STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CONCORD	**515 LAKE CONCORD ROAD NE CONCORD, NC 28025**

(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 000	Initial Comments An unannounced recertification survey and complaint investigation survey was conducted on 12/02/24 through 12/11/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: ITBP11.	E 000		
F 000	INITIAL COMMENTS An onsite recertification and complaint survey was conducted from 12/02/23 through 12/05/24. Additional information was obtained on 12/11/24. Therefore, the exit date was changed to 12/11/24. The following intakes were investigated NC00209803, NC00214284, NC00215244, NC00216985, NC00217647, NC00218277, NC00218641, NC00219775, NC00222180, NC00223459, NC00224006, NC00224817, and NC00224818. Intake NC00224006 resulted in immediate jeopardy. 10 of the 24 complaint allegations resulted in deficiencies. Immedicate Jeopardy was identified at: CFR 483.10 tag F583 scope and severity of J. CFR 483.12 tag F600 scope and severity of J. CFR 483.12 tag F607 scope and severity of J. The tags F602 and F607 constituted Substandard Quality of Care. Immediate jeopardy began on 10/4/24 and was removed on 12/5/24. An extended survey was completed.	F 000		
F 583 SS=J	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical	F 583		12/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 12/27/2024

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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F 583	Continued From page 1 records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and responsible party, Lieutenant of Criminal Investigations and staff interviews the facility failed to protect a resident's privacy for 1 of 3 residents (Resident #2). Nurse aide (NA) # 1 and NA # 2 provided personal care to Resident # 2 while live streaming on a cell phone. The staff	F 583	#1 On 12/2/24 at 1:35pm, the DON suspended NA #1 pending outcome of abuse investigation and notified the Medical Director (MD) of allegation. Because the resident was unknown at this time and the presence of a witness was unknown, the facility was unable to make	

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allowed a prison inmate who was watching the live stream to view the resident while the resident was naked from the waist up and while care was provided; the staff allowed this live streaming while other inmates were observed in the open area behind him. As Resident #2 was severely cognitively impaired, the reasonable person concept was applied. A reasonable person would have been traumatized and have feelings of worthlessness, powerlessness and dehumanization through people that were not caregivers viewing them naked and while care was provided without consent.

Immediate jeopardy began on 10/4/24 when Resident #2's privacy was violated. Immediate jeopardy was removed on 12/5/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at the scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems put into place and are effective.

The findings included:

Resident #2 was admitted to the facility on 03/21/23 with diagnoses which included anxiety, Alzheimer's, dementia, and mood disturbance.

Review of Resident #2s quarterly Minimum Data Set (MDS) dated 08/10/24 revealed the resident was severely cognitively impaired.

Review of video footage provided by the Sheriff Department revealed the following events took place on 10/04/24 at 10:30 PM. The video

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notifications to Resident #2's resident representative or initiate immediate suspension of NA #2. On 12/2/24 at 2:15pm, the Social Worker (SW) notified the local police department and adult protective services (APS). A police report number was obtained. On 12/2/24 at 3:30pm, the Administrator submitted the initial allegation report to North Carolina Department of Health Human Services (NCDHHS).
On 12/4/24 at 3:30pm, additional information was provided to the facility to include identification of resident (Resident #2) and addition of a witness (NA #2). In response to this new information, the Director of Nursing (DON) immediately suspended NA #2, notified Resident #2 resident representative(s) and the MD and the Vice President of Risk and Quality Assurance (VPRQA) notified local law enforcement and APS with updated information to initial 12/2/24 reports. The Vice President of Clinical Operations (VPCO) assessed Resident #2 for physical injury, pain and signs or symptoms of psychosocial distress and no concerns were observed, and resident was pleasantly confused at baseline.

On 12/4/2024 the VPCQA, VPCO and DON attempted to obtain information regarding the location of the prison. Upon receipt of this information, the facility ensured the security of the recording to ensure Resident #2 remains protected from any additional violation of privacy by others who are unauthorized to have such information. No further concerns

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revealed NA #1 and NA #2 located in a facility in the resident's room on live stream video through a cell phone with a prison inmate. The inmate was observed talking into a telephone receiver in an open area with several other inmates behind him. The inmate was looking at the live stream.

The video was reviewed on 12/4/24 at 4:45 PM. The following was found and documented by the time mm:ss (minutes colon seconds) where "mm" represents minutes and "ss" represents seconds.

-:01 Video starts with NA #1 walking down the facility hallway towards Resident #2's room. No residents were shown at this time.

-:33 NA #1 entered Resident #2's room.

-:45 NA #1 laid the cell phone down. The video showed several inmates walking around the inmate while he was speaking to NA #1 and Resident #2 was visible sitting in the wheelchair with NA #1 and NA #2 present in the resident's room. NA #2 was observed undressing Resident #2 and taking off her shirt. It was observed that multiple inmates and a guard walked by the inmate during this time.

-:53 NA #2 was observed jerking the resident's shirt out of Resident #2's hands aggressively. Residents #2's bare shoulders were observed to be showing.

-2:09 NA #1 pointed the live stream video at Resident #2 and Resident #2 was visible in the wheelchair with her shirt removed and NA # 1 was trying to remove her bra from her right arm; both breasts were showing. The inmate stated, "come on man, come on man." The inmate

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identified.

On 12/2/24 and on 12/4/2024, the DON, VPCO, VPRQA, Administrator and Medical Director held an Ad Hoc meeting to discuss incident to determine root cause analysis of the facility's failure to maintain privacy for a resident while personal care was being provided. Root cause analysis determined that the facility failed to implement an effective system to ensure strict enforcement and monitoring measures to prohibit cellular phones and video recording devices in resident care areas.

On 12/4/24 the facility was made aware of immediate jeopardy and an acceptable plan of correction was provided and jeopardy removed effective 12/5/24.

On 12/6/24, upon completion of investigation, NA #1 and NA #2 were terminated indefinitely and reported to the nurse aide registry.

#2 On 12/2/24 at 4:00pm, the Administrator completed an observational round of facility residents and staff to ensure that resident's right to privacy is maintained. Observations include 1) care being provided only be authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/draping to prevent exposure of body parts, 3) no cellular or other video devices used by staff in resident care areas and 4) any other violation of resident right to personal privacy not only of a residents' own

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stated, "I got to go, bye." NA #1 states "no we're talking." The inmate replies, "that s ... just p ..... me off." NA #2 comes in the live video frame and was laughing. During this time multiple inmates were behind the inmate in an open public area.

-3:02 NA #1 was holding the cell phone and pointed it to NA #2 smiling and laughing into the camera. NA #2 acknowledged again she is on a live video stream call with the inmate.

-3:07 NA #2 was viewed fastening Resident #2's gown behind her back and the inmate states, "y'all are crazy., y'all crazy as hell. Y'all two together is trouble."

-3: The inmate stated, "you just put anything on camera you need to stop that s ...." NA #1 replied "I don't give a damn."

-4:29 NA #1 was observed standing on the right side of the bed and NA #2 was on the left between the resident's beds with Resident #2 sitting in the mechanical lift sling suspended. NA #1 had the phone live streaming Resident #2 and laughing. The privacy curtain was not pulled between the two beds. The roommate was not visualized at this time.

-4:42 NA #1 turned the cell phone camera, and Resident #2 was suspended in the mechanical lift. Inmates were passing by behind the inmate that was watching.

-5:01 Resident #2 was being transferred to her bed in the mechanical lift and there was another resident in the room in the opposite bed. The privacy curtain was not pulled while Resident #2 was being transferred.

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physical body, but of his or her personal space. No additional concerns identified. Effective 12/2/2024, questionnaires were also completed following in-servicing with current facility staff to validate competency of education received and to identify if additional incidences of resident privacy had been violated. No additional concerns reported.

#3 Effective 12/2/24, all current facility staff were in-serviced on the Resident Rights Policy, CMS guidance 483.10(h) and the Cell Phone Policy by the Staff Development Coordinator (SDC) and licensed nurse manager. Training included examples of violation of residents' privacy to include, but not limited to 1) privacy of not only a residents' own physical body, but of his or her personal space, including accommodations and personal care, 2) only authorized staff directly involved in providing care and services for the resident may be present when care is provided, unless the resident consents to other individuals being present during the delivery of care, 3) during the delivery of personal care and services, staff must remove residents from public view, pull privacy curtains or close doors, and provide clothing or draping to prevent exposure of body parts, 4) photographs or recordings of a resident and/or his or her body or private space without the resident's, or designated representative's written consent, is a violation of the resident's right to privacy and confidentiality, 5) staff taking unauthorized

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-6:01 NA #1 laid the cell phone down still showing care and rolled Resident #2 aggressively on to her left side by jerking up by the lift pad. Resident #2's face was away from the camera with her full brief exposed. The inmate stated, "damn, don't roll her out of bed." NA #1 looked back at the video and laughed. NA #2 was still present in the room on the other side of the bed assisting with Resident #2. Two inmates were observed in the back in the open area.

-6:08 NA #1 stated, "patient confidentiality" and moved the phone to the side of the bed pointing towards the end wall not viewing the resident but still live streaming while giving care to the resident.

-7:17 NA #1 stated to resident, "open your legs girl". NA # 1 stated more that was not discernable.

-8:45 NA #1 and NA #2 exited the resident's room and walked down the facility hall and continued to talk to the inmate on the cell phone.

-9:46 Video ends.

A phone interview conducted with the Lieutenant of Criminal Investigations on 12/2/24 at 11:30 AM revealed he had obtained video footage of an inmate and NA #1 having a video call where NA #1 had shown the inmate view of an elderly resident in a wheelchair. The Lieutenant stated he had reported the concerns to Adult Protective Services (APS) and was concerned NA #1 had exploited Resident #2.

A follow up phone interview with Lieutenant of

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photographs of a resident's room or furnishings (which may or may not include the resident), or a resident eating in the dining room, or a resident participating in an activity in the common area, 6) taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment (for example, cameras, smart phones, and other electronic devices), 7) keeping or distributing them through multimedia messages or on social media networks is a violation of a resident's right to privacy and confidentiality, 8) potential effects on residents whose privacy is not maintained to include, humiliation, dignity, respect and feelings of dehumanization, 9) strict prohibition and NO TOLERANCE to use cellular phones or any type of audio or video device in resident care areas, resident rooms, common areas such as hallways, dining rooms, courtyards, etc.,10) cell phones are allowed to be kept in staff possession in the facility on a silenced or vibrate mode to allow for emergency alerts but may only be used in breakrooms or other non-resident areas and 11) staff are responsible to intervene if witnessing any violation of the Cell Phone Policy and/or the Resident Rights Policy and immediately remove risk from resident and notify Administrator and 12) violation of the Cell Phone Policy or Resident Rights Policy will result in disciplinary action up to and including termination of employment and/or notification to licensing boards and law enforcement where applicable to ensure resident privacy is maintained. The SDC

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F 583	Continued From page 6 Criminal Investigations on 12/05/24 at 9:20 AM explained the video occurred on 10/4/24 and the video call app used was Home WAV which is a video call that is recorded of both parties. The Lieutenant indicated when a video call occured the inmate had a phone receiver to hear the conversation but had a computer size screen mounted on the wall to see who they are face calling. The Lieutenanr stated other inmates were unable to hear the conversation but could visually see the video because the screen is in a non-private area with other inmates present. An interview conducted with NA #1 on 12/02/24 at 2:35 PM revealed she had worked in the facility for two years. NA #1 further revealed she had completed an in-service on resident privacy and video and telephone calls were prohibited in care areas. NA #1 stated she had never taken any pictures or videos of any resident in the facility. A phone interview conducted with Nurse Aide (NA) #2 on 12/4/24 at 6:00 PM revealed she had been employed by the facility for approximately two years. NA #2 further revealed she had been educated on residents' privacy. NA #2 stated she had never observed any staff or had taken a video or picture of a resident. NA #2 indicated if she was to observe a staff member record a resident that she would report it to the Administrator. NA #2 denied any staff videoing Resident #2 while giving care. An interview conducted with the Director of Nursing (DON) and Administrator on 12/02/24 at 2:45 PM revealed they both had been recently employed at the facility. The interview revealed no staff had reported concerns about staff having their phones out in care areas and taking pictures	F 583	will be responsible for ensuring all staff are trained by tracking and reviewing the daily schedule and ensuring training is provided. Newly hired staff and staff not receiving education by 12/2/2024 will receive education prior to first worked shift by the SDC, DON or licensed nurse supervisor. #4 Effective 12/2/2024, the Administrator, DON or designee will complete observational rounds of facility residents and staff to ensure that resident's right to privacy is maintained. Observations will be completed daily for one (1) week, three (3) times weekly for four (4) weeks, two (2) times weekly for four (4) weeks, weekly for four (4) weeks and as needed thereafter. Monitoring to include 1) care being provided only by authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/draping to prevent exposure of body parts, 3) no cellular or other video devices used by staff in resident care areas and 4) any other violation of resident right to personal privacy not only of a residents' own physical body, but of his or her personal space. The Administrator will report findings of the monitoring to the Quality Assurance Performance Improvement (QAPI) Committee during monthly QAPI meetings and will make changes to the plan as necessary to maintain compliance with resident rights to personal privacy. Compliance Date: 12/11/2024	

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or video footage of a resident. Both indicated nursing staff had been in-service at hire, annually, and anytime on resident privacy and person phones were not allowed to be out in resident rooms.

