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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS HEALTH AND REHABILITATION	**430 BROOKWOOD AVENUE NE CONCORD, NC 28025**

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F 000	INITIAL COMMENTS A complaint survey was conducted from 01/06/2025 through 01/09/2025. The following intake was investigated NC00224980 and NC00223397. 2 of 3 allegations resulted in a deficiency. Intake NC00224980 resulted in immediate jeopardy. Past non-compliance was identified at: CFR 483.12 at tag F600 at a scope and severity (J) The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 12/7/24 and was removed on 12/12/24. A partial extended survey was completed.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to 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;	F 600		

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

Electronically Signed — 01/24/2025

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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This REQUIREMENT is not met as evidenced by:
Based on record review, and staff and physician interviews, the facility failed to protect Resident # 2's right to be free from resident-to-resident abuse for 1 of 6 residents reviewed for abuse. On 12/7/2024, Resident #1 who had a history of aggression and anger outbursts; and received as needed antipsychotic medications, required a net bed (bed with mesh tent over hospital bed to prevent a person from getting out of bed) and a sitter while hospitalized, wandered into Resident #2's room and pulled Resident #2 from his bed while Resident #2 was asleep. Resident #1 struck Resident #2 in the throat and upper body with his foot and his fist. Both Resident #1 and Resident #2 were sent to the hospital for further evaluation on 12/7/2024. The resident-to-resident abuse had a high likelihood of resulting in serious physical and psychosocial harm. A reasonable person expects to be protected from physical abuse in their home and would suffer trauma such as feelings of fear, anxiety, and intimidation.

Past noncompliance: no plan of correction required.

The findings included:

Hospital admission history and physical dated 10/2/2024 stated Resident #1 had been brought to the emergency department due to aggressive behavior displayed at a group home shortly after admission. Resident #1 became hostile towards staff and pulled a television off the wall.

Telepsychiatry note dated 12/2/2024 while Resident #1 was in the hospital, revealed he was oriented only to self, displayed no behavioral concerns and was tolerating an increased dose of Seroquel without oversedation. The note further revealed Resident #1 had a nurse and/or sitter in

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the room and there were no psychiatric contraindications to placement.

Hospital progress note dated 12/3/2024 stated Resident #1 was brought to the emergency department on 10/2/24 due to complaints of aggressive behavior and confusion. Resident #1 did have on and off anger outbursts and needed the net bed off and on. Resident #1 was receiving as needed (PRN) intramuscular (IM) Zyprexa (antipsychotic medication). The progress note further stated Resident #1 remained in the net bed which was opened with sitter present.

Review of hospital progress note dated 12/4/2024 stated Resident #1 must remain out of restraints and the net bed for 48 hours prior to placement. The note indicated Resident #1 wanted to stay in the net bed despite it being discontinued.

Hospital discharge summary dated 12/6/2024 included:
- Resident #1's admission to the hospital on 10/2/2024 was due to complaints of aggressive behavior and confusion
- Psychiatry had been consulted to evaluate and assist with Resident #1's behavioral disturbance
- Psychotropic medications had been adjusted by psychiatry: Seroquel 100 milligrams (mg) twice daily (BID); Zyprexa for anxiety as needed (PRN)

Resident #1 was admitted to the facility on 12/6/2024 with diagnoses that included congestive heart failure (CHF) and progressive dementia with behavioral disturbance.

The admission/readmission nursing collection tool written by the interim Director of Nursing dated 12/6/2024 at 2:15 PM revealed Resident #1

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was ambulatory and wandering in and out of other residents' room beginning at arrival to the facility. There was no intervention documented for Resident #1's wandering or potentially aggressive behaviors. Resident #1 was 80 years of age, 70 inches in height and weighed 121 pounds (lbs.).

Resident #2 was admitted to the facility on 6/25/2024 with diagnoses that included cerebrovascular accident with left hemiparesis (paralysis on one side of the body), anxiety, and major depression.

The annual Minimum Data Set (MDS) assessment dated 11/14/2024, stated Resident #2 was severely cognitively impaired. The MDS revealed Resident #2 did not display physical or verbal behaviors toward others and had no rejection of care. Resident #2 was dependent on staff for all activities of daily living (ADL) and had upper and lower extremity impairments. Resident # 2 was 58 years of age, was 70 inches in height and weighed 129.2 lbs.

