STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345482	A. BUILDING _____ B. WING _____	C 04/07/2025

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BROOKDALE CARRIAGE CLUB PROVIDENCE	5804 OLD PROVIDENCE ROAD CHARLOTTE, NC 28226

(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 and complaint investigation survey was conducted on 04/01/25 through 04/03/25. Additional information was obtained offsite on 04/04/25 and 04/07/25, therefore, the exit date was changed to 04/07/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #OMTG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 04/01/25 to 04/03/25. Additional information was obtained offsite on 04/04/25 and 04/07/25. Therefore, the exit date was changed to 04/07/25. The following intakes were investigated NC00228821 and NC00224345. Event ID# OMTG11 2 of the 2 complaint allegations did result in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		5/1/25

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

Electronically Signed | 04/25/2025

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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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to treat 1 of 3 sampled residents with dignity by performing care in a manner that the resident felt was "rude and hurried" (Resident #117). The findings included: Resident #117 admitted to the facility on 11/1/2024 with diagnoses which included a compression fracture of the second lumbar vertebra.	F 550	Immediate Correction "On 11/19/24 Associate NA #1 was suspended pending investigation. On 11/26/24 Associate NA #1 was terminated from employment. "On 11/19/24 a Licensed Nurse completed a skin review on resident # 117 with no new findings. Other Resident Impact "On 11/18/24 and 11/19/24, Social	

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F 550	Continued From page 2 A review of Resident #117's comprehensive care plan dated 11/4/2024 revealed a focus area for alteration in musculoskeletal status related to the compression fracture of the second lumbar vertebra. The interventions included that she required the mechanical lift for transfers. The admission Minimum Data Set (MDS) dated 11/5/2024 revealed Resident #117 was cognitively intact. An initial allegation report dated 11/19/2024 revealed an allegation of abuse. The allegation indicated on 11/19/2024 Resident #117 called the Administrator to her room to express concerns about NA #1 when she was providing her care the evening of 11/18/2024. Resident #117 told the Administrator that NA #1 was getting her into bed for the night and turned her on her side and her legs hit one another and she yelled out "oh, that hurts." NA #1 stated "I need to get these off" referring to her shoes and socks. Resident #117 stated she proceeded in a rude and hurried fashion. Resident #117 requested NA #1 not come back to her room in the future. The initial allegation report was signed by the Administrator. A telephone interview on 4/2/2025 at 12:58 PM with NA #1 revealed that she (NA #1) did not recall Resident #117. She further revealed she had never had any issues with any residents during a mechanical lift transfer. A telephone interview on 4/2/2025 at 11:19 AM with NA #2 revealed on 11/18/2024 she was assisting with Resident #117's transfer back to bed when NA #1 moved the mechanical lift in a jerky, rushed manner which caused the	F 550	Services (SS) conducted interviews on residents with a Brief Interview for Mental Status (BIMS) Score of 13 or above in regards to concerns with care or customer service. No additional concerns identified. "On 11/18/24 and 11/19/24, a licensed nurse completed skin checks on residents with a BIMS Score < 13. No concerns were identified. Systemic Changes "From 11/21/24 to 11/27/24, the Administrator and/ or designee completed re-education on Abuse, Neglect, Exploitation and Reporting Policy along with a post-test to licensed nurses and Certified Nursing Assistants (C.N.As). From 4/25/25 to 4/30/25, the Administrator and/ or designee completed additional re-education to licensed nurses and C.N.As on Resident Rights/ Exercise of Rights and Abuse, Neglect, Exploitation and Reporting Policy. Employee re-education was completed on proper transfer techniques and policy with licensed nurses and C.N.As by the Therapy Manager on 11/20/24. Additional re-education was completed by the Therapy Manager and/ or designee on 4/25/25 to 4/30/25. The Administrator and/ or designee will train new licensed nurses and C.N.As upon hire on Resident Rights/ Exercise of Rights and Abuse, Neglect, Exploitation and Reporting Policy. The Director of Clinical Services (DCS),	