The video was shared with facility staff on 12/4/24 at 5:45 PM. Those present were the Director of Nursing (DON), Vice President of Clinical Operations, and Vice President of Risk and QAPI (quality assurance and performance improvement). The facility staff cried. After the video was reviewed, Resident #2, NA #1, and NA #2 were identified by the DON. It was further revealed nursing staff were not allowed to have personal cell phones in care areas and it was not permitted to record any audio or image of a resident. The DON stated NA #1 failed to protect the privacy of Resident # 2 and NA #2 failed to report the exploitation and privacy of Resident #2.

An interview conducted with Resident #2's Responsible Party (RP) on 12/5/24 at 3:15 PM revealed the facility had notified the family of the video on 12/04/24. The RP further revealed she was upset this had happened to Resident #2 but was glad it was being investigated and hoped justice would be served to NA #1 and NA #2.

An interview conducted with the Administrator on 12/9/24 at 4:00 PM revealed she had been employed by the facility for a short period of time but assisted with the initial investigation. The Administrator further revealed NA #1 and NA #2 had denied being in any video or on a telephone call with a resident present. The Administrator further revealed she expected nursing staff to not break confidentiality and protect residents' privacy.

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The Director of Nursing (DON), Vice President of Clinical Operations, and Vice President of Risk and QAPI were notified of immediate jeopardy on 12/5/24 at 12:35 PM. The Administrator was not present.

The facility provided the following immediate jeopardy removal plan.

The facility failed to maintain privacy for Resident # 2 while personal care was provided. NA # 1 used her personal cell phone while in the residents' room to facetime with a male inmate which allowed Resident # 2 to be observed sitting in a wheelchair, naked, with no shirt or bra on, with her breasts exposed without her consent. The observation was provided in real time through the use of a wall mounted screen in a common area of an incarceration center while other people in the prison were also observed walking past the screen.

On 12/2/24 at 1:35pm, the DON suspended NA #1 pending outcome of abuse investigation and notified the Medical Director (MD) of allegation. Because the resident was unknown at this time and the presence of a witness was unknown, the facility was unable to make notifications to Resident #2's resident representative or initiate immediate suspension of NA #2.

On 12/2/24 at 2:15pm, the Social Worker (SW) notified the local police department and adult protective services (APS). A police report number was obtained.

On 12/2/24 at 3:30pm, the Administrator submitted the initial allegation report to North

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Carolina Department of Health Human Services (NCDHHS).

On 12/2/24 at 4:00pm, the Administrator completed an observational round of facility residents and staff to ensure that resident's right to privacy is maintained. Observations include 1) care being provided only be authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/draping to prevent exposure of body parts, 3) no cellular or other video devices used by staff in resident care areas and 4) any other violation of resident right to personal privacy not only of a residents' own physical body, but of his or her personal space. No additional concerns identified.

On 12/2/24 and on 12/4/2024, the DON, VPCO, VPRQA, Administrator and Medical Director held an Ad Hoc meeting to discuss incident to determine root cause analysis of the facility's failure to maintain privacy for a resident while personal care was being provided. Root cause analysis determined that the facility failed to implement an effective system to ensure strict enforcement and monitoring measures to prohibit cellular phones and video recording devices in resident care areas.

On 12/4/24 at 3:30pm, additional information was provided to the facility to include identification of resident (Resident #2) and addition of a witness (NA #2). In response to this new information, the DON immediately suspended NA #2, notified Resident #2 resident representative(s) and the MD and the VPRQA notified local law enforcement and APS with updated information to initial 12/2/24 reports. The VPCO assessed Resident #2 for physical injury, pain and signs or

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symptoms of psychosocial distress and no concerns were observed and resident was pleasantly confused at baseline.

On 12/4/2024 the VPCQA, VPCO and DON attempted to obtain information regarding the location of the prison. Upon receipt of this information, the facility plans to inquire on the security of the recording and ensure that Resident #2 is protected from any additional violation of privacy by others who are unauthorized to have such information.

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

Effective 12/2/24, all current facility staff were in-serviced on the Resident Rights Policy, CMS guidance 483.10(h) and the Cell Phone Policy by the Staff Development Coordinator (SDC) and licensed nurse manager. Training included examples of violation of residents' privacy to include, but not limited to 1) privacy of not only a residents' own physical body, but of his or her personal space, including accommodations and personal care, 2) only authorized staff directly involved in providing care and services for the resident may be present when care is provided, unless the resident consents to other individuals being present during the delivery of care, 3) during the delivery of personal care and services, staff must remove residents from public view, pull privacy curtains or close doors, and provide clothing or draping to prevent exposure of body parts, 4) photographs or recordings of a resident and/or his or her body or private space without the resident's, or designated representative's

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ACCORDIUS HEALTH AT CONCORD	**515 LAKE CONCORD ROAD NE CONCORD, NC 28025**

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F 583	Continued From page 11	F 583		

written consent, is a violation of the resident's right to privacy and confidentiality, 5) staff taking unauthorized photographs of a resident's room or furnishings (which may or may not include the resident), or a resident eating in the dining room, or a resident participating in an activity in the common area, 6) taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment (for example, cameras, smart phones, and other electronic devices), 7) keeping or distributing them through multimedia messages or on social media networks is a violation of a resident's right to privacy and confidentiality, 8) potential effects on residents whose privacy is not maintained to include, humiliation, dignity, respect and feelings of dehumanization, 9) strict prohibition and NO TOLERANCE to use cellular phones or any type of audio or video device in resident care areas, resident rooms, common areas such as hallways, dining rooms, courtyards, etc.,10) cell phones are allowed to be kept in staff possession in the facility on a silenced or vibrate mode to allow for emergency alerts but may only be used in breakrooms or other non-resident areas and 11) staff are responsible to intervene if witnessing any violation of the Cell Phone Policy and/or the Resident Rights Policy and immediately remove risk from resident and notify Administrator and 12) violation of the Cell Phone Policy or Resident Rights Policy will result in disciplinary action up to and including termination of employment and/or notification to licensing boards and law enforcement where applicable to ensure resident privacy is maintained.

Effective 12/2/2024, questionnaires were also completed following in-servicing with current

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F 583	Continued From page 12	F 583		

facility staff to validate competency of education received and to identify if additional incidences of resident privacy had been violated. No additional concerns reported. The SDC will be responsible for ensuring all staff are trained by tracking and reviewing the daily schedule and ensuring training is provided. Newly hired staff and staff not receiving education by 12/2/2024 will receive education prior to first worked shift by the SDC, DON or licensed nurse supervisor.

Effective 12/2/2024, the Administrator, DON or designee will complete observational rounds of facility residents and staff to ensure that resident's right to privacy is maintained. Observations to include 1) care being provided only by authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/draping to prevent exposure of body parts, 3) no cellular or other video devices used by staff in resident care areas and 4) any other violation of resident right to personal privacy not only of a residents' own physical body, but of his or her personal space. On 12/2/24, licensed nurses were educated and notified by the VPCO of their responsibility to complete observational rounds each shift for his/her unit as above. Effective 12/2/2024, the Administrator is ultimately responsible for the implementation and completion of this removal plan.

Alleged Date of IJ Removal: 12/05/2024

On 12/10/2024, the facility's credible allegation for immediate jeopardy was validated. Resident #2 was observed in the dining room pleasant and smiling with other residents in the table. During the tour of the facility residents were observed to

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F 583	Continued From page 13 have their doors closed for care and curtains were seen pulled to cover for privacy. There were no signs of staff cell phone use in the hallways and in resident care areas. The in-services by the facility included information on abuse, privacy, resident rights, and cellphone use, including notification of administration for any resident's behavior changes, and increased rounding observations of residents and staff. Staff interviews confirmed education was received for abuse, privacy, resident rights, and cellphone use. The facility provided psych evaluation follow up for Resident #2 regarding the incident. The facility provided evidence of daily Quality Assurance auditing of all residents divided on cognitively intact residents for interview and cognitively impaired residents for body audits, the auditing for the observational rounds every shift, staff abuse questionnaires, and new on-hire screening process and employee handbook review were executed. The facility showed evidence of communication with the sheriff's office that the video was encrypted and secured with only authorized person could access and view the footage. The IJ removal date if 12/05/24 was validated.	F 583		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		12/11/24

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F 600	Continued From page 14 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 observation, record review, and family, Lieutenant of Criminal Investigations and staff interviews, the facility failed to protect a resident's right to be free from abuse for 1 of 3 residents (Resident #2). Nurse aide (NA) # 1 and NA # 2 provided personal care to Resident # 2 while live streaming on a cell phone, the resident was naked from the waist up, the staff and the prison inmate watching the live stream spoke with profanity and vulgarity without any regard for the resident; the staff did not explain care as it was provided to the resident; the staff were physically aggressive during care; the staff allowed an inmate who was watching the live stream to view the resident and speak to the resident; the staff allowed this live streaming while other inmates were observed in the open area behind him. As Resident #2 was severely cognitively impaired, the reasonable person concept was applied. A reasonable person would have been traumatized by being abused by caregivers in their home environment making them feel worthless, angry, dehumanized and powerless. Immediate jeopardy began on 10/4/24 when Resident #2 was abused. Immediate jeopardy was removed on 12/5/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at the scope and severity of "D" (no	F 600	#1 On 12/2/24 at 1:35pm, the DON suspended NA #1 pending outcome of abuse investigation and notified the Medical Director (MD) of allegation. Because the resident was unknown at this time and the presence of a witness was unknown, the facility was unable to make notifications to Resident #2's resident representative or initiate immediate suspension of NA #2. On 12/2/24 at 2:15pm, the Social Worker (SW) notified the local police department and adult protective services (APS). A police report number was obtained. On 12/2/24 at 3:30pm, the Administrator submitted the initial allegation report to North Carolina Department of Health Human Services (NCDHHS). On 12/4/24 at 4:00pm, the DON, VPCO and VPRQA were notified of additional information and observed video surveillance provided by the survey team identifying Resident #2 as a resident of the facility and of mental and sexual abuse by NA #1 in the presence of NA #2. DON immediately suspended NA #2 pending investigation. The VPRQA notified police and provided additional information and left a message with APS. The DON notified Resident #2's resident	

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actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems put into place and are effective.

The findings included:

Resident #2 was admitted to the facility on 03/21/23 with diagnoses which included anxiety, Alzheimer's disease, dementia, and mood disturbance.

Review of Resident #2's quarterly Minimum Data Set (MDS) dated 08/10/24 revealed the resident was severely cognitively impaired and required extensive assistance with two-person for bed mobility and transfers. The MDS further revealed Resident #2 had adequate hearing and vision and was able to understand others. The MDS indicated no behaviors of rejection and care.

Review of Resident #2's care plan dated 04/07/23 revealed the resident had an activities of daily living (ADL) self-care performance deficient due to Alzheimer's disease, impaired cognition, and muscle weakness. The goal was for Resident #2 to maintain its current level of function through the review date.

Resident #2's care plan revised on 08/19/24 revealed the resident was resistive to care and refused to see the dentist and other medical directors at time due to dementia. The goal was for the resident to cooperate with care through the next review date. Interventions included for Resident #2 to make decisions about treatment regime and to give clear explanation of all care activities prior to an as they occur during each contact.