The review of nurse progress note written by Nurse #1 dated 12/7/24 stated Resident #2 had been attacked by Resident #1 and had been pulled from bed to floor by arm, bumping his head. Resident #2 had complained of head, arm, back, throat, and leg pain. Nurse #1 called the facility Administrator who advised Nurse #1 to send both Resident #2 and Resident #1 out for evaluation. Nurse #1 called the facility provider and contacted Resident #2's emergency contact to notify of incident and transfer to hospital. The police department responded, and Resident #2 was transported to the hospital by Emergency Medical Services (EMS.)

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Interview with Nurse #1 on 1/7/25 at 9:24 AM revealed she recalled getting to her shift around 11:00 PM on 12/6/24. She stated she observed Resident #1 walking toward the room they originally had him in upon admission. She believed the facility moved Resident #1's room due to his original roommate having a tracheostomy (a surgical hole in the windpipe that helps with breathing). She stated the facility was nervous due to Resident #1 wandering around his roommate and fear he would touch his roommate's tracheostomy equipment. Resident #1 was moved to a 4-person room. She stated Resident #1 wandered all night in several resident rooms. Nurse #1 revealed due to his wandering she had Resident #1 sit with her at the nursing station. The resident watched a little of a movie she had on an i-pad. When Resident #1 started to fall asleep, she took Resident #1 to his room to sleep. She stated he did not sleep long because she recalled being approached by nursing assistant (NA) #2 and asked where the other nurse could be located. NA #2 reported her resident (Resident #1) was dragging Nurse #1's resident (Resident #2) out of his bed. The nursing assistants she recalled notifying her were NA #1 and NA #2. Nurse #1 stated when she got to Resident #2's room he was lying on the floor like a pretzel and screaming. Resident #2 had his night gown around his upper torso and his brief was still in the bed. Resident #2 kept screaming why did Resident #1 do that to him. She stated one of the NAs went to locate the other nurse but could not locate her. While in Resident #2's room, Resident #1 was standing against the wall with his hands in his pockets, but he looked as if he was going to aggress towards Resident #2 again. She and the NAs could not get Resident

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#1 from Resident #2's room although staff were trying to redirect him out of the room. She further revealed Resident #1 stated it was his bedroom, and his bed and that's why he attacked Resident #2. Nurse #1 explained due to it being difficult to redirect Resident #1 she had NA #1 and NA #2 stay with Resident #1 while Nurse #1 took Resident #2 to the nursing station where the other nurse was located. She recalled the police showing up shortly after. She recalled Resident #2 having a reddened area to his neck and Resident #2 stating his head hurt, his back hurt and she believed he also mentioned his leg. Nurse #1 indicated she contacted the Administrator and the Interim Director of Nursing. She indicated after the incident she became aware that Resident #1 had tendencies to be aggressive and had an aggressive episode at his last placement. She was unaware of any interventions put into place for Resident #1's potentially aggressive behaviors.

Interview with NA #1 on 1/7/25 at 7:30 PM revealed she recalled Resident #1 was in the process of a room change upon her arrival to the facility 12/6/24. She indicated her shift was from 7:00 PM to 7:00 AM. The only report she recalled being provided about Resident #1 was that he was a new admit, he walked and might have been incontinent. She was unsure of why Resident #1 was being moved but stated he was being moved to a 4-person room. NA #1 stated as the shift went on it got harder and harder to redirect Resident #1. Resident #1 would wander in and out of other resident rooms and NAs had to continuously tell Resident #1 that it was not his room. She stated other residents in the facility started to complain about Resident #1 standing in their doorways or entering their rooms, so she