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F 550	Continued From page 3 mechanical lift to swing and resulted in Resident #117 yelling out in pain. NA #2 stated she intervened and told NA #1 to slow down and be more careful. NA #2 indicated she moved to the other side of the bed to guide Resident #117 in the mechanical lift and ease her down onto the bed. Resident #117 asked for pain medication. Once secure in bed, she (NA #2) left the room to find Nurse #1 to advise that Resident #117 was asking for pain medication and to also report NA #1 as NA #2 thought her behavior was unsafe and not caring toward Resident #117. NA #2 also reported the incident to the Administrator the morning of 11/19/2024. NA #2 stated she cared for Resident #117 after the incident and never saw any new bruising or visible injuries. NA #2 stated Resident #117 was alert and oriented, could direct her own care and never displayed any behavior issues. NA #2 stated she had left the room to locate Nurse #1 and did not witness NA #1 taking off Resident #117's pants without removing her shoes first. A telephone interview on 4/2/2025 at 11:49 AM with Nurse #1 revealed that she was giving report on 11/18/2024 to the next shift nurse when NA #2 advised her Resident #117 requested pain medication and reported NA #1 had been rude to Resident #117, used the mechanical lift in a hurried fashion and had not shown concern when Resident #117 had expressed pain. Nurse #1 stated NA #2 told her NA #1 had not treated Resident #117 properly or in a caring manner. Nurse #1 stated she reported the incident to the Administrator on 11/19/2024. A social services progress note dated 11/21/2024 indicated Resident #117 was in a pleasant mood, reported progress in her physical therapy and	F 550	Therapy Manager, and/ or designee will train licensed nurses and C.N.As on proper transfer techniques. Ongoing Monitoring "SS and/ or designee will conduct interviews with two (2) residents a week on staff approach, weekly for four (4) weeks and monthly for two (2) months. The results will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) Meeting for three (3) months. "Director of Clinical Services and/ or designee will conduct two (2) observations of resident transfers weekly for four (4) weeks and monthly for two (2) months. The results will be reviewed at the monthly QAPI Meeting for three (3) months.	

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F 550	Continued From page 4 expressed no concerns. The investigation report dated 11/25/2024 revealed additional details that included NA #1 was very rushed in her care of Resident #117 on 11/18/2024 and attempted to remove Resident #117's pants without removing her shoes first. NA #1 had been using the mechanical lift to transfer Resident #117 into bed and NA #2 witnessed NA #1 rushing through the transfer process causing the mechanical lift to swing. NA #1 was suspended on 11/19/2024 and employment subsequently terminated for lack of customer service and care. The investigation report was signed by the Administrator. A nursing progress note dated 12/4/2024 at 4:28 PM stated Resident #117 was pronounced deceased by Hospice at 4:06 PM. An interview on 4/3/2025 at 2:37 PM with the Administrator revealed she was called to Resident #117's room the morning of 11/19/2024. Resident #117 reported that NA #1 had been rude and hurried when getting her back into bed using the mechanical lift and when taking off her pants without removing her shoes first. The Administrator stated after the facility's investigation, the resident's abuse allegation was not substantiated. NA #1 was terminated due to poor customer service and care.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		5/1/25

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F 578	Continued From page 5 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and nurse practitioner interviews, the facility failed to	F 578	Immediate Correction On 4/3/25 an order was updated to reflect	