F 600

representative (RP) and MD was provided updated information received. On 12/4/2024 at 6:00pm, the VPCO assessed Resident #2 for physical injury, pain and signs or symptoms of psychosocial distress and no concerns were observed and was pleasantly confused at baseline. On 12/2/2024 and on 12/4/2024, the DON, VPCO, VPRQA, Administrator and Medical Director held an Ad Hoc meeting to discuss incident to determine root cause analysis of the facility's failure protect a resident's right to be free from abuse. Root cause analysis determined that the facility failed to implement an effective system to ensure strict enforcement and monitoring measures to prohibit cellular phones and video recording devices in resident care areas. On 12/4/24 the facility was made aware of immediate jeopardy and an acceptable plan of correction was provided and jeopardy removed effective 12/5/24.

On 12/6/24, upon completion of investigation, NA #1 and NA #2 were terminated indefinitely and reported to the nurse aide registry.

#2   On 12/2/24 at 4:00pm, the Administrator completed an observational round of facility residents and staff to ensure that resident rights to privacy and freedom from abuse is maintained. Observations included 1) care being provided only by authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/draping to prevent exposure of body parts, 3) no

F 600

Continued From page 16

Review of video footage provided by the Sheriff Department revealed the following events took place on 10/04/24 at 10:30 PM. The video revealed NA #1 and NA #2 located in a facility in the resident's room on live stream video through a cell phone with a prison inmate. The inmate was observed talking into a telephone receiver in an open area with several other inmates behind him. The inmate was looking at the live stream.

The video was reviewed on 12/4/24 at 4:45 PM. The following was found and documented by the time mm:ss (minutes colon seconds) where "mm" represents minutes and "ss" represents seconds.

-:01 Video starts with NA #1 walking down the facility hallway towards Resident #2's room. No residents were shown at this time.

-:33 NA #1 entered Resident #2's room.

-:45 NA #1 laid the cell phone down and shook her rear in the camera as the inmate states, "that damn ass is fat. Look at that ass.
That mother f ..... is fat." The video showed several inmates walking around the inmate while he was speaking to NA #1 and Resident #2 was visible sitting in the wheelchair with NA #1 and NA #2 present in the resident's room. NA #2 was observed undressing Resident #2 and taking off her shirt. It was observed that multiple inmates and a guard walked by the inmate during this time. Staff were not observed to be explaining their actions related to care to the resident.

-:53 NA #2 was observed jerking the resident's shirt out of Resident #2's hands aggressively. Residents #2's bare shoulders were observed to

F 600

cellular or other video devices used by staff in resident care areas and 4) any other violation of resident right to personal privacy not only of a residents' own physical body, but of his or her personal space and 5) observations to ensure residents have no physical signs or behaviors indicative of potential abuse. No additional concerns identified.

Effective 12/2/2024, licensed nurses completed resident abuse questionnaires with cognitively intact residents and body audits with cognitively impaired residents to identify any additional concerns of resident abuse. No additional concerns reported or observed.
Effective 12/2/2024, abuse questionnaires were also completed with current facility staff to validate competency of education received and to identify any additional allegations or incidence of resident abuse. No additional concerns reported.

#3 Effective 12/2/2024, all current facility staff were in-serviced on the Abuse, Neglect and Exploitation Policy, Resident Rights Policy and Cell Phone Policy by the Staff Development Coordinator (SDC) and licensed nurse manager. Abuse training topics included preventing, reporting and identifying what constitutes abuse and NO TOLERANCE for failure to comply and ensure resident protection. Identification examples included; physical, mental, sexual, verbal, neglect, exploitation and signs of mental or emotional abuse such as, sudden unexplained changes in behavior, changes in eating habits,

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F 600	Continued From page 17 be showing. NA #2 was not observed to explain care to the resident. -1:28 NA #1 picked up the cell phone and spoke to the inmate walking throughout the resident's room. -2:07 NA #2 was observed waving and smiling at the inmate through the cell phone acknowledging the inmate. -2:09 NA #1 pointed the live stream video at Resident #2 and Resident #2 was visible in the wheelchair with her shirt removed and NA # 1 was trying to remove her bra from her right arm; both breasts were showing. The inmate stated, "come on man, come on man." NA #1 pointed the live stream video at NA #2, and she is observed smiling and laughing. The inmate stated, "I got to go, bye." NA #1 states "no we're talking." The inmate replies "that s ... just p ..... me off." NA #2 comes in the live video frame and was laughing. During this time multiple inmates were behind the inmate in the open public area. -3:02 NA #1 was holding the cell phone and pointed it to NA #2 smiling and laughing into the camera. NA #2 acknowledged again she is on a live video stream call with the inmate. -3:07 NA #2 was viewed fastening Resident #2's gown behind her back and the inmate stated, "y'all are crazy., y'all crazy as hell. Y'all two together is trouble." Staff did not explain the care being provided to the resident. -3:32 NA #1 stated, "this mother f ..... about to hit this resident in the head" and proceeded to state "it's not going to hurt her; she isn't going to bruise	F 600	withdrawal from care, fear of certain persons or expressions of guilt or shame and staff obligation of reporting abuse immediately to the Administrator and prevention of abuse by the immediate intervention of removing the harm or potential for harm from the resident by removing the perpetrator or threat. To protect resident's right to privacy, the facility is adopting a NO TOLERANCE Cell Phone Policy focusing on the strict prohibition of cellular phones and any type of electronic recording device use in resident care areas, especially while providing personal care. Training included examples of violation of residents' privacy to include, but not limited to 1) privacy of not only a residents' own physical body, but of his or her personal space, including accommodations and personal care, 2) only authorized staff directly involved in providing care and services for the resident may be present when care is provided, unless the resident consents to other individuals being present during the delivery of care, 3) during the delivery of personal care and services, staff must remove residents from public view, pull privacy curtains or close doors, and provide clothing or draping to prevent exposure of body parts, 4) photographs or recordings of a resident and/or his or her body or private space without the resident's, or designated representative's written consent, is a violation of the resident's right to privacy and confidentiality, 5) staff taking unauthorized photographs of a resident's room or furnishings (which may or may not include	

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because she is black." The inmate stated, "you just put anything on camera you need to stop that s ...." NA #1 replied "I don't give a damn."

-4:05 NA #1 stated, "Resident #2 (Name of resident) say hey to him," and put the camera in the resident's face while sitting in the lift sling starting to be lifted. Resident #2 was moving her mouth and breathing heavy. NA #1 and NA #2 did not explain to the resident they were putting her into a mechanical lift. NA #1 stated, "she is trying to focus on going into the lift. She is scared as hell." The inmate stated, "are yall about put her in the bed?" NA #1 replied "hell yeah she will be falling like a mother f ... I know I am not lifting her up." While the inmate was speaking to NA #1 another inmate was observed behind him in the open area.

-4:29 NA #1 was observed standing on the right side of the bed and NA #2 was on the left between the resident's beds with Resident #2 sitting in the mechanical lift sling suspended. NA #1 had the phone live streaming Resident #2 and laughing. The privacy curtain was not pulled between the two beds. A roommate was not visualized at that time.

-4:42 NA #1 had the phone pointed towards her and stated, "who the f ... shoes she got on (NA #2's nickname.)" NA #1 and NA #1 started to laugh, and NA #1 stated, "this is not this ladies' shoes." NA #1 turned the cell phone camera, and Resident #2 was suspended in the mechanical lift with neither aide beside her. Inmates were passing by behind the inmate that was watching.

-5:01 Resident #2 was being transferred to her bed in the mechanical lift and there was another

F 600

the resident), or a resident eating in the dining room, or a resident participating in an activity in the common area, 6) taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment (for example, cameras, smart phones, and other electronic devices), 7) keeping or distributing them through multimedia messages or on social media networks is a violation of a resident's right to privacy and confidentiality, 8) potential effects on residents whose privacy is not maintained to include, humiliation, dignity, respect and feelings of dehumanization, 9) strict prohibition and NO TOLERANCE to use cellular phones or any type of audio or video device in resident care areas, resident rooms, common areas such as hallways, dining rooms, courtyards, etc., 10) cell phones are allowed to be kept in staff possession in the facility on a silenced or vibrate mode to allow for emergency alerts but may only be used in breakrooms or other non-resident areas and 11) staff are responsible to intervene if witnessing any violation of the Cell Phone Policy and/or the Resident Rights Policy and immediately remove risk from resident and notify Administrator and 12) violation of the Cell Phone Policy or Resident Rights Policy will result in disciplinary action up to and including termination of employment and/or notification to licensing boards and law enforcement where applicable to ensure resident privacy is maintained and resident's remain free from abuse. The SDC will be responsible for ensuring all

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resident in the room in the opposite bed. The privacy curtain was not pulled while Resident #2 was being transferred.

-5:09 Resident #2 was still in the mechanical lift sling and NA #1 put the camera in the resident's face and stated, "say hey." Resident's face was scrunched up. The inmate stated, "why you looking so mean?" speaking about the resident's facial expression. NA #1 stated, "she is mad, but she doesn't even understand what we are saying."

-5:18 NA #1 laid the phone down while she was still being shown on live video stream and the inmate stated, "put that camera down a little more let me see that mother f .... (inaudible words)." NA #1 grabbed the phone and lowered it showing off her rear. The inmate stated, "that mother f ...." NA #1 and NA #2 began to laugh.

-6:01 NA #1 laid the cell phone down still showing care and rolled Resident #2 aggressively on to her left side by jerking up by the lift pad. The care was not explained to the resident. Resident #2's face was away from the camera with her full brief exposed. The inmate stated, "damn, don't roll her out of bed." NA #1 looked back at the video and laughed. NA #2 was still present in the room on the other side of the bed assisting with Resident #2. Two inmates were observed in the back in the open area.

-6:08 NA #1 stated, "patient confidentiality" and moved the phone to the side of the bed pointing towards the end wall not viewing the resident but still live streaming while giving care to the resident.

F 600

staff are trained by tracking and reviewing the daily schedule and ensuring training is provided. Newly hired staff and staff not receiving education by 12/2/2024 will receive education prior to first worked shift by the SDC, DON or licensed nurse supervisor.
On 12/2/24, licensed nurses were educated and notified by the VPCO of their responsibility to complete observational rounds each shift for his/her unit and observe resident and staff interactions as above.

Effective 12/4/24, the facilities new hire screening process has been updated to include additional measures to better determine the candidate's probability of providing excellent resident care to further ensure residents are free from abuse. Updates include improved interview process, a minimum of two professional references, screening of social media content for inappropriate content and improved screening of background checks. Human Resources (HR) and/or the Administrator, DON or SDC are responsible for the interview process, screening reference checks and screening social media platforms. With the guidance of our legal counsel, a template including a set of questions will be used during the interview process which include the categories of background, interpersonal skills and qualifications and a template for reference checks will be used. Screening of social media platforms will be used via internet search to provide information related to a

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F 600	Continued From page 20 -6:16 Resident #2 stated, "oh, oh," while NA #1 assisted the resident and NA # 1 stated, "you aren't about to fight me." -6:20 Resident #2 grabbed NA #1's left pant leg and NA #1 stepped back and then stepped forward, and the resident swatted at NA #1. NA #1 looked at the camera and laughed while continuing care. The inmate stated, "what happened why did you move the phone?" NA #1 stated, "because she is trying to fight me. F ... she is trying to fight us. I am not going to get my ass whooped by an old lady." -7:17 NA #1 stated to resident "open your legs girl". NA # 1 stated more that was not discernable. -7:30 NA #1 stated "good night (residents name) ... After you fought like a mother f ..." Then stated "God d...." NA #2 stated "go to sleep (residents name)." -7:40 NA #2 was observed taking off two sets of gloves and the inmate asked, "why you put on two gloves?" NA #1 stated "this mother f .... be sh ... ... like hell." NA #2 stated "and pissin'." NA #1 agreed and stated, "pissin' like hell." -7:54 NA #1 picked up phone and turned towards Resident #2 and showed the resident in bed with covers up to her neck and stated, "good night boo". Resident #2 had facial grimacing. -7:58 NA #2 stated "the way she pissed is like she can hold her piss all day." NA #1 replied and stated, "yeah, she can hold her piss all day. Like a waterfall." NA #2 replied "yep."	F 600	candidate's personal character. The Human Resource (HR) Director will process and review criminal background checks and forward to the Administrator or DON for approval if a criminal record is identified. The Administrator or DON will consider all screening results to make a final determination. However, the facility will NOT extend employment to any candidate with convictions or pending convictions involving elder abuse, neglect or exploitation. #4 Effective 12/2/2024, the Administrator, DON or designee will complete observational rounds of facility residents and staff to ensure that residents are free from abuse and resident rights to privacy is maintained, including strict prohibition of staff cellular phone use or any type of audio or video device use in resident care areas. Observations will be completed daily for one (1) week, three (3) times weekly for four (4) weeks, two (2) times weekly for four (4) weeks, weekly for four (4) weeks and as needed thereafter. Monitoring to include observations of 1) care being provided only be authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/ draping to prevent exposure of body parts, 3) no cellular or other video devices used by staff in resident care areas, 4) any other violation of resident right to personal privacy not only of a residents' own physical body, but of his or her personal space, 5) observations of any form of physical, sexual or emotional abuse which include but are not limited to; a. ensuring	