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F 600	Continued From page 6 notified Nurse #1. She stated she was told by Nurse #1 to redirect Resident #1 to get him familiar with his room. NA #1 recalled when she would take Resident #1 to his room, he would continue to state that it was not his house. NA #1 stated after getting a resident a snack she observed Resident #1 standing over Resident #2 yelling at Resident #1 to get out of his room. She told Resident #1 that he was not in the right room. NA #1 stated before she could get all of her words out, Resident #1 grabbed Resident #2 by his contracted arm and with one hand tossed Resident #2 onto the floor from his lowered bed. NA#1 stated it happened quickly; she screamed. She stated once Resident #2 was on the floor, Resident #1 punched and stomped on his neck and chest area. NA #1 described Resident #2 as not being able to protect himself. She further revealed the incident happened so quickly; Resident #2 didn't have time to realize what was going on. Resident #2 asked out loud, "why is he doing this to me". Referring to Resident #1. NA #1 revealed she had to push Resident #1 back from Resident #2 to get between them. NA #1 stated she had to stay between Resident #1 and Resident #2 because Resident #1 was continuously trying to get to Resident #2. NA #1 stated she asked if Resident #1 was ok and called out for help. Resident #2 had a red area to his throat and stated his neck hurt. She stated NA #2 came to assist and went to get the nurse. She recalled Nurse #1 stayed with NA #1 and the other Nurse was assisting with getting Resident #1 out of Resident #2's room. She stated after they got Resident #1 out of the room, he opened the door and re-entered the room. Resident #1 continued to state Resident #2 was sleeping in his bed and with his wife. NA#1 described the situation as a "street fight".	F 600		

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An interview was conducted with NA #2 on 1/7/25 at 8:20 PM. NA#2 indicated she was assigned the rehabilitation hall 12/6/24 and NA #1 was assigned to Resident #1's hall. She recalled hearing NA #1 yell out for help. When she arrived at Resident #2's room, NA #1 looked in shock. NA #2 indicated as soon as she got to the door of Resident #2's room, she observed Resident #1 grab Resident #2 by his arm and his leg and drag Resident #2 from his lowered bed to the floor. Resident #1 stomped on Resident #2's upper body with his foot while he was on the floor. She stated Resident #1 was angry and moved quickly. NA #2 described Resident #2 as a resident who could not defend himself against Resident #1's attack. Resident #1 kept saying it was his room. NA #2 stated she called for a nurse while she and NA #1 got in-between Resident #1 and Resident #2. NA #2 stated she had to grab Resident #1 by his arm to help get him away from Resident #2. Nurse #1 arrived first then Nurse #2. She recalled Nurse #1 trying to get Resident #1 from Resident #2's room. She stated after Resident #1 was removed from Resident #2's room he re-entered the room and demanded Resident #2 get out of what he believed was his bed.

Interview with Nurse #2 on 1/7/24 at 9:53 AM revealed she recalled meeting Resident #1 as he was walking down the hall 12/6/24. Her assigned shift on 12/6/24 was 11:00 PM to 7:00 AM. Nurse #2 stated she had gotten in report that there was a new admission who was confused and wanted to go home. She did not recall getting the report that Resident #1 had a history of aggression. She assumed it was Resident #1 due to him looking lost. Nurse #2 recalled introducing herself and told Resident #1 she would walk him

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to his room. He was assigned to a room with 3 other residents. She stated on the way to Resident #1's room she recalled a couple of residents stating Resident #1 had walked into their rooms. Nurse #2 reoriented Resident #1 to his room, but she recalled being approached later by an NA (not known) and asked if Resident #2 was hers. Before she could answer the NA, Nurse #1 stated the NA revealed Resident #1 was hurting Resident #2. Nurse #2 stated 2 NAs (NA #1 and NA #2) had already separated Resident #1 and Resident #2. She further recalled Resident #2 being on the floor and Resident #1 having already been removed from the room.

Nurse progress note dated 12/7/2024 at 7:54 AM written by an unknown nurse stated NA #1 notified Nurse #2 that Resident #1 pulled Resident #2 out of his bed to the floor then stomped on him. Nurse# 2 called Emergency Services, medical provider and Resident #1's representative.

Review of the initial allegation report dated 12/7/24 revealed an allegation of abuse. The details of the report stated Resident #1 pulled Resident #2 from his bed while he was asleep. Resident #1 began striking Resident #2 in the throat. Resident #1 attacked Resident #2 for no reason. Resident #1 and Resident #2 were both separated. The police had to be called to the facility as staff could not get Resident #1's behavior under control. A head-to-toe assessment was completed, and no injuries were noted to Resident #2. Both residents were sent to the hospital for additional assessments. Resident #1 was removed from the facility with law enforcement assistance. The initial report

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was completed by the Administrator.

