all concerns identified	F 600		

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during the questionnaires to include notification of the Administrator and/or DON per facility protocol.

10 Abuse Quizzes will be completed by the Unit Managers, Treatment nurse, RN Supervisors and/or Quality Assurance Nurse with staff weekly x 4 weeks to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and receptionist. The quizzes are to ensure staff maintain knowledge and understanding of the abuse policy, reporting abuse and protection of the resident. The Nursing Supervisor, Staff Facilitator and Quality Assurance nurse will address all areas of concern identified during the quiz to include re-education of staff. The DON and/or Administrator will review quizzes weekly x 4 weeks to ensure all concerns are addressed. Audits will be reviewed by Quality Assurance and Performance Improvement (QAPI) monthly for 3 months to ensure compliance is achieved and maintained.

" Include dates when corrective action will be completed: 5/21/24

Onsite validation was completed on 6/05/24 through staff interviews, and record review. Staff were interviewed to validate in-services completed on domestic, verbal and physical abuse and reporting abuse to the Administrator and/or DON. A review of the audits of resident progress notes for past abuse and a review of skin checks for all residents unable to report signs/symptoms of abuse were confirmed to be completed. Review of the questionnaires for all

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F 600	Continued From page 12 alert and oriented residents interviewed for abuse and review of the questionnaires for all staff do they know of any resident who had been abused were verified. Review of the Abuse quizzes for all staff and the Concerns Audit tool revealed no concerns. Review of residents' progress notes audited for past abuse and resident interviews verified no additional issues were identified. The facility's action plan was validated to be completed as of 5/21/24.	F 600		