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F 600	Continued From page 21 -8:15 NA #1 stated, "I'm fixing to clock out." NA #1 had the cell phone pointed towards her with NA #2 following her. NA #2 stated "it's not even 11 o'clock where the f ... are you going?" NA #1 replied, "I'm ready to go I'm tired as a mother f ...,. " The NAs walked towards the resident's door to leave. -8:45 NA #1 and NA #2 exited the resident's room and walked down the facility hall and continued to talk to the inmate on the cell phone. -9:46 Video ends. A phone interview conducted with the Lieutenant of Criminal Investigations on 12/2/24 at 11:30 AM revealed he had obtained video footage of an inmate and NA #1 having a video call where NA #1 had shown the inmate view of an elderly resident in a wheelchair and completed a phone call where NA #1 discussed abusing residents and not leaving bruises on them. The Lieutenant stated he had reported the concerns to Adult Protective Services (APS) and was concerned NA #1 had exploited Resident #2. A follow up phone interview with Lieutenant of Criminal Investigations on 12/05/24 at 9:20 AM explained the video occurred on 10/4/24 and the video call app used was Home WAV which is a video call that is recorded of both parties. The Lieutenant indicated when a video call occured the inmate had a phone receiver to hear the conversation but had a computer size screen mounted on the wall to see who they are face calling. The Lieutenanr stated other inmates were unable to hear the conversation but could visually see the video because the screen is in a non-private area with other inmates present.	F 600	residents are not harmed physically or handled roughly during care but are provided with care that is gentle, kind, dignified; b. residents are free from offensive comments, profanities or other form of verbal abuse and c. observations to ensure residents are not exhibiting signs of mental anguish such as tearfulness, withdrawal, fear, guarding, aggressiveness and other unusual changes in resident behaviors. The Administrator will report findings of the monitoring to the Quality Assurance Performance Improvement (QAPI) Committee during monthly QAPI meetings and will make changes to the plan as necessary to maintain compliance ensuring residents are free from abuse. Compliance Date: 12/11/24	

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An interview conducted with NA #1 on 12/02/24 at 2:35 PM revealed she had worked in the facility for two years. NA #1 further revealed she had completed an in-service on abuse and neglect and was educated to report abuse or neglect to the administrator. NA #1stated she had never taken any pictures or videos of any resident in the facility.

A phone interview conducted with Nurse Aide (NA) #2 on 12/4/24 at 6:00 PM revealed she had been employed by the facility for approximately two years. NA #2 further revealed she had been educated on abuse upon hire, yearly, and randomly. NA #2 stated she had never observed any staff or had taken a video or picture of a resident. NA #2 indicated if she was to observe a staff member record a resident that she would report it to the Administrator. NA #2 denied any staff videoing Resident #2 while giving care.

An interview conducted with the Director of Nursing (DON) and Administrator on 12/02/24 at 2:45 PM revealed they both had been recently employed at the facility. The interview revealed no staff had reported concerns about staff having their phones out in care areas and taking pictures or video footage of a resident. Both indicated nursing staff had been in-service at hire, annually, and anytime on resident privacy and person phones were not allowed to be out in resident rooms.

The video was shared with facility staff on 12/4/24 at 5:45 PM. Those present were the Director of Nursing (DON), Vice President of Clinical Operations, and Vice President of Risk and QAPI

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(quality assurance and performance improvement). Facility staff were crying. After the video was reviewed, Resident #2, NA #1, and NA #2 were identified by the DON. It was further revealed NA #1 and NA #2 had been in-serviced on abuse and neglect and reporting upon hire, annually, and during any abuse investigations. It was indicated Resident #2 was not alert and oriented and could be combative and resistive to care. The DON revealed she expected staff to walk away and get help if the resident becomes frustrated or combative. It was further revealed nursing staff were not allowed to have personal cell phones in care areas and it was not permitted to record any audio or image of a resident. The DON stated NA #1 failed to protect the privacy of Resident # 2 and NA #2 failed to report the exploitation and privacy of Resident #2.

An interview conducted with Resident #2's Responsible Party (RP) on 12/5/24 at 3:15 PM revealed the facility had notified the family of the video on 12/04/24. The RP further revealed she was upset this had happened to Resident #2 but was glad it was being investigated and hoped justice would be served to NA #1 and NA #2.

An interview conducted with the Administrator on 12/9/24 at 4:00 PM revealed she had been employed by the facility for a short period of time but assisted with the initial investigation. The Administrator further revealed NA #1 and NA #2 had denied being in any video or on a telephone call with a resident present. The Administrator further revealed she expected nursing staff to prevent abuse and neglect and report.

The Director of Nursing (DON), Vice President of Clinical Operations, and Vice President of Risk

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and QAPI were notified of immediate jeopardy on 12/5/24 at 12:35 PM. The Administrator was not present.

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 failed to protect a resident's right to be free from mental and sexual abuse (Resident #2). On 10/4/24 Resident #2 was shown in compromised positions during an audiovisual phone call from Nursing Assistant (NA) #1 with a male individual who was witnessing the audiovisual through the use of a wall mounted screen in a common area of an incarceration center while other people in the prison were observed walking past the screen. During the audiovisual surveillance, NA #1 was observed to show Resident #2 to the male through her phone camera, the resident sitting in a wheelchair, naked, with no shirt or bra on, with her breasts exposed.
There were two NAs witnessed in the video, NA #1 and NA #2. The NA's did not explain to the resident before each step of care was provided; NA # 1 shoved the resident to turn on her side aggressively; NA # 1 and the inmate talked inappropriately, using vulgar language including f**k and sh*t, about the resident and to the resident while NA # 1 and the inmate carried on their own private, foul mouthed (including discussion of NA #1's buttocks), conversation in the presence of the resident.

On 12/2/2024 at 1:30pm, the Director of Nursing

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F 600	Continued From page 25 (DON), Vice President of Clinical Operations (VPCO) and Vice President of Risk and Quality Assurance (VPRQA) were notified by a surveyor during a recertification and complaint survey that a complaint was received from the community alleging an inappropriate photo or video of an unknown elderly female, partially unclothed and a female identified as NA #1was witnessed. On 12/2/24 at 1:35pm, the DON suspended NA #1 pending outcome of abuse investigation and notified the Medical Director (MD) of allegation. Because the resident was unknown at this time and the presence of a witness was unknown, the facility was unable to make notifications to Resident #2's resident representative or initiate immediate suspension of NA #2. On 12/2/24 at 2:15pm, the Social Worker (SW) notified the local police department and adult protective services (APS). A police report number was obtained. On 12/2/24 at 3:30pm, the Administrator submitted the initial allegation report to North Carolina Department of Health Human Services (NCDHHS). On 12/2/24 at 4:00pm, the Administrator completed an observational round of facility residents and staff to ensure that resident rights to privacy and freedom from abuse is maintained. Observations included 1) care being provided only by authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/draping to prevent exposure of body parts, 3) no cellular or other video devices used by staff in resident care areas and 4) any other violation of resident right to personal privacy not	F 600		

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only of a residents' own physical body, but of his or her personal space and 5) observations t ensure residents have no physical signs or behaviors indicative of potential abuse. No additional concerns identified.

On 12/2/2024 and on 12/4/2024, the DON, VPCO, VPRQA, Administrator and Medical Director held an Ad Hoc meeting to discuss incident to determine root cause analysis of the facility's failure protect a resident's right to be free from abuse. Root cause analysis determined that the facility failed to implement an effective system to ensure strict enforcement and monitoring measures to prohibit cellular phones and video recording devices in resident care areas.

Effective 12/2/2024, licensed nurses completed resident abuse questionnaires with cognitively intact residents and body audits with cognitively impaired residents to identify any additional concerns of resident abuse. No additional concerns reported or observed.

On 12/4/24 at 4:00pm, the DON, VPCO and VPRQA were notified of additional information and observed video surveillance provided by the survey team identifying Resident #2 as a resident of the facility and of mental and sexual abuse by NA #1 in the presence of NA #2. The DON immediately suspended NA #2 pending investigation. The VPRQA notified police and provided additional information and left a message with APS. The DON notified Resident #2's resident representative (RP) and MD was provided updated information received.

On 12/4/2024 at 6:00pm, the VPCO assessed Resident #2 for physical injury, pain and signs or

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symptoms of psychosocial distress and no concerns were observed and was pleasantly confused at baseline.

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

Effective 12/2/2024, all current facility staff were in-serviced on the Abuse, Neglect and Exploitation Policy, Resident Rights Policy and Cell Phone Policy by the Staff Development Coordinator (SDC) and licensed nurse manager. Abuse training topics included preventing, reporting and identifying what constitutes abuse and NO TOLERANCE for failure to comply and ensure resident protection. Identification examples included; physical, mental, sexual, verbal, neglect, exploitation and signs of mental or emotional abuse such as, sudden unexplained changes in behavior, changes in eating habits, withdrawal from care, fear of certain persons or expressions of guilt or shame and staff obligation of reporting abuse immediately to the Administrator and prevention of abuse by the immediate intervention of removing the harm or potential for harm from the resident by removing the perpetrator or threat.

Education of proper resident care includes examples such as ensuring residents are not harmed physically or handled roughly during care but are provided with care that is gentle, kind, dignified and that residents are free from offensive comments, profanities or other form of verbal abuse. To protect resident's right to privacy, the facility is adopting a NO TOLERANCE Cell Phone Policy focusing on the

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F 600	Continued From page 28 strict prohibition of cellular phones and any type of electronic recording device use in resident care areas, especially while providing personal care. Training included examples of violation of residents' privacy to include, but not limited to 1) privacy of not only a residents' own physical body, but of his or her personal space, including accommodations and personal care, 2) only authorized staff directly involved in providing care and services for the resident may be present when care is provided, unless the resident consents to other individuals being present during the delivery of care, 3) during the delivery of personal care and services, staff must remove residents from public view, pull privacy curtains or close doors, and provide clothing or draping to prevent exposure of body parts, 4) photographs or recordings of a resident and/or his or her body or private space without the resident's, or designated representative's written consent, is a violation of the resident's right to privacy and confidentiality, 5) staff taking unauthorized photographs of a resident's room or furnishings (which may or may not include the resident), or a resident eating in the dining room, or a resident participating in an activity in the common area, 6) taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment (for example, cameras, smart phones, and other electronic devices), 7) keeping or distributing them through multimedia messages or on social media networks is a violation of a resident's right to privacy and confidentiality, 8) potential effects on residents whose privacy is not maintained to include, humiliation, dignity, respect and feelings of dehumanization, 9) strict prohibition and NO TOLERANCE to use cellular phones or any type of audio or video device in resident care areas,	F 600		

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resident rooms, common areas such as hallways, dining rooms, courtyards, etc., 10) cell phones are allowed to be kept in staff possession in the facility on a silenced or vibrate mode to allow for emergency alerts but may only be used in breakrooms or other non-resident areas and 11) staff are responsible to intervene if witnessing any violation of the Cell Phone Policy and/or the Resident Rights Policy and immediately remove risk from resident and notify Administrator and 12) violation of the Cell Phone Policy or Resident Rights Policy will result in disciplinary action up to and including termination of employment and/or notification to licensing boards and law enforcement where applicable to ensure resident privacy is maintained and resident's remain free from abuse.

Effective 12/2/2024, abuse questionnaires were also completed with current facility staff to validate competency of education received and to identify any additional allegations or incidence of resident abuse. No additional concerns reported. The SDC will be responsible for ensuring all staff are trained by tracking and reviewing the daily schedule and ensuring training is provided. Newly hired staff and staff not receiving education by 12/2/2024 will receive education prior to first worked shift by the SDC, DON or licensed nurse supervisor.