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F 578	Continued From page 6 maintain accurate advance directive information throughout the electronic and paper medical records for 1 of 3 residents reviewed for advance directive (Resident #119). The findings included: Resident #119 was admitted to the facility on 3/25/2025. A review of the nursing admission note dated 3/25/2025 at 2:42 PM indicated that Resident #119 was alert and verbal. A review of Resident #119's electronic medical record revealed an order written by the nurse practitioner dated 3/25/2025 for full code status. This order was created by the Director of Clinical Services. A review of Resident #119's comprehensive care plan revealed a focus area for advance directives initiated on 3/26/2025 indicating Resident #119's code status was a full code. The goal was for Resident #119's wishes and directives to be carried out in accordance with her advanced directives through the next review date. An intervention was to honor resident choice for code status. A review of the paper medical record revealed on 3/27/2025 Resident #119 signed a Medical Orders for Scope of Treatment (MOST) form for do not attempt resuscitation (DNR/no cardiopulmonary resuscitation (CPR). Further review of the paper medical record revealed a Golden Rod DNR form signed on 3/27/2025 by the Nurse Practitioner.	F 578	Do Not Resuscitate (DNR) status and care plan for resident # 119 was updated on 4/5/25 by MDS Coordinator. Other Resident Impact An audit of resident Code Statuses was conducted by the Administrator on 4/7/25 and Social Worker on 4/3/25 to verify accuracy and consistently of Advance Directive orders, forms, and care plans for current residents. Systemic Changes SS and licensed nurses will receive re-training on documenting Advance Directives from 4/25/25 to 4/30/25 by DCS and/ or designee. DCS and/ or designee will provide training to licensed nurses upon hire on Resident Rights/Exercise of Rights which also includes their choice to have Advance Directives. A licensed nurse will review resident code status on admission and obtain an order. The DCS, SS, and/ or designee will verify in the Daily Stand Up Meeting that the Code Status Order and form matches. A licensed nurse will update orders based on code status changes as indicated. SS will update the advance directive care plans as indicated. Ongoing Monitoring "DCS or SS or designee will conduct an audit of advance directives for three (3) residents weekly for four (4) weeks and	

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F 578	Continued From page 7 Resident #119's admission Minimum Data Set (MDS) dated 3/29/2025 revealed that it was in progress. An interview on 4/3/2025 at 10:19 AM with the Nurse Practitioner (NP) revealed she met with Resident #119 on 3/27/2025 and confirmed Resident #119's advance directive choice which was a DNR status. The NP stated the order for a full code was not correct and should have been updated when the MOST form and Golden Rod form were completed. An interview on 4/3/2025 at 11:30 AM with the Director of Clinical Services revealed she recalled there was confusion regarding what Resident #119's advance directive wishes were on admission. She stated she discussed advance directive choice with Resident #119 on admission. She was not clear what Resident #119 wanted after the discussion. As a result of this confusion, the Nurse Practitioner and the Director of Clinical Services made Resident #119 a full code status until the Nurse Practitioner could discuss advance directives further with Resident #119. The Director of Clinical Services reported if Resident #119 had experienced an emergency, the nurse would have followed the information in the electronic medical record which showed full code status. The Director of Clinical Services stated that both the electronic medical record and paper medical record should always reflect the same information regarding advance directives. She stated the Nurse Practitioner order should have been updated after Resident #119 signed the MOST form dated 3/27/2025. She indicated she was responsible for the care plan and should have updated it to reflect Resident #119's DNR status as of 3/27/2025.	F 578	monthly for two (2) months. The results will be reviewed at the monthly QAPI Meeting for three (3) months.	

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F 578	Continued From page 8 An interview on 4/3/2025 at 2:19 PM with the Administrator indicated Resident #119's advance directive information was not correct across the electronic medical record and the paper medical record. She stated that advance directive information was very important and should always be accurate and up to date to reflect the resident's choice.	F 578		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident representative, local law enforcement, resident and staff interviews, the facility failed to protect a cognitively impaired Resident's right to be free from sexual abuse when Resident #116 was observed on 03/27/25 by the Physical Therapy Director with a Visitor seated beside her in his wheelchair. The Visitor was observed to touch and massage Resident #116's breast over	F 600	Immediate Correction " On 3/27/25, the Physical Therapy Director immediately separated the Assisted Living resident visitor and Resident # 116. " On 3/31/25, a licensed nurse completed a skin review for Resident # 116 and no	5/1/25