Review of emergency department note dated 12/7/2024 stated the first provider evaluation of Resident #2 was completed at 6:34 AM. Resident #2 underwent computed tomography (CT) of his head, pelvis, chest, spine and abdomen. All CT scans were negative and showed no injuries or acute changes. Resident #2 was discharged back to the facility 12/7/2024. The emergency department note further indicated Resident #2's psychiatric status was cooperative, and he had normal judgment.

Review of Resident #1's emergency department note dated 12/7/24 revealed a chief complaint of aggressive behaviors. The history of present Illness stated Resident #1 was an 80-year-old male, who presented to the emergency department for evaluation of aggressive behaviors. He was brought by EMS for wandering into another patients' room and pulling him out of bed. Patient states he thought that the other resident was in his bed. Resident #1 did not fall and had no injuries.

An interview was conducted on 1/7/25 at 3:17 PM with the Nurse Liaison. She revealed all the nursing liaisons had access to referrals. She stated the case manager for the hospital would do a referral in which a bedside visit would be conducted. During the bedside visit the resident was assessed for medical readiness. The Nurse Liaison indicated she was assigned to the facility to assess referrals for potential admissions. She stated she discusses the referral with the Admissions Director who also had access to the potential referrals medical chart. She would verbally tell the facility what she observed while at

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bedside. The Nurse Liaison stated she would ask the hospital if restraints could be removed for 48-hour prior to admission. The hospital would not remove the restraints unless the resident was stable. The Nurse Liaison indicated she assessed Resident #1 as stable for admission to the facility because he did not have a restraint or a sitter for 48 hours and was not being chemically restrained.

Interview with the Admissions Director on 1/6/24 at 2:47 PM revealed the admission process was once a resident's referral was uploaded, she would ask about behaviors, wounds, medical equipment needed, etc. The nurse liaison would conduct a bedside visit with the potential admission. If a resident had restraints the nurse liaison would inquire when the restraints would be discontinued because the facility did not admit residents who required restraints. Residents could be admitted to the facility if they were not displaying the behavior they were admitted to the hospital for and had to be without a sitter or restraint for 48 hours prior to admission. The Admissions Director indicated she was not clinical, so nurses did review the information provided by the hospital as well. She indicated that prior to Resident #1's admission she recalled discussing his admission with his guardian and was further aware of the resident having aggressive behaviors. She indicated she recalled the hospital documentation indicated Resident #1 was aggressive with staff and not residents. The Admissions Director could not recall who conducted Resident #1's bedside visit.

Interview with the former interim Director of Nursing (no longer employed) via telephone on 1/6/25 at 3:45 PM revealed it was the

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responsibility of the nurse to complete admission assessment. Within the first 24 hours an interim care plan should be developed. She stated sometimes the discharge summary was not available upon a resident's admission and was unable to be used in developing the admission assessment. She could not recall if Resident #1's discharge summary was available for review upon his admission. The interim Director of Nursing stated she documented Resident #1 was wandering in other residents' rooms upon admission because she was approached by nursing and NAs. She further stated nursing staff had indicated Resident #1 was difficult to redirect. She stated she knew nothing about the resident prior to admission due to having several admissions in a couple of days. She indicated she did not recall implementing interventions due to his wandering. Nursing staff were aware they needed to redirect residents who wandered, provide them with activity, and in the instance, they became aggressive implement a one on one. She recalled being contacted by phone that Resident #1 had gone into Resident #2's room, grabbed Resident #2 by his contracted arm, pulled him out of bed and beat him. Resident #2 was sent to the hospital to be assessed for injuries.