Effective 12/2/2024, the Administrator, DON or designee will complete ongoing daily observational rounds of facility residents and staff to ensure that residents are free from abuse and resident rights to privacy is maintained, including strict prohibition of staff cellular phone use or any type of audio or video device use in resident care areas. Observations to include 1) care being

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F 600	Continued From page 30 provided only be authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/draping to prevent exposure of body parts, 3) no cellular or other video devices used by staff in resident care areas, 4) any other violation of resident right to personal privacy not only of a residents' own physical body, but of his or her personal space, 5) observations of any form of physical, sexual or emotional abuse which include but are not limited to; a. ensuring residents are not harmed physically or handled roughly during care but are provided with care that is gentle, kind, dignified; b. residents are free from offensive comments, profanities or other form of verbal abuse and c. observations to ensure residents are not exhibiting signs of mental anguish such as tearfulness, withdrawal, fear, guarding, aggressiveness and other unusual changes in resident behaviors. On 2/2/24, licensed nurses were educated and notified by the VPCO of their responsibility to complete observational rounds each shift for his/her unit and observe resident and staff interactions as above. Effective 12/4/24, the facilities new hire screening process has been updated to include additional measures to better determine the candidate's probability of providing excellent resident care to further ensure residents are free from abuse. Updates include improved interview process, a minimum of two professional references, screening of social media content for inappropriate content and improved screening of background checks. Human Resources (HR) and/or the Administrator, DON or SDC are responsible for the interview process, screening reference checks and screening social media platforms. With the guidance of our legal counsel,	F 600		

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a template including a set of questions will be used during the interview process which include the categories of background, interpersonal skills and qualifications and a template for reference checks will be used. Screening of social media platforms will be used via internet search to provide information related to a candidate's personal character. The Human Resource (HR) Director will process and review criminal background checks and forward to the Administrator or DON for approval if a criminal record is identified. The Administrator or DON will consider all screening results to make a final determination. However, the facility will NOT extend employment to any candidate with convictions or pending convictions involving elder abuse, neglect or exploitation.

Effective 12/2/2024, the Administrator is ultimately responsible for the implementation and completion of this removal plan.

Alleged Date of IJ Removal: 12/5/2024

On 12/10/2024, the facility's credible allegation for immediate jeopardy was validated. Resident #2 was observed in the dining room pleasant and smiling with other residents in the table. During the tour of the facility residents were observed to have their doors closed for care and curtains were seen pulled to cover for privacy. There were no signs of staff cell phone use in the hallways and in resident care areas. The in-services by the facility included information on abuse, privacy, resident rights, and cellphone use, including notification of administration for any resident's behavior changes, and increased rounding observations of residents and staff. Staff interviews confirmed education was received for

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abuse, privacy, resident rights, and cellphone use. The facility provided evidence of daily Quality Assurance auditing of all residents divided on cognitively intact residents for interview and cognitively impaired residents for body audits, the auditing for the observational rounds every shift, staff abuse questionnaires, and new on-hire screening process and employee handbook review were executed.

The immediate jeopardy removal date of 12/5/24 was validated.

F 602 SS=D | F 602

Free from Misappropriation/Exploitation
CFR(s): 483.12

§483.12
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.
This REQUIREMENT is not met as evidenced by:
Based on record review, and interviews with staff, the facility failed to protect the resident's right to be free from misappropriation of controlled medications for 1 of 3 residents reviewed for misappropriation of a resident's property (Resident #6). The resident received her pain medication as scheduled.

Past noncompliance: no plan of correction required.

Findings included:

The facility's Abuse, Neglect, and Exploitation Policy, last updated on 10/22/24, was reviewed and it included misappropriation in part was the

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protection of resident property "means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent."

Resident #6 was admitted to the facility on 3/17/20 with a diagnosis of chronic pain.

Resident #6 had an order for oxycodone 10 milligrams (mg) every 6 hours for chronic pain dated 2/13/24.
A pharmacy packing slip dated 3/25/24 documented dispense date of 3/25/24 of 4 cards of oxycodone 10 mg and each card had 10 tablets for a total of 40 tablets.

A review of the medication monitoring/control record received by Nurse #4 documented between 3/25/24 through 3/27/24 there were 10 oxycodone 10 mg administered every 6 hours as ordered, signed with correct descending amount. The remaining amount was "0" for card number one. There were three remaining oxycodone 10 mg cards with 10 tablets each with a medication monitoring/control record.

The daily nursing schedule dated 3/27/24 had Nurse #2 scheduled on B-Hall assigned to Resident #6 on day shift, and she was responsible for this hall's medication cart.

The shift change narcotic count verification for total number of narcotic sheets for all residents on Hall B medication cart ending date 3/26/24 was documented by Nurse #3 total number 32 sheets. Four sheets were added for a total of 36. A 6 was written with a 4 for the column "sheets added" and the "total" column was written as 38.

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The "8" appeared to be written on with another number that was not legible. The comments column documented Resident #6 had 4 oxycodone cards on 3/26/24. All rows were filled on this sheet.

A new shift change narcotic count verification sheet was started dated 3/27/24 3 pm shift "oncoming nurse" signature Nurse #2 and "off going" nurse was blank. Number 36 was in the "narcotic sheets" column. A new row on the narcotic count verification sheet was started dated 3/27/24 11 pm shift "oncoming nurse" and "off going nurse" columns were both signed with a signature of Nurse #3's name. There was no number in the "narcotic sheets" column. The handwriting of the signatures on this sheet appeared to be the same for both names, all 3 signatures.

The Director of Nursing (DON) provided a folder with Resident #6's narcotic misappropriation investigation dated 3/27/24 documentation:

On 3/27/24 the 2nd shift nurse reported that Resident #6 was missing 1 of 4 cards of oxycodone 10 mg that were delivered on 3/25/24. The DON completed a review of the shift verification count sheet and noted that the sheet count number had been altered. Further investigation revealed 1 medication monitoring control record and 1 card of 10 oxycodone 10 mg tablets were missing. The pharmacy and police were notified. All other facility medication carts of narcotic counts were audited, and no other concerns were noted. Nurse #2 was suspended pending investigation. The pharmacy confirmed that 4 cards of oxycodone 10 mg were delivered on 3/25/24. The pharmacy packing slip indicated

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that 4 cards of oxycodone 10 milligrams with 10 tablets on each card were delivered. Nurse #2 was contacted by phone and refused to provide a statement related to oxycodone. Nurse #2 was reported to the North Carolina Board of Nursing on 4/3/24. Education was initiated with licensed nurses regarding the narcotic count and correcting errors in the medication record properly. Corrective actions: The pharmacy was contacted by the DON on 3/28/24 and a replacement refill card of oxycodone 10 mg 10 tablets was obtained at the expense of the facility. The police were contacted, and they informed the facility they were unable to reach Nurse #1 by phone or the address on file by the agency. Nurse #2 will not be allowed to work in the facility.

On 4/8/24 a urine specimen was obtained from Nurse #3. The test was negative for all drugs including opiate.

Nurse #2 was left messages on 3/27/24 and 3/28/24 twice. A return call was received from her on 3/29/24 at 10:40 am. She stated that she wanted her pay approved. Nurse #2 was asked to come to the facility and provide a statement. A statement was not provided.

All residents that had narcotic orders were reviewed for accuracy of administration and count. All medication control records were reviewed and medication audited, and no other misappropriation of medication was identified.

Audits were completed for weeks 4/3/24 through 5/1/24 weekly for 4 weeks or longer if concerns were identified. Goal: Residents' controlled drugs will be properly handled and the facility will have correct records/documentation on the narcotic

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count sheets. The audits were completed, and counts were correct.

An in-service roster of nurses signed for education about the policy "controlled substance administration and accountability" revision November 2017 had 32 staff signatures. Additional information to correct mistakes appropriately was included.

On 12/5/24 at 2:54 pm an interview was conducted with Nurse #2. She stated on 3/25/27 four oxycodone cards with 10 tabs each were received for Resident #6 and Nurse #3 and #4 observed, documented, and counted that this was added to the shift change narcotic count verification sheet and there was a medication monitoring control record for each oxycodone card. Both nurses signed for the received oxycodone. The new cards were added to the shift change narcotic count verification sheet, and "we used the last row of that sheet with a date of 3/26/24." A new shift change narcotic count verification sheet was started and signed by Nurse #3 and #4. Nurse #2 was on day shift 3/27/24 responsible for the narcotics and counted with Nurse #3 at shift change 3:00 pm. The Medication monitoring control record that was being used was accurate. There were the correct number of shift change narcotic count verification sheets numbered. Nurse #3 stated she went to administer an oxycodone at the beginning of her evening shift and checked the paperwork. She noticed that the new shift change narcotic count verification sheet was not the sheet she and Nurse #4 had started and signed on 3/26/24. The signatures were not theirs and both appeared to be signed by the same person. A check of the previous shift change narcotic count verification

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sheet ending date 3/26/24 that Nurse #3 and #4 had completed to the last row of the sheet had the number of narcotic sheets added and total number of narcotic sheets on the cart were changed. The numbers were written over and were not the correct numbers, the numbers written by Nurse #3 the evening before 3/26/24. Nurse #3 noticed that one of the oxycodone cards was missing. There should have been 3 cards remaining and now there were only 2. Nurse #2 had left immediately after report at shift change and narcotic count and was unable to be reached by telephone.

On 12/5/24 at 2:40 pm an interview was conducted with the Vice President of Quality. She stated the Administrator was not present and the DON employed March 2024 was no longer working at this facility. She also stated she would look for additional nursing education roster sheets, QAPI (Quality Assurance/Performance Improvement) minutes, and Drug Enforcement Administration notification.

On 12/5/24 at 4:20 pm the Vice President of Quality provided a QAPI minute meeting dated 3/27/24 with the topic drug diversion and the team roster.

Nurse # 4 was interviewed on 12/10/24 at 12:25 pm. Nurse #4 stated 4 cards of oxycodone 10 mg were received for Resident #6 on 3/25/24. Nurse #3 and Nurse #4 counted, documented, and signed for the receipt of the Oxycodone 3/25/24 at 7:00 am. One card of the Oxycodone 10 mg was used and counted down to 0 on 3/27/24. The count was correct when Nurse #4 left after night shift 3/27/24 7:00 am and counted with Nurse #2. Nurse #4 started a new shift

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change narcotic count sheet with Nurse #3 and signed and dated 3/26/24. Nurse #4 counted with Nurse #2 at the beginning of her day shift 3/27/24 at 7:00 am and the narcotic count was correct. The sheet Nurse #4 started was present and there were 3 full cards of oxycodone 10 mg remaining. On 3/27/24 at 3:00 pm the shift change narcotic count sheet that Nurse #3 and Nurse #4 started was missing. Another sheet was started by an agency nurse (Nurse #2). Nurse #4's name was not on this new sheet. Nurse #3 and Nurse #2's name were on the new sheet and the handwriting looked the same.

On 12/10/14 the Vice President of Quality provided the remaining nurse education roster and a statement that the Drug Enforcement Administration was notified under the facility's previous name and identification number and the document was not obtainable.

The facility provided the following corrective action plan with a completion date of 4/7/24:

F602
1. Corrective action for resident(s) affected by the alleged deficient practice:
Resident #6 was affected by misappropriation of her schedule oxycodone pain medication. The resident received her medication as scheduled. The medication was replaced by the facility.
2. Corrective action for residents with the potential to be affected by the alleged deficient practice:
All residents with a narcotic order for pain had potential to be affected. The Director of Nursing completed an audit of all medication carts with narcotics to verify that all narcotics and narcotic sheets were accounted for with no other concerns

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identified. The audit was completed on 3/27/24.

3. Measures/Systemic changes to prevent recurrence of alleged deficient practice:

On 3/27/24 through 4/7/24 training on the following topics for all licensed nurses and medication aids regarding misappropriation of personal property that focused on shift-to-shift count, verifying medications on hand, misappropriation, and documentation. The Director of Nursing and/or designee would continue to maintain and monitor controlled medication records to ensure consistency and accountability. Education was completed by 4/7/24 for all nursing staff, including agency staff. Monitoring of the medication carts began on 3/27/24 with the initial audit after the misappropriation. The monitoring continued weekly for 4 weeks. The QA members were notified on 3/27/24.

4. Monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Director of Nursing audited all medication carts weekly for 4 weeks. There were no adverse findings. The misappropriation was reported to the QAPI (Quality Assurance/Performance Improvement) Committee) on 3/27/24.

Compliance Date: 4/8/24

Validation of the corrective action plan was completed on 12/11/24.

Review of documentation/staff roster of education

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F 602	Continued From page 40 that was completed with 33 nurses and medication aides who had responsibility to administer narcotic medication and had access to controlled substances covered drug loss or theft, administration, and shift-to-shift drug count was completed. The education took place between 3/27/24 through 4/7/24. On 12/5/24 interviews were conducted individually with Nurse #1 and #3 and on 12/10/24 with Nurse #4. The Nurses stated they participated in education for narcotic misappropriation, storage, reporting, count, and documentation. The compliance date of 4/8/24 was validated.	F 602		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include	F 607		12/11/24

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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 observation, record review, and responsible party, Lieutenant of Criminal Investigations and staff interviews, the facility failed to develop and implement abuse policies in the area of identification, protection and reporting for 1 of 3 residents (Resident #2). While Resident # 2 was being abused, neither of the two nurse aides (NA #1 and NA #2) in the room identified the abuse, intervened to stop the abuse, and neither of the two nurse aides reported the abuse immediately to licensed staff or administrative staff.

Immediate jeopardy began on 10/4/24 when Resident #2 was abused without staff identification, intervention or reporting. Immediate jeopardy was removed on 12/5/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at the scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems put into place and are effective.

The findings included:

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#1 On 12/4/24 at 4:00pm, the Director of Nursing (DON), Vice President of Clinical Operations (VPCO) and Vice President of Risk and Quality Assurance (VPRQA) were first made aware of the presence of NA #2 during the incident on 10/4/2024. The DON immediately suspended NA #2 pending investigation. The VPRQA notified police and provided additional information and left a message with APS. The DON notified Resident #2's resident representative (RP) and MD was provided updated information received. On 12/4/2024 at 6:00pm, the VPCO assessed Resident #2 for physical injury, pain and signs or symptoms of psychosocial distress and no concerns were observed and was pleasantly confused at baseline. On 12/4/2024, the DON, VPCO, VPRQA, Administrator and Medical Director held an Ad Hoc meeting to discuss incident to determine root cause analysis of the facility's failure to protect a resident right to be free from abuse when NA #2 did not identify, prevent or report the incident on 10/4/2024. Root cause analysis determined that the facility failed to 1) implement an effective system to ensure

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A review of the facility policy and procedure titled "Abuse, Neglect, and Exploitation", with a revised date of 10/22/24, read in part "it is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property." As read in section 1: "Policy Explanation and Compliance Guidelines," reads 1a.) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.

This tag is cross referred to F600

Based on observation, record review, and family, Lieutenant of Criminal Investigations and staff interviews, the facility failed to protect a resident's right to be free from abuse for 1 of 3 residents (Resident #2). Nurse aide (NA) # 1 and NA # 2 provided personal care to Resident # 2 while live streaming on a cell phone, the resident was naked from the waist up, the staff and the prison inmate watching the live stream spoke with profanity and vulgarity without any regard for the resident; the staff did not explain care as it was provided to the resident; the staff were physically aggressive during care; the staff allowed an inmate who was watching the live stream to view the resident and speak to the resident; the staff allowed this live streaming while other inmates were observed in the open area behind him. As Resident #2 was severely cognitively impaired, the reasonable person concept was applied. A reasonable person would have been traumatized by being abused by caregivers in their home environment making them feel worthless, angry, dehumanized and powerless.

F 607 (Plan of Correction)

staff knowledge of the Abuse, Neglect and Exploitation Policy to include detailed examples of how to identify, prevent and report abuse and validation of staff understanding and 2) the facility failed to enforce a strict NO TOLERATION for cell phone use and video recording device use in resident care areas per the Cell Phone Policy.

On 12/4/24 the facility was made aware of immediate jeopardy and an acceptable plan of correction was provided and jeopardy removed effective 12/5/24.

On 12/6/24, upon completion of investigation, NA #1 and NA #2 were terminated indefinitely and reported to the nurse aide registry.

#2 On 12/2/24 at 4:00pm, the Administrator completed an observational round of facility residents and staff to ensure that resident rights to privacy and freedom from abuse is maintained. Observations included 1) care being provided only by authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/draping to prevent exposure of body parts, 3) no cellular or other video devices used by staff in resident care areas and 4) any other violation of resident right to personal privacy not only of a residents' own physical body, but of his or her personal space and 5) observations to ensure residents have no physical signs or behaviors indicative of potential abuse. No additional concerns identified.

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Immediate jeopardy began on 10/4/24 when Resident #2 was abused. Immediate jeopardy was removed on 12/5/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at the scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems put into place and are effective.

The Director of Nursing (DON), Vice President of Clinical Operations (VPCO), and Vice President of Risk and QAPI (VPRQA) were notified of immediate jeopardy on 12/5/24 at 1:45 PM. The Administrator was not present.

The facility provided the following credible allegation of immediate jeopardy removal.

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

The facility failed to follow their abuse policy in the areas of identification, prevention, and reporting when NA #2 witnessed NA #1 conduct an audiovisual phone call where NA #1 showed Resident #2 in compromised positions during a recorded call NA #1 was having with a male individual who was witnessing Resident #2 through the use of a wall mounted screen in a common area of an incarceration center. During the audiovisual conversation NA #1 was observed to show Resident #2 to the male individual through her phone camera, the resident sitting in a wheelchair, naked, with no shirt or bra on, with her breasts exposed. NA #2 failed to intervene to

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Effective 12/2/2024, licensed nurses completed resident abuse questionnaires with cognitively intact residents and body audits with cognitively impaired residents to identify any additional concerns of resident abuse. No additional concerns reported or observed.
Effective 12/2/2024, abuse questionnaires were also completed with current facility staff to validate competency of education received and to identify any additional allegations or incidence of resident abuse. No additional concerns reported.
Effective 12/2/24, abuse questionnaires were completed with current facility staff to validate competency of education received and to identify any additional allegations or incidence of resident abuse. No additional concerns reported.

#3 Effective 12/2/2024, all current facility staff were in-serviced on the Abuse, Neglect and Exploitation Policy, Resident Rights Policy and Cell Phone Policy by the Staff Development Coordinator (SDC) and licensed nurse manager. Abuse training topics included preventing, reporting and identifying what constitutes abuse and NO TOLERANCE for failure to comply and ensure resident protection. Identification examples included; physical, mental, sexual, verbal, neglect, exploitation and signs of mental or emotional abuse such as, sudden unexplained changes in behavior, changes in eating habits, withdrawal from care, fear of certain persons or expressions of guilt or shame and staff obligation of reporting abuse immediately to the Administrator and

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stop the audiovisual device and protect the resident from ongoing mental abuse, and did not immediately get licensed staff or administrative staff to intervene and stop it, nor did she notify administration, or a supervisor.

On 12/4/24 at 4:00pm, the DON, VPCO and VPRQA were first made aware of the presence of NA #2 during the incident on 10/4/2024. The DON immediately suspended NA #2 pending investigation. The VPRQA notified police and provided additional information and left a message with APS. The DON notified Resident #2's resident representative (RR) and MD was provided updated information received.

On 12/4/2024 at 6:00pm, the VPCO assessed Resident #2 for physical injury, pain and signs or symptoms of psychosocial distress and no concerns were observed and was pleasantly confused at baseline.

On 12/4/2024 the VPCQA, VPCO and DON attempted to obtain information regarding the location of the prison. Upon receipt of this information, the facility plans to inquire on the security of the recording and ensure that Resident #2 is protected from any additional violation of privacy by others who are unauthorized to have such information.

On 12/4/2024, the DON, VPCO, VPRQA, Administrator and Medical Director held an Ad Hoc meeting to discuss incident to determine root cause analysis of the facility's failure to protect a resident's right to be free from abuse when NA #2 did not identify, prevent or report the incident on 10/4/2024. Root cause analysis determined that the facility failed to 1) implement an effective

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prevention of abuse by the immediate intervention of removing the harm or potential for harm from the resident by removing the perpetrator or threat. To protect resident's right to privacy, the facility is adopting a NO TOLERANCE Cell Phone Policy focusing on the strict prohibition of cellular phones and any type of electronic recording device use in resident care areas, especially while providing personal care. Training included examples of violation of residents' privacy to include, but not limited to 1) privacy of not only a residents' own physical body, but of his or her personal space, including accommodations and personal care, 2) only authorized staff directly involved in providing care and services for the resident may be present when care is provided, unless the resident consents to other individuals being present during the delivery of care, 3) during the delivery of personal care and services, staff must remove residents from public view, pull privacy curtains or close doors, and provide clothing or draping to prevent exposure of body parts, 4) photographs or recordings of a resident and/or his or her body or private space without the resident's, or designated representative's written consent, is a violation of the resident's right to privacy and confidentiality, 5) staff taking unauthorized photographs of a resident's room or furnishings (which may or may not include the resident), or a resident eating in the dining room, or a resident participating in an activity in the common area, 6) taking unauthorized photographs or recordings

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system to ensure staff knowledge of the Abuse, Neglect and Exploitation Policy to include detailed examples of how to identify, prevent and report abuse and validation of staff understanding and 2) the facility failed to enforce a strict NO TOLERATION for cell phone use and video recording device use in resident care areas per the Cell Phone Policy.

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

Effective 12/2/2024, all current facility staff were in-serviced on the Abuse, Neglect and Exploitation Policy, Resident Rights Policy and Cell Phone Policy by the Staff Development Coordinator (SDC) and licensed nurse manager. Abuse training topics included preventing, reporting and identifying what constitutes abuse and NO TOLERANCE for failure to comply and ensure resident protection. Identification examples included; physical, mental, sexual, verbal, neglect, exploitation and signs of mental or emotional abuse such as, sudden unexplained changes in behavior, changes in eating habits, withdrawal from care, fear of certain persons or expressions of guilt or shame and staff obligation of reporting abuse immediately to the Administrator and prevention of abuse by the immediate intervention of removing the harm or potential for harm from the resident by removing the perpetrator or threat. Education of proper resident care includes examples such as ensuring residents are not harmed physically or handled roughly during care but are provided with care that is gentle, kind, dignified and that residents are free from offensive comments,

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of residents in any state of dress or undress using any type of equipment (for example, cameras, smart phones, and other electronic devices), 7) keeping or distributing them through multimedia messages or on social media networks is a violation of a resident's right to privacy and confidentiality, 8) potential effects on residents whose privacy is not maintained to include, humiliation, dignity, respect and feelings of dehumanization, 9) strict prohibition and NO TOLERANCE to use cellular phones or any type of audio or video device in resident care areas, resident rooms, common areas such as hallways, dining rooms, courtyards, etc., 10) cell phones are allowed to be kept in staff possession in the facility on a silenced or vibrate mode to allow for emergency alerts but may only be used in breakrooms or other non-resident areas and 11) staff are responsible to intervene if witnessing any violation of the Cell Phone Policy and/or the Resident Rights Policy and immediately remove risk from resident and notify Administrator and 12) violation of the Cell Phone Policy or Resident Rights Policy will result in disciplinary action up to and including termination of employment and/or notification to licensing boards and law enforcement where applicable to ensure resident privacy is maintained and resident's remain free from abuse. The SDC will be responsible for ensuring all staff are trained by tracking and reviewing the daily schedule and ensuring training is provided. Newly hired staff and staff not receiving education by 12/2/24 will receive