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F 600	Continued From page 9 her shirt. The Physical Therapy Director intervened and removed the Visitor from the area and accompanied him home to his Assisted Living apartment. Resident #116 was severely cognitively impaired, and her Resident Representative stated, "Resident #116 was very modest, and it would have been the worst feeling in her life". The Resident Representative further indicated that "Resident #116 would have felt violated and would not have welcomed any inappropriate touch from anyone if cognitively able to express herself". This affected 1 of 3 residents reviewed for abuse (Resident #116). The findings included: Resident #116 was admitted to the facility on 12/22/23. Her diagnosis included Alzheimer's Disease with late onset, metabolic encephalopathy (a brain disease that alters brain function), and depression. Review of the annual Minimum Data Set (MDS) dated 12/27/24 revealed Resident #116 was severely cognitively impaired and demonstrated no behaviors. She was unable to walk, required extensive assistance by staff for all activities of daily living (ADL) and mobility. Resident #116 used a manual wheelchair. A review of Resident #116's plan of care dated 01/09/25 revealed that she had difficulty with communication due to her impaired mental function from Alzheimer's Disease. The goal of the care plan was that Resident #116 would be able to communicate basic needs daily. The interventions included anticipation of her needs, allowing adequate time to express her needs, and for staff to observe nonverbal cues which may	F 600	concerns noted. " On 3/28/25, the Assisted Living Director provided a letter of expectation to the Assisted Living resident visitor that he was not allowed to visit the skilled nursing facility. " On 3/27/25, the Administrator notified the police of the alleged occurrence. " On 3/27/25, the Administrator notified Resident # 116 legal representative of the alleged occurrence. Other Resident Impact " On 3/28/25 five (5) additional residents with a BIMS Score of 13 or above were interviewed by SS to determine if they had any potential inappropriate exchanges with visitors or associates. All the other residents were not alert and oriented enough to be interviewed. No other concerns identified. " On 3/30/25 a licensed nurse completed a skin check on residents with a BIMS < 13 and no new skin concerns were identified. Systemic Changes " From 4/4/25-4/11/25, the HCA and/ or designee completed re-education on Abuse, Neglect, Exploitation, and the visitor log policy to licensed nurses, C.N.As, and therapist. The Administrator and/ or designee will train new licensed nurses, C.N.As, and	

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F 600	Continued From page 10 indicate care needs or distress. A review of Physical Therapy Directors undated and unsigned typed witness statement revealed she observed the Visitor's hands on Resident #116's breast. After pulling the Visitor's wheelchair out of reach from Resident #116, she remained seated in her wheelchair and was observed bent over at the waist with her face down in her lap afterwards. An interview with the Physical Therapy Director on 04/03/25 at 09:03 AM revealed she was walking down the hall around 2:30 PM on 03/27/25 when she witnessed a male Visitor in the activity room seated in his wheelchair beside Resident #116 (who was seated in her wheelchair at the table). The Physical Therapy Director indicated she observed the male Visitor touch and massage Resident #116's breast with his hand over her shirt. The male Visitor's other hand was either on Resident #116's wheelchair or on her leg, but the Physical Therapy Director was unsure of the exact location of his other hand. The Physical Therapy Director stated she observed Resident #116 was alert and was not yelling for help. When the Visitor was interrupted by the Physical Therapy Director and removed from the area, Resident #116 slumped forward in her wheelchair bending over at the waist with her head in her lap. She stated Resident #116 had not cried out or called for help. A telephone interview with Nurse #1 on 04/03/25 at 11:36 AM revealed she worked 03/27/25 from 7:00 AM to 7:00 PM. She confirmed she had cared for Resident #116 during her shift that date. She stated she was not present for and did not witness the incident because she was in another	F 600	therapist upon hire on Resident Rights/ Exercise of Rights and Abuse, Neglect, Exploitation and visitor log policy. " On 4/4/25, the HCA created a staff memo to alert skilled staff that the Assisted Living resident visitor was not permitted to visit the skilled nursing facility and educated the skilled nursing associates on the memo. " On 3/31/25 the Executive Director posted a visual sign on the first floor staff entrance directing visitors to proceed to the main entrance of the skilled nursing facility. Ongoing Monitoring " The HCA and/ or designee will conduct two (2) resident interviews a week for four (4) weeks and monthly for two (2) months to verify there are no concerns with visitor to resident interactions.	

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resident's room. Nurse #1 stated she did not know what happened specifically, but she overheard the Physical Therapy Director state that someone touched Resident #116 inappropriately. Nurse #1 revealed that Resident #116 was in her room at the time she became aware of the incident, and Nurse #1 observed Resident #116 smiling and in no distress. Nurse #1 revealed that the Director of Nursing (DON) asked her to help her do a skin assessment on Resident #116, which she performed and noted no injury. Nurse #1 stated she did not document the skin assessment in the medical record and thinks that the Director of Nursing documented it. Nurse #1 was not sure if local law enforcement had been notified of the incident. She revealed she last worked 03/31/25 and 04/01/25 and she was aware that the Visitor that touched Resident #116 was not allowed in the facility any longer.