Interview with The Administrator on 1/7/25 at 2:12 PM revealed potential admissions were initially screened by nurse liaisons. The nurse liaison would look at the resident's physical condition and if the resident was being watched by a sitter. She stated if the resident had a sitter in place they would communicate that to the facilities Admission Director. Prior to admission a resident would need to be without a sitter or a restraint for 24 to 48 hours. She further revealed nursing

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F 600	Continued From page 12 should review a resident's record prior to admission. The Admissions Director should have access to the same information and would bring the information to the facility to review for the potential admission. The baseline care plan was put into place by the admitting nurse. The Administrator stated she was not aware Resident #1 was displaying wandering behaviors upon admission until after the incident occurred. She stated she expected the nursing staff to let her know Resident #1 was wandering so she could make a determination and included the DON for interventions. She stated interventions could be put into place such as one on one. The admission/readmission form included the interim plan of care. The admission/readmission form in the electronic medical record (PCC) form did not identify a place for behaviors. It only populated interim plan of care areas of side of effects of antianxiety, antipsychotic and antidepressant medications. The Administrator stated she believed the breakdown in communication was between the Nurse Liaison to the Admissions Director. Once the information was passed by the nurse liaison they were hands off. She stated the facility depended on the nurse liaison's expertise and that they were getting good information from the hospital. Interview with the Regional Consultant on 1/7/25 at 4:00 PM revealed the in-house admission nurse should review the discharge summary for potential behaviors and review the residents' medications. She stated Resident #1 had been cleared by psychiatry in the hospital and he was admitted to the facility. She stated when a resident began wandering in the facility, staff would have been expected to redirect the resident and to reorient him to the facility. She	F 600		

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stated Resident #1's room was moved shortly after his admission due to his wandering.

Interview with the Physician on 1/8/25 at 2:26 PM revealed it was his expectation that the facility reviews a resident discharge summary when available prior to potentially admitting a resident to the facility. As far as screening a resident prior to admission he was unaware of the process. He further stated he expected he could trust the discharge summary and the hospital discharge team when they indicated a resident was stable.

The Administrator was notified of Immediate Jeopardy on 1/8/25 at 12:31 PM.

The facility implemented the following Corrective Action Plan with a completion date of 12/12/24.

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

Facility failed to protect resident #2 from abuse after admitting resident #1 on 12/06/2024. On 12/7/24 at 5:30AM, Resident #1 wandered into Resident #2's room, who was a severely cognitively impaired resident and had impaired movement of both upper and lower extremities, while Resident #2 was asleep, and pulled him from his bed to the floor. Resident #1 physically attacked Resident #2 after he was pulled out of bed by his left arm (contracted) to the floor. Resident #1 stomped on Resident #2's upper body close to his neck and punched Resident #2 repeatedly. The 2 Residents (Resident #1 and Resident #2) were separated by 2 Nursing Assistants. Resident #2 was observed to have

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redness to his neck. Resident #1 stated he fought Resident #2 because he though Resident #2 was in his bed. Resident #2, who was receiving an anti-coagulant, complained of pain in his head, arm, back, throat, and leg pain.
Nurse #1 notified the administrator and medical provider immediately. Resident #2 was sent to the hospital for evaluation. A computed tomography scan (CT) scan and chest x-ray revealed no injury. He was discharged back the facility on 12/7/24 with no new orders. Resident #1 was sent out immediately to the hospital for an evaluation. Resident # 1 was admitted to the hospital for eval and remains in psychiatric care.

Resident #2 received a trauma screen assessment following the incident on 12/10/24 by Social Work staff. The 12/10/24 trauma screen indicated he was not fearful, in good spirits and not affected by the trauma. The trauma screen assessment recognizes Trauma Informed Care and acknowledges that residents who are trauma survivors may experience emotional, physical, and/or psychological difficulties that should be addressed immediately upon admission and throughout their stay in the Center.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Current residents are at risk for deficient practice.

The last seven days of progress notes of all residents as of 12/10/24 were reviewed for dementia behaviors including aggression, wandering, yelling, delusions, hallucinations, paranoia to ensure interventions are in place including psychiatric services as appropriate on