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 46 profanities or other form of verbal abuse. To protect resident's right to privacy, the facility is adopting a NO TOLERANCE Cell Phone Policy focusing on the strict prohibition of cellular phones and any type of electronic recording device use in resident care areas, especially while providing personal care. Training included examples of violation of residents' privacy to include, but not limited to 1) privacy of not only a residents' own physical body, but of his or her personal space, including accommodations and personal care, 2) only authorized staff directly involved in providing care and services for the resident may be present when care is provided, unless the resident consents to other individuals being present during the delivery of care, 3) during the delivery of personal care and services, staff must remove residents from public view, pull privacy curtains or close doors, and provide clothing or draping to prevent exposure of body parts, 4) photographs or recordings of a resident and/or his or her body or private space without the resident's, or designated representative's written consent, is a violation of the resident's right to privacy and confidentiality, 5) staff taking unauthorized photographs of a resident's room or furnishings (which may or may not include the resident), or a resident eating in the dining room, or a resident participating in an activity in the common area, 6) taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment (for example, cameras, smart phones, and other electronic devices), 7) keeping or distributing them through multimedia messages or on social media networks is a violation of a resident's right to privacy and confidentiality, 8) potential effects on residents whose privacy is not maintained to include, humiliation, dignity, respect	F 607	education prior to first worked shift by the SDC, DON or licensed nurse supervisor.The SDC will be responsible for ensuring all staff are trained by tracking and reviewing the daily schedule and ensuring training is provided. Newly hired staff and staff not receiving education by 12/2/24 will receive education prior to first worked shift by the SDC, DON or licensed nurse supervisor. Effective 12/4/24, the facilities new hire screening process has been updated to include additional measures to better determine the candidate’s probability of providing excellent resident care to further ensure residents are free from abuse. Updates include improved interview process, a minimum of two professional references, screening of social media content for inappropriate content and improved screening of background checks. Human Resources (HR) and/or the Administrator, DON or SDC are responsible for the interview process, screening reference checks and screening social media platforms. With the guidance of our legal counsel, a template including a set of questions will be used during the interview process which include the categories of background, interpersonal skills and qualifications and a template for reference checks will be used. Screening of social media platforms will be used via internet search to provide information related to a candidate’s personal character. The Human Resource (HR) Director will process and review criminal background checks and forward to the Administrator	

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F 607	Continued From page 47 and feelings of dehumanization, 9) strict prohibition and NO TOLERANCE to use cellular phones or any type of audio or video device in resident care areas, resident rooms, common areas such as hallways, dining rooms, courtyards, etc., 10) cell phones are allowed to be kept in staff possession in the facility on a silenced or vibrate mode to allow for emergency alerts but may only be used in breakrooms or other non-resident areas and 11) staff are responsible to intervene if witnessing any violation of the Cell Phone Policy and/or the Resident Rights Policy and immediately remove risk from resident and notify Administrator and 12) violation of the Cell Phone Policy or Resident Rights Policy will result in disciplinary action up to and including termination of employment and/or notification to licensing boards and law enforcement where applicable to ensure resident privacy is maintained and resident's remain free from abuse. Effective 12/2/24, abuse questionnaires were also completed with current facility staff to validate competency of education received and to identify any additional allegations or incidence of resident abuse. No additional concerns reported. The SDC will be responsible for ensuring all staff are trained by tracking and reviewing the daily schedule and ensuring training is provided. Newly hired staff and staff not receiving education by 12/2/24 will receive education prior to first worked shift by the SDC, DON or licensed nurse supervisor. Effective 12/2/24, abuse questionnaires were also completed with current facility staff to validate competency of education received and to identify any additional allegations or incidence of resident	F 607	or DON for approval if a criminal record is identified. The Administrator or DON will consider all screening results to make a final determination. However, the facility will NOT extend employment to any candidate with convictions or pending convictions involving elder abuse, neglect or exploitation. #4 Effective 12/2/2024, the Administrator, DON or designee will complete observational rounds of facility residents and staff to ensure that residents are free from abuse and resident rights to privacy is maintained, including strict prohibition of staff cellular phone use or any type of audio or video device use in resident care areas. Observations will be completed daily for one (1) week, three (3) times weekly for four (4) weeks, two (2) times weekly for four (4) weeks, weekly for four (4) weeks and as needed thereafter. Monitoring to include observations of 1) care being provided only be authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/draping to prevent exposure of body parts, 3) no cellular or other video devices used by staff in resident care areas, 4) any other violation of resident right to personal privacy not only of a residents' own physical body, but of his or her personal space, 5) observations of any form of physical, sexual or emotional abuse which include but are not limited to; a. ensuring residents are not harmed physically or handled roughly during care but are provided with care that is gentle, kind, dignified; b. residents are free from	

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abuse. No additional concerns reported. The SDC will be responsible for ensuring all staff are trained by tracking and reviewing the daily schedule and ensuring training is provided. Newly hired staff and staff not receiving education by 12/2/24 will receive education prior to first worked shift by the SDC, DON or licensed nurse supervisor.

Effective 12/2/2024, the Administrator, DON or designee will complete ongoing daily observational rounds of facility residents and staff to ensure that residents are free from abuse and resident rights to privacy is maintained, including strict prohibition of staff cellular phone use or any type of audio or video device use in resident care areas. Observations to include 1) care being provided only be authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/draping to prevent exposure of body parts, 3) no cellular or other video devices used by staff in resident care areas, 4) any other violation of resident right to personal privacy not only of a residents' own physical body, but of his or her personal space, 5) observations of any form of physical, sexual or emotional abuse which include but are not limited to; a. ensuring residents are not harmed physically or handled roughly during care but are provided with care that is gentle, kind, dignified; b. residents are free from offensive comments, profanities or other form of verbal abuse and c. observations to ensure residents are not exhibiting signs of mental anguish such as tearfulness, withdrawal, fear, guarding, aggressiveness and other unusual changes in resident behaviors. On 2/2/24, licensed nurses were educated and notified by the VPCO of their responsibility to complete observational rounds each shift for his/her unit

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offensive comments, profanities or other form of verbal abuse and c. observations to ensure residents are not exhibiting signs of mental anguish such as tearfulness, withdrawal, fear, guarding, aggressiveness and other unusual changes in resident behaviors.

The Administrator will report findings of the monitoring to the Quality Assurance Performance Improvement (QAPI) Committee during monthly QAPI meetings and will make changes to the plan as necessary to ensure the facility maintains an effective Abuse and Neglect program.

Compliance Date: 12/05/24

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and observe resident and staff interactions as above.

Effective 12/4/24, the facilities new hire screening process has been updated to include additional measures to better determine the candidate's probability of providing excellent resident care to further ensure residents are free from abuse. Updates include improved interview process, a minimum of two professional references, screening of social media content for inappropriate content and improved screening of background checks. Human Resources (HR) and/or the Administrator, DON or SDC are responsible for the interview process, screening reference checks and screening social media platforms. With the guidance of our legal counsel, a template including a set of questions will be used during the interview process which include the categories of background, interpersonal skills and qualifications and a template for reference checks will be used. Screening of social media platforms will be used via internet search to provide information related to a candidate's personal character. The Human Resource (HR) Director will process and review criminal background checks and forward to the Administrator or DON for approval if a criminal record is identified. The Administrator or DON will consider all screening results to make a final determination. However, the facility will NOT extend employment to any candidate with convictions or pending convictions involving elder abuse, neglect or exploitation.

Effective 12/2/2024, the Administrator is ultimately responsible for the implementation and completion of this removal plan.

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F 607	Continued From page 50 Alleged Date of IJ Removal: 12/5/2024 On 12/10/2024, the facility's credible allegation for immediate jeopardy was validated. Resident #2 was observed in the dining room pleasant and smiling with other residents in the table. During the tour of the facility residents were observed to have their doors closed for care and curtains were seen pulled to cover for privacy. There were no signs of staff cell phone use in the hallways and in resident care areas. The in-services by the facility included information on abuse, privacy, resident rights, and cellphone use, including notification of administration for any resident's behavior changes, and increased rounding observations of residents and staff. Staff interviews confirmed education was received for abuse, privacy, resident rights, and cellphone use. The facility provided evidence of an Ad Hoc meeting discussion of the root cause analysis of the facility failure to implement effective systems of their abuse policy. The facility provided evidence of daily Quality Assurance auditing of all residents divided on cognitively intact residents for interview and cognitively impaired residents for body audits, the auditing for the observational rounds every shift, staff abuse questionnaires, and new on-hire screening process and employee handbook reviewed. The facility's IJ removal date of 12/05/24 was validated.	F 607		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623		12/20/24

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representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section

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F 623	Continued From page 52 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 53 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify Resident #27's Representative and Resident #28 in writing, of transfers to the hospital for 2 of 3 residents reviewed for hospitalization (Resident #27 and Resident #28). The findings included: 1. Resident #27 was admitted to the facility on 6/20/23. Resident #27 was readmitted to the facility on 3/7/24, 8/4/24, and 11/9/24. The most recent quarterly Minimum Data Set assessment dated 11/20/24 assessed Resident #27 to be severely cognitively impaired. a. Review of Resident #27's medical record revealed a progress note dated 2/28/24 that documented Resident #27's transfer to the hospital for difficulty swallowing. A progress note dated 3/7/24 documented Resident #27's return from the hospital with a diagnosis of elevated sodium level. Review of the medical record revealed no transfer	F 623	#1 Resident #27 representative and Resident #28 will receive timely written notice for any future facility-initiated transfer or discharge. #2 On 12/19/24, the Vice President of Risk (VPR) completed an audit of resident hospital transfers occurring during previous two weeks (12/4/24 - 12/18/24) for evidence of timely written notice to Resident/Representative. Eight (8) of 8 resident transfers reviewed had written notice of transfers provided to Resident/Representative by the SW. #3 On 12/5/24, the Administrator provided education to the SW and Director of Nursing (DON) on the requirements of the facility to notify the resident and the resident's representative(s) prior to any facility-initiated transfer or discharge and the reasons for the move in writing and in a language and manner they understand (form NC Medicaid-9050). The facility must send a copy of the notice to the local Ombudsman representative. The SW will be responsible for providing written	

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notification.

b. A progress note dated 8/3/24 documented Resident #27's transfer to the hospital after a fall and complaints of head pain. A progress note dated 8/4/24 documented Resident #27's readmission to the facility after hospitalization for fall.
Review of the medical record revealed no transfer notification.

c. A progress note dated 11/6/24 documented Resident #27 was experiencing nausea and vomiting, and he was sent to the hospital for evaluation. A progress note dated 11/9/24 documented Resident #27's return from the hospital. The hospital discharge note dated 11/9/24 documented Resident #27 was admitted to the hospital for intractable nausea and vomiting.

Review of the medical record revealed no transfer notification.

The Social Worker (SW) was interviewed on 12/5/24 at 3:25 PM. The SW reported the previous administrator had told her she needed to provide a written notice of transfer for residents sent to the hospital, but she had not started to provide the written notice of transfer to residents or their representative. The SW reported she had not provided a written notice of transfer for any resident.

The Administrator was interviewed by phone on 12/9/24 at 11:10 AM. The Administrator reported she was not aware the SW was not providing a written notice of transfer for residents, or their representatives and she expected all residents or

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notices prior to transfer/discharge or as soon as practical and will maintain a Transfer/Discharge Notice Log with date and method written notices are provided. Newly hired SW□s will receive education upon hire.
#4 The Administrator or DON will complete quality assurance monitoring of facility-initiated transfers and discharges for accurate, timely notifications. Monitoring will be completed three (3) times weekly for four (4) weeks, two (2) times weekly for four (4) weeks, weekly for four (4) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Quality Assurance Performance Improvement (QAPI) Committee during monthly QAPI meetings and will make changes to the plan as necessary to maintain compliance with notice requirements before transfer/discharge.

Completion date: 12/20/2024

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their representatives to receive a written notice of transfer.

2. Resident #28 was admitted to the facility 8/27/24.

The most recent quarterly Minimum Data Set assessment dated 11/13/24 documented Resident #28 was cognitively intact.

A progress note dated 12/3/24 documented Resident #28 was sent to the hospital for cellulitis (infection of the soft tissue) of the leg, elevated white blood cells, and elevated kidney function.

Resident #28 remained hospitalized during the survey.

Review of the medical record revealed no transfer notification to Resident #28.

The Social Worker (SW) was interviewed on 12/5/24 at 3:25 PM. The SW reported the previous administrator had told her she needed to provide a written notice of transfer for residents sent to the hospital, but she had not started to provide the written notice of transfer to residents or their representative. The SW reported she had not provided a written notice of transfer for any resident.

The Administrator was interviewed by phone on 12/9/24 at 11:10 AM. The Administrator reported she was not aware the SW was not providing a written notice of transfer for residents, or their representatives and she expected all residents or their representatives to receive a written notice of transfer.