A review of skin assessment dated 03/27/25 at 3:45 PM for Resident #116 revealed no signs of injury.

A review of the initial allegation report submitted by the facility to the Department of Health and Human Services (DHHS) on 03/27/25 at 5:39 PM, revealed an allegation type of resident abuse that occurred on 03/27/25. The initial allegation report was completed by the Director of Nursing (DON). The allegation details noted that the staff (Physical Therapy Director) had witnessed a male Visitor touch Resident #116's breast. The man was removed from the facility and escorted back to his own apartment. The initial allegation report indicated that he was now restricted from the facility. Local law enforcement was notified of the incident on 03/27/25 at 5:00 PM. The Nurse Practitioner (NP) was notified, and a skin

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assessment of Resident #116 was performed by nursing staff.

Review of progress note dated 03/27/25 at 7:24 PM by the Administrator, revealed that Resident #116's representative was contacted and notified of the incident, and it was undergoing investigation.

An interview with NA #4 on 04/03/25 at 10:57 AM revealed she worked with Resident #116 on 03/27/25. She explained that Resident #116 spoke at times but was confused at baseline, and her speech was nonsensical due to dementia. She stated she was not aware the incident occurred. NA #4 verbalized that she had toileted Resident #116 later that day and had not observed any signs of abuse (redness, bruising, swelling, etc.) when providing assistance with ADL. NA #4 indicated she had not observed a Visitor touch another resident inappropriately while working at the facility and she was not aware of any Visitor being restricted from visiting the facility.

A review of the Nurse Practitioner Provider Note dated 03/27/25 revealed Resident #116 was assessed by the Nurse Practitioner after the incident. The report stated that Resident #116 had a man attempt to touch her breasts and she told him to leave her alone. Resident #116 was without signs or symptoms of distress. No further information was obtained from Resident #116. Resident #116's breasts were noted to be without injury (redness, bruising, abrasions). Resident #116 was noted to be wheelchair bound and has decreased mobility and poor strength on report.

A telephone interview with the Nurse Practitioner

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on 04/04/25 at 11:44 AM revealed that she was on-call on 03/27/25. She stated she was made aware of the incident between a male Visitor and Resident #116 when the Director of Nursing stopped her and told her about what occurred and asked her to assess Resident #116. She reported that Resident #116 told her a man tried to touch her breast, and she told him to leave her alone. She stated that Resident #116 was calm and seated in her wheelchair when assessed. She cooperated and was alert, but confused per baseline, she denied pain, and no injury was noted.

A telephone interview with Resident #116's Representative occurred on 04/01/25 at 4:30 PM revealed he was aware of the incident that occurred on 03/27/25. He stated that he was informed by the Administrator on 03/27/25. A subsequent telephone interview with Resident's Representative occurred on 04/03/25 at 4:32 PM and he stated that "Resident #116 was very modest, and it would have been the worst feeling in her life". He indicated that she would have felt "violated and would not have welcomed any inappropriate touch from anyone if cognitively able to express herself".

Observations of Resident #116 on 04/01/25 at 1:47 PM and 04/03/25 at 3:21 PM both revealed Resident #116 was alert and smiling with no signs of injury (redness, bruising, swelling, etc.) noted to visible skin areas. An interview with Resident #116 was attempted during this time, however, Resident #116 did not answer questions appropriately and responded in a confused and nonsensical manner.

Interviews with Director of Nursing 04/03/25 at

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12:27 PM and 04/03/25 at 3:23 PM revealed she submitted the initial allegation report to DHHS. She was working on 03/27/25 and stated around 3:30 PM, the Administrator came to her and told her that the male Visitor had put his hands on Resident #116. She stated the staff removed him from the building and moved Resident #116 to her room. She stated that she and Nurse #1 performed the skin assessment on Resident #116, and there were no signs of injury. She stated that the skin assessment was completed on paper and not in the Electronic Health Record. The DON stated she had not witnessed the incident directly but when she arrived, Resident #116 was observed, and she was alert and noted no distress. She denied having met the Visitor before and was not familiar with his care but was told he was independent, alert and oriented, and the Administrator had provided a description of him in case he tried to return. She stated she was not aware of any other incidents that occurred with the Visitor, and she does not recall seeing him visit before. He was no longer allowed in the building after the incident.