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F 600	Continued From page 15 12/10/24 by the Administrator. All residents identified are receiving effective interventions and services from psych services as indicated. Current resident MD notes, incident accidents reports for behaviors or any resident to resident incidents were reviewed in the last 14 days for order of psychiatric consult, and referrals made if appropriate. This was completed 12/10/24 by the Director of Nursing and the Unit manager. All identified residents from review are currently being seen as indicated by psych services. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Resident #1 has not resided at the facility since the incident on 12/7/2024. Administrator, Director of Nursing, and/or the Unit Manager ensured training to all staff in all departments utilizing online learning education modules on dementia care to include wandering and managing aggressive behaviors. This education includes examples of dementia, wandering and aggressive behaviors and ways to prevent and manage these behaviors. This was completed 12/11/24. Including agency staff. All staff in all departments were educated by Administrator or designee that when a resident exhibits aggressive behavior, they will stay with them to provide one-on-one supervision and immediately notify a supervisor. This was completed 12/11/24. The Administrator or Director of Nursing will make the decision how long the resident will continue to receive one on one based on investigation. Any staff who did not	F 600		

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receive the education by the compliance date was removed from the schedule until completed; this will be completed by the Director of Nursing. All new staff will receive education during the orientation process prior to floor training. All agency staff will be educated prior to beginning their first shift. This will be completed by the Director of Nursing or designee to ensure education is completed.

Social Work staff are responsible for the initiation of psychiatric services when a consultation is placed. Administrator provided training to current social work staff to ensure psychiatric services referral are initiated following dementia behaviors including aggression. This was completed 12/11/24.

The Administrator provided training to all current Social Work staff on 12/11/24 to ensure they will notify Medical Provider and Administrator when a resident or responsible party refuses psychiatric services.

The Administrator provided education to all current Medical Providers on 12/11/24 that they will discuss on a case-by-case basis with the Administrator if services for psychiatry can be managed by the Medical Provider in house or if involuntary commitment is needed to provide psychiatric services. This is for resident or responsible parties who refuse psychiatry services.

Director of Nursing will educate all staff on abuse and neglect related to what abuse is, the types of abuse to include resident to resident abuse and reporting. This was completed by 12/11/24. All new staff will receive education during the

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orientation process prior to floor training. All agency staff will be educated prior to beginning their first shift. This will be monitored by the Director of Nursing to ensure completion of education.

All Nurses are responsible for notifying Medical Providers of each instance of change in condition which includes dementia behaviors and aggression. This practice is a current process as of 12/11/2024.

In reviewing a resident for potential admission, the facility Admission staff reviews their history and physical and current hospital documentation including diagnosis and medication management. This process is currently in place as of 12/11/2024. Any potential admissions identified prior to admission with behaviors will be reviewed prior to admission by nursing to ensure interventions needed for potential behaviors and staff in-serviced on interventions as needed. After reviewing potential admission if resident behaviors identified are outside facility capabilities to manage admissions can deny admission of potential resident.

Administrator or designee educated social work staff on 12/11/24 that when admitting a resident that has behaviors such as delusions/paranoia they will interview potential resident responsible party for information regarding current triggers and history of behaviors. This information will be communicated to the Director of Nursing.

The Administrator educated The Director of Nursing on 12/11/24 that nursing will initiate interventions as appropriate at time of admission based on resident history related to aggressive

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behaviors and residents with signs of or history of wondering.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

On 12/11/24 the Quality Assurance committee to include Director of Nursing, Assistant Director of Nursing, Director of Admissions, Unit Coordinator, Maintenance Director, Medical Records, Director of Social Work, Activities Director, Business Office Manager, Human Resources, Administrator, Assistant Administrator, Director of Rehabilitation Services, Medical Director met and initiated the following monitoring plan.

Director of Nursing and/or Unit Managers will review current resident and new admissions progress notes for dementia behaviors including aggression and ensure interventions are in place on resident baseline care plan daily Monday-Friday x 4 weeks then 3x a week x 4 weeks and then weekly x 4 weeks. Monday audits will include the prior Friday, Saturday and Sunday.

Director of Nursing or designee will audit physician progress notes and ensure that any psychiatric referrals have been consented and sent to psychiatric services Monday- Friday x 4 weeks then 3x a week x 4 weeks and then weekly x 4 weeks. Monday audits will include the prior Friday, Saturday and Sunday.