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F 677	Continued From page 56	F 677		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with Resident #65 and staff, the facility failed to provide nail care and hand hygiene for a dependent resident (Resident #65). This deficient practice affected 1 of 4 sampled dependent residents. Findings included: Resident #65 was admitted to the facility on 1/10/22 with the diagnosis of limited range of motion. Resident #65's Minimum Data Set dated 9/13/24 documented her cognition was intact. The resident required assistance from one staff member for bathing and personal grooming. The care plan for Resident #65 dated 9/13/24 included the resident required assistance with all activities of daily living. The intervention was nail care to be provided with showers or bathing. On 12/2/24 at 11:40 am an observation and interview was completed of Resident #65. The Resident was sitting in her bed in a hospital gown. The Resident's nails were noted to be uneven, long, and had black matter underneath the nails, especially the right hand. The resident stated she usually had a bed bath and had no	F 677	#1 On 12/6/24, Resident #65 was provided nail care by the nurse aide to ensure nails were clean, trimmed and free of jagged edges. Resident #65 will continue to receive nail care during routine daily care and prior to meals as needed for hygiene. #2 On 12/13/24, the Unit Managers (UMs) completed an observational audit of resident nail care. All resident nails clean, trimmed and free of jagged edges, unless care plan reflects refusal of care or preference for long nails. #3 Effective 12/20/24, the Director of Nursing (DON) and UMs provided education to licensed nurses and nurse aides on providing nail care to dependent residents. Nurse aides will be responsible for providing resident nail care during routine daily care to ensure nails are clean, trimmed and free of jagged edges. Nails will be cleaned prior to meals as needed for hygiene. The licensed nurse assigned to the resident will monitor for proper nail care during routine shift observations and assist nurse aides as needed. Newly hired licensed nurses and nurse aides and those not receiving education by 12/20/24 will receive education during orientation or prior to	12/20/24

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	345130	A. BUILDING ___ B. WING ___	C 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 57 offer from the Nursing Assistant (NA) to provide nail care. The resident stated she would like nail care, and she had not refused care. The resident also stated she had asked an NA to cut her nails, but the NA had not returned to provide care a couple of days earlier. On 12/5/24 at 1:50 pm an observation and interview was completed with Resident #65. The Resident's nails remained long, uneven but had less black matter. The right hand had two nails that remained with black matter underneath. The Resident stated she was taken to the dining room by the Activity Director yesterday for an activity. The Resident was informed she was going to receive a manicure including nail polish. The Resident stated she had not gotten her nails done and was taken back to her room and had not known why. The resident stated she had a bed bath yesterday and the NA assigned had not provided nail care and she did not know why. The Resident had not asked for nail care. The Resident stated she required assistance with all bathing and nail care. She could not cut her own nails and had no access to wash her hands/nails without staff assistance. An interview was conducted with NA #4 on 12/5/24 at 1:55 pm. NA #4 stated he was assigned on day shift to Resident #65 on 12/4/24 and 12/5/24. NA #4 stated he provided a bed bath on 12/4/24 but had not provided nail care. NA #4 had not provided nail care because his "assignment was heavy." NA #4 stated he ran out of time. NA #4 had not offered or provided nail care today (12/5/24) but would provide care now. NA #4 stated he was aware and had observed the resident place her hand inside her brief to scratch and had not provided hand	F 677	first shift worked. #4 The DON or UMs will complete quality assurance monitoring of five (5) dependent residents to ensure nails are clean, trimmed and free of jagged edges, unless care plan reflects refusal of care or preference for long nails. Monitoring will be completed three (3) times weekly for four (4) weeks, two (2) times weekly for four (4) weeks, weekly for four (4) weeks and as necessary thereafter. The DON will report findings of the monitoring to the Quality Assurance Performance Improvement (QAPI) Committee during monthly QAPI meetings and will make changes to the plan as necessary to maintain compliance with nail care for dependent residents. Compliance Date: 12/20/24	

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F 677	Continued From page 58	F 677		

hygiene before meals. The resident had itchy skin all over her body. NA #4 further stated he had not informed the nurse about the scratching.

On 12/5/24 at 1:45 pm an interview was conducted with NA #3. NA #3 stated she was assigned to Resident #65 on 12/5/24, day shift. The NA stated she provided morning care for the resident and her bath was yesterday. The NA stated on rounds this morning the resident was observed to have her hands in her brief scratching what appeared to be her "private" area. The resident told the NA that she was scratching her leg. The NA stated she had not offered to clean the resident's hands after the scratching and before lunch. The NA had not known why the resident's nails were long, uneven, and dirty underneath. The NA stated she would provide nail care following the interview.

On 12/5/24 at 1:55 pm an interview was conducted with the Activity Assistant. She stated there was an activity yesterday for manicures. She stated the activity ran out of time and the dining room was needed for lunch. Resident #65 was not able to have her manicure due to a lack of time. The Activity Director was also an NA and would clean/cut a resident's nails if needed. The Activity Assistant stated she was going to have another manicure activity on Saturday but could not cut the resident's nails, she was not an NA. She further stated Resident #65 would be added to the list for manicure this Saturday (12/7/24).

On 12/4/24 at 3:39 pm an interview was conducted with Nurse #1. She stated the NAs were responsible to provide the residents with nail care during the shower or bed bath unless refused and the nurse would need to be notified.

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F 677	Continued From page 59 She stated the NAs had not notified her Resident #65 had refused care, including nail care. Nurse #1 was not aware that the resident's nails required care and would let the NA scheduled know. An interview was conducted with Nurse #1 on 12/5/24 at 2:05 pm. She was not aware that the resident's nails were not cared for yesterday with the bath (12/4/24). The resident sometimes preferred a bath over a shower but had not refused care. She was not aware that the resident was observed by NA #3 and NA #4 putting her hand into her brief and scratching. She could not remember which NA provided the bed bath yesterday. On 12/5/24 at 3:45 pm an interview was conducted with the Director of Nursing (DON). The DON was not aware Resident #65 had not received nail care and was scratching her skin, including inside her undergarment. The DON would want staff to provide hand hygiene before meals if a resident was scratching inside an undergarment.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 689	#1 On 12/9/24, the licensed nurse	12/20/24

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F 689	Continued From page 60 facility failed to complete a quarterly smoking assessments for 2 of 3 residents reviewed for smoking (Resident #31 and Resident #72). The findings included: 1a. Resident #31 was admitted to the facility on 01/12/20 with diagnoses which included hypertension, muscle weakness, dementia, and blindness in one eye. Review of Resident #31's annual MDS dated 05/10/24 revealed the resident was coded for smoking. Review of Resident #31's quarterly Minimum Data Set (MDS) dated 10/16/24 revealed the resident was severely cognitively impaired and was totally dependent on staff for most activities of daily living (ADL). Resident #31 was coded for moderate visual impairment. The MDS indicated Resident #31's mobility device was a wheelchair use. Review of Resident #31's care plan revised on 12/4/24 revealed the resident was a smoker and was supervised because he was once non-compliant with smoking policy and witnessed smoking in his room. The goal was for Resident #31s smoking related injuries to be minimized with intervention through next review. Interventions included smoking assessment to be completed per facility policy. Review of Resident #31's smoking assessments revealed the only smoking assessment completed since the last recertification dated 07/08/23 was on 09/17/24. The smoking assessment dated 09/17/24 concluded Resident	F 689	completed an updated smoking assessment for Resident #31 and Resident #72. Smoking assessments will continue to be completed for Resident #31 and Resident #72 quarterly and with changes in condition or smoking status. #2 On 12/9/24, the Unit Managers (UMs) completed updated smoking assessments on all current facility residents to accurately reflect resident smoking status. #3 Effective 12/20/24, the Director of Nursing (DON) and UMs provided education to licensed nurses on completing smoking assessments upon admission, quarterly and with changes in resident condition or smoking status. Smoking assessments will be completed by the licensed nurse assigned to the resident and monitored by the Unit Manager for timely, accurate completion. Newly hired licensed nurses and those not receiving education by 12/20/24 will receive education during orientation or prior to first shift worked. #4 The DON or UMs will complete quality assurance monitoring of five (5) residents to ensure smoking assessments are completed upon admission, quarterly and with changes in condition or smoking status. Monitoring will be completed three (3) times weekly for four (4) weeks, two (2) times weekly for four (4) weeks, weekly for four (4) weeks and as necessary thereafter. The DON will report findings of the monitoring to the Quality Assurance Performance Improvement (QAPI) Committee during monthly QAPI meetings and will make changes to the plan as necessary to maintain compliance	

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F 689	Continued From page 61 #3 was a supervised smoker because he was unable to demonstrate and understand the smoking policy, times, and place to smoke. 1b. Resident #72 was originally admitted to the facility on 03/10/23 with diagnoses which included hypertension and unsteadiness of feet. Review of Resident #72's annual MDS dated 03/20/24 revealed the resident was not coded for smoking. Review of Resident #72's quarterly Minimum Data Set (MDS) dated 09/20/24 revealed the resident's cognition was moderately impaired and required supervision for most ADL. The MDS further revealed Resident #72 had adequate vision. Resident #72 was coded for wheelchair and walking cane use. Resident #72's had a smoking assessment completed on 12/02/23 and the next smoking assessment was not conducted until 06/02/24 which assessed Resident #72 as an independent smoker. Review of Resident #72's care plan revised on 07/24/24 revealed the resident was an independent smoker. The goal was for Resident #72 to not suffer injury from unsafe smoking practices. The interview conducted with Nurse #6 on 12/05/24 at 12:55 PM revealed Resident #31 was a supervised smoker and Resident #72 was an unsupervised smoker. Nurse #6 further revealed nurses assigned to residents were expected to complete smoking assessment quarterly. The Nurse indicated the computer system notified	F 689	with resident smoking assessment requirements. Compliance Date: 12/20/24	

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F 689	Continued From page 62 staff when a residents' assessment needs to be completed. Nurse #6 revealed she does not know why they were not completed on time but should have been. Interview conducted with Unit Manager (UM) #1 on 12/05/24 at 1:20 PM revealed smoking assessments were expected to be completed quarterly. UM #1 indicated nurses were notified by the computer what assessments were pending and needed to be completed during their shift, and they were expected to do so. UM #1 indicated she was not aware Resident #31 and Resident #72's smoking assessments had not been completed quarterly. Interview conducted with the Director of Nursing on 12/05/24 at 3:10 PM revealed she had not been employed with the facility for long but expected quarterly smoking assessments to be completed. The DON further revealed she was not aware Resident #31 and Resident #72 went several months without a smoking assessment being conducted.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		12/20/24

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F 761	Continued From page 63 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on manufacturer's recommendations, observations, and staff interviews, the facility failed to date three opened bottles of artificial tears stored for use in 1 of 2 medication carts reviewed for medication storage (the B-hall medication cart). Findings included: A review of the manufacturer's recommendations for artificial tears stated after the bottle was opened it should have been discarded after 28 days. On 12/3/2024 at 11:00 am an observation of the B-hall medication cart with Nurse #5 revealed 3 bottles of artificial tears were found without an open date. Nurse #5 stated the bottles were in the boxes and the date was on the box on the previous evening. Nurse #5 stated either the bottle or the box should be dated when the bottle is opened.	F 761	#1 On 12/3/24, the licensed nurse disposed of three bottles on artificial tears that were opened without a labeled date. #2 On 12/13/24, the Director of Nursing (DON) and Unit Managers (UMs) completed an audit of medication carts and medication rooms for proper storage and labeling of drugs and biologicals. Items improperly stored without proper labeling were disposed of accordingly. #3 On 12/20/24, the DON and UMs completed education with licensed nurses on labeling of drugs and biologicals Drugs and biologicals. The licensed nurse will be responsible for labeling in accordance with manufacturer recommendations and will not administer medications that are improperly labeled, stored or expired and will properly dispose of drug or biological accordingly. Newly hired licensed nurses and those not receiving education by 12/20/24 will receive education during orientation or prior to next worked shift.	

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F 761	Continued From page 64 On 12/9/2024 at 11:06 am the Director of Nursing was interviewed by phone, and she sated the bottles of artificial tears that were opened in the B-hall medication cart should have been dated when they were opened. The Administrator was present during the interview and stated either the box or the bottle of the artificial tears should have been dated when the bottle was opened.	F 761	#4 The DON or UMs will complete quality assurance monitoring of medication carts and rooms for proper labeling and storage of drugs and biologicals. Monitoring will be completed three (3) times weekly for four (4) weeks, two (2) times weekly for four (4) weeks, weekly for four (4) weeks and as necessary thereafter. The DON will report findings of the monitoring to the IDT during QAPI meetings monthly and will make changes to the plan as necessary to maintain compliance with the labeling and storage of drugs and biologicals. Compliance Date: 12/20/24	