A review of the investigation report submitted to DHHS on 04/03/25 at 5:03 PM revealed that the male Visitor was given a letter stating that he was no longer allowed to visit the skilled facility. A typed statement dated 04/03/25 signed by the Administrator attached to the 5-day investigation report revealed the Administrator became aware of an inappropriate interaction between a male Visitor and Resident #116 on 03/27/25 at 3:15 PM. The interaction was witnessed by the Physical Therapy Director who observed a male Visitor who resided in the Assisted Living Facility, seated beside Resident #116 with his "hand touching her blouse". The Visitor was immediately

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removed from the skilled unit. The Administrator documented she checked on Resident #116 and the Resident stated to her "He took all he could get". The Administrator and the Administrator of Assisted Living interviewed the Visitor and informed him he could no longer visit the skilled nursing facility. Resident #116's representative was notified. Local law enforcement was notified and investigated the allegation. Nursing performed a skin assessment with no noted injury. Resident #116 was noted to be severely cognitively impaired. Staff training was being conducted on resident abuse and reporting. "After thorough investigation, it was concluded that the female Resident was touched by the male Resident residing in the Assisted Living unit. The male Resident was issued a letter of expectations moving forward." The Department of Social Services was notified of the allegation on 04/03/25. The Administrator substantiated the allegation.

An interview with the Administrator on 04/03/25 at 1:15 PM reported that on 03/27/25 she was headed upstairs and when she stepped out of the elevator, she witnessed the Physical Therapy Director wheeling the Visitor out of the activity room. The Physical Therapy Director asked her to go check on Resident #116. She then checked her, and she was observed leaning forward in her wheelchair with her head in her lap. When she approached Resident #116 and asked what happened, Resident stated, "He just took all he could get". She then went to her office and called the Administrator of Assisted Living to make him aware of what occurred. Together, they went to hold a conversation with the Visitor and interviewed him about the incident. The Visitor reported that he went to the skilled nursing unit to

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visit his old roommate. When he saw Resident #116 in the activity room, he stopped to say hello because he had become friends with her during his stay. The Administrator asked him if he had touched any part of her body, and he denied that he touched her but eventually reported he had touched her hand and her shoulder. She told him there were witnesses that saw him do more. He responded that he was not sure what they saw but he had not done anything else, and he denied the allegation. She explained to the Visitor that he was no longer allowed to visit the skilled nursing unit and specifically Resident #116. He responded to her that he could visit his friends if he wanted. She informed him that Resident #116's family asked that he not visit her. He then agreed not to visit anymore, and the interview ended. She was not aware of any other times he was inappropriate to any other residents. She stated that no other issues were ever brought to her attention about the Visitor. The police were contacted and arrived at the facility to investigate. They interviewed the Administrator and then they interviewed the Visitor. They told her after their interview they explained to the Visitor that he was not allowed to visit and that if he was found in the skilled building outside of needing care, he could face criminal charges. She reported that she and the Administrator of Assisted Living had been in contact with Corporate who was sending the Visitor a warning letter. She stated her understanding was that the Administrator of Assisted Living had hand delivered that letter to the Visitor.

A telephone interview with local law enforcement on 04/04/25 at 4:01 PM revealed that he was dispatched to the facility on the evening of 03/27/25. He stated the initial report from the

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F 600	Continued From page 17 dispatch was for a sexual assault. When he arrived, the Administrator explained that staff had witnessed a male Visitor in the facility who placed his hand on Resident #116's breast. He stated that staff reported that when the Visitor realized staff had seen him, he pulled his hand away. He stated that the Visitor was not a resident of the skilled facility but resided in the Assisted Living area of the campus. Local law enforcement did not observe Resident #116 since staff told him she was confused at baseline. He was in contact with the Administrator of Assisted Living, and they approached the Visitor's apartment for an interview. During the interview, the Visitor denied the allegation and when he told him there were witnesses, he continued to tell them he did not know what they were talking about. Local law enforcement explained to him that he could not enter the skilled facility any longer or he would face trespassing charges. He reported that no formal police reports were completed, but that there were notes from the incident. Multiple attempts made to contact the Visitor for interview were unsuccessful.	F 600		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		5/1/25