The Activity Director or designee will monitor Resident # 2 for changes in activity participation and will notify administrator of any changes for psychiatric intervention. This will occur 5 x

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F 600	Continued From page 19 weekly x 4 weeks then 3x a week x 4 weeks and then weekly x 4 weeks. Social Worker or designee will complete psychosocial visits on Resident #2 for changes in current psychosocial state such as depression and/or anxiety 3x weekly x 8 weeks, then weekly x 4 weeks. Any changes will be reported to the administrator for psychiatric intervention. The Quality Assurance Performance Improvement committee will review all monitoring tools monthly for 3 months and make any necessary changes as needed immediately. Date of Compliance: 12/12/2024 The Corrective Action Plan was validated on 01/09/25 and concluded the facility had implemented an acceptable Corrective Action Plan on 12/12/24. Interviews with nursing staff revealed the facility had provided education and training on abuse, neglect and exploitation, handling combative residents/ resistant to care and how to deescalate and provide care to aggressive residents. Review of new admissions after 12/12/24 revealed the facility screened potential new admissions to include behaviors and potential interventions. The audits conducted starting on 12/11/24 revealed audits continued weekly through the validation date. The corrective action plan was reviewed with the Quality Assurance committee. The compliance date of 12/12/24 for the corrective action plan was validated. Immediate Jeopardy was removed on 12/12/24.	F 600		
F 609 SS=D	Reporting of Alleged Violations	F 609		1/28/25

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F 609	Continued From page 20 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview facility failed to submit a 5-day investigative report to the State Agency within the required time frame for 1 of 4 allegations of abuse (Resident #1 and Resident#2) reviewed for resident to resident abuse.	F 609	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies	

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The findings included:

1. Review of the facility policy dated 1/23/20 "patient protection" section "abuse/neglect/misappropriation/crime" stated there was a zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the health and rehabilitation care.

The procedures included:

5. The Administrator must thoroughly investigate and file a complete written report of the investigation of the submitted facility reported incident (FRI) to the State Agency within five (5) working days of the incident.

Review of the initial allegation report (24-hour report) dated 12/7/24 revealed an allegation of abuse. The details of the report stated Resident #1 pulled Resident #2 from his bed while he was asleep. Resident #1 began striking Resident #2 in the throat. Resident #2 attacked Resident #1 for no reason. Resident #1 and Resident #2 were both separated. The police had to be called to the facility as staff could not get Resident #1's behavior under control. A head-to-toe assessment was completed, and no injuries were noted to Resident #2. Both residents were sent to the hospital for additional assessments. Resident #1 was removed from the facility with law enforcements assistance. The 24-hour report was completed by the Administrator.

An email from the complaint intake unit of the state agency on 12/17/24 to the Administrator indicated the investigation report related to the 12/7/24 initial report for Resident #1 and Resident #2's allegation of resident-to-resident abuse had

F 609

cited have been or will be corrected by the date or dates indicated.

F609 Reporting of Alleged Violations

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
The facility□s administrator was educated by the Vice President of Operations on the MFA policy and procedures on reporting abuse per state and federal regulations. Education was completed on 1/23/25.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
The Vice President of Operations and/or the Regional Director of Clinical Service audited all facility FRIs reported to the state within the last 14 days. All reports were completed per MFA policy and procedures and state and federal regulations. Audits were completed by 1/28/25.

3. Address what measure put into place or systemic changes made to ensure that the deficient practice will not reoccur.
The Administrator will notify the Vice President of Operations as soon as possible once she is aware of an allegation of abuse. She will email the 24-hour initial report and the 5- day investigation report to the Vice President of Operations for review and verification of timely reporting.

4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained.
The Vice President of Operations will

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F 609	Continued From page 22 not been received. Review of the facilities facsimile report dated 12/17/24 revealed the investigation report regarding an allegation of resident-to-resident abuse (Resident #1 and Resident #2) was submitted to the state agency on 12/17/24. Interview with the Administrator on 1/7/25 at 2:12 PM revealed she had gotten notification that she had not submitted the 5-day working report for the allegation of abuse for Resident #1 and Resident #2. She stated she had mistakenly sent the 24-hour report twice and neglected to submit the investigation report within 5 working days. The Administrator indicated the investigation report should have been submitted within 5-working days.	F 609	audit facility reportable incidents for timely reporting 1x per week for 12 weeks. The administrator will report the results of the audits to the Quality Assurance and Performance Improvement Committee monthly x3 months or until substantial compliance is achieved and maintained. 5.Date when corrective action will be completed: January 28, 2025	