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F 812	Continued From page 18 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to perform hand hygiene between handling soiled and then clean dishes to prevent cross-contamination of the clean dishes. These practices had the potential to affect food served and distributed to 9 of 9 residents who received an oral diet. Findings included: A continuous observation of the skilled nursing satellite kitchen was conducted on 04/02/25 from 1:09 PM through 1:16 PM. Dietary Aide #1 was observed operating the dish machine and washing dishes. Dietary Aide #1 had gloves on both hands with left hand glove observed with large ripped in area over the palm. While waiting for the dish cycle to complete, she removed food debris from soiled plates in the sink area located to the right of the dish machine in the dish room and then moved to the drying area side of the dish machine wearing the same gloves. Dietary Aide #1 then opened the dish machine after the washing cycle was completed. She removed all the clean dishes which consisted of 8 bowls, 2 plates, 1 soup bowl, 4 ice cream scoops, 5 pieces of silverware, and 3 metal food storage bins out of the dish machine without removing her gloves	F 812	Food Procurement, Store/Prepare/Serve-Sanitary Immediate Correction " Dietary Aide # 1 was retrained immediately by a Registered Dietitian on proper hand washing procedures on 4/2/25 and submitted to survey team along with in-service paperwork and post test results. " On 4/2/25 the Registered Dietitian provided a copy of the dietary handwashing in-service completed on 2/15/25. Other Resident Impact " All residents have the potential to be impacted. The dining associate rewashed the dishes in the dish room area before placing them into service. Systemic Changes " A workflow reference guide was placed on the dish machine by Executive Director	

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F 812	Continued From page 19 or washing her hands and placed these items on a drying rack in the drying area. During the observation, the Kitchen Supervisor stepped into the dishwashing area and asked Dietary Aide #1 for a pair of tongs. Dietary Aide #1 was observed reaching for the tongs on the wall holder with the same torn gloved hand. Dietary Aide #1 touched the tooth area of the tongs but could not get the tongs off the wall holder. The Corporate Kitchen Supervisor then entered the dishwashing area and grabbed the tongs down from the drying area and exited the dishwashing area with the tongs. An interview with Dietary Aide #1 was conducted 04/02/25 at 1:16 PM who stated she was behind in food service today and that was why she had not changed her gloves or washed her hands between touching soiled plates and then clean dishware. She indicated that she usually wears 3 pairs of gloves to remove a pair when contaminated between the dirty and clean dishes. Dietary Aide #1 had been trained on the dish machine when she was hired. She verbalized she was aware that she should have washed her hands and changed her gloves before going from dirty to clean dishes, and if gloves were soiled or torn. She explained what occurred today had been due to being behind on service. An interview with the Dietitian and Corporate Kitchen Supervisor on 04/02/25 at 1:24 PM revealed staff performing dishwashing would not handle dirty dishes and then touch clean dishes without removing gloves and washing their hands in between. The Dietitian stated that multiple gloves should not be used and if a glove was torn, it should be changed immediately. An interview with the Administrator on 04/02/25 at	F 812	showing the sequence of appropriate hand hygiene and handwashing on 4/3/25. " Executive Director installed the hand sanitizer dispenser that was placed on the wall near the dish machine on 4/3/25 to assist with hand hygiene compliance. The Dining Service Director and/ or designee completed re-education to dining associates on hand hygiene from 4/3/25 to 4/30/25. The Dining Service and/ or designee will train new dining associates on hand hygiene upon hire. Ongoing Monitoring " The Administrator, Dining Service Director, and/ or designee will conduct observations three (3) times a week of hand hygiene compliance in the kitchen weekly for twelve (12) weeks. " Dining Service Director and/ or designee will complete the monthly sanitation inspections, including handwashing observations for three (3) months. " Registered dietitian will complete an inspection, including handwashing observations, on 4/30/25 to verify employees demonstrate competency. " The results of the audits will be reviewed at the monthly QAPI Meeting for three (3) months.	

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F 812	Continued From page 20 03:43 PM revealed that she was not familiar with the specific dishwashing procedure the facility follows.	F 812		