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	345102	A. BUILDING _____ B. WING _____	C 05/29/2025

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(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
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 05/28/25 through 05/29/25. Event ID# VP4P11. The following intakes were investigated: NC00229320, NC00230513, and NC00230526. 3 of the 5 complaint allegations resulted in deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with resident, staff, and law enforcement agent, the facility failed to protect a resident's right to be free from abuse when a family member (Family Member #2) pinched and twisted Resident #2's upper right shoulder during a visit. A staff member that intervened at the time of the incident asked Resident #2 if she was okay and Resident #2 started crying and appeared distressed. Resident #2 reported the incident	F 600	Resident #1: is alert and oriented x 4, Upon admission, the facility conducted a baseline care plan which ask if the resident had any history of traumatic stress (PTSD), abuse, other and NONE, the resident stated NONE. The facility reported the incident to the local law enforcement on 03/13/25 at 10:00 AM as there was a reasonable suspicion of crime against Resident #1. Resident #1 Family	5/30/25

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

Electronically Signed | 06/13/2025

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F 600	Continued From page 1 resulted in pain, bruises, and soreness in her right shoulder and right forearm areas. In addition, the facility failed to protect a resident's right to be free from abuse when a family member (Family Member #1) grabbed and pinched Resident #1's right arm during a visit. Resident #1 stated Family Member #1 grabbed and pinched her right arm so hard that it caused a lot of pain and circular bruises to her right antecubital (the front of the elbow) area. This affected 2 of 3 residents reviewed for abuse (Resident #2 and Resident #1). The findings included: 1. Resident #2 was admitted to the facility on 04/26/25 with diagnoses including heart failure and anxiety disorder. The admission Minimum Data Set (MDS) assessment dated 05/02/25 coded Resident #2 with intact cognition. She had adequate hearing and vision with clear speech. She did not exhibit behavioral symptoms during the review period and used a wheelchair or limb prosthesis for locomotion. The MDS indicated she required partial/moderate assistance on staff for transfer. The incident report dated 05/15/25 prepared by the Director of Nursing (DON) revealed the incident occurred at 3:00 PM. Family Member #2 was noted to be sleeping in Resident #2's roommate's bed and was asked by the staff to stop doing that. Then, he got into a verbal argument with Resident #2 and was seen by staff hitting, pinching, and shoving Resident #2's wheelchair when she was sitting in it. Family Member #2 was separated from Resident #2 and asked to leave the facility immediately. Local law	F 600	Member was issued" a no trespassing" order on 03/13/25 by the Administrator. The "no trespassing" order was posted at the nurses station, in the resident's chart and at the front desk until the resident discharged home. Resident #1 discharged home on 3/19/25 prior to the Psyciatric Nurse Practitioner's visit to the facility as her schedule varies. Staff were educated concerning reporting allegations of abuse/neglect on 3/13/25 through SNF Clinic, the facility on-line staff training portal and will be educated annually and the Abuse/Neglect Policy is included in the family admission packet. Resident #2: Resident #2 is alert and oriented x 4, Upon admission, the facility conducted a baseline care plan which ask if the resident had any history of traumatic stress (PTSD), abuse, other and None, the resident stated NONE. Family Member #2 was separated from Resident #2 and was escorted out of the facility immediately. Local law enforcement and Haywood County Adult Protective Services was notified on 05/15/25 at 3:15 PM of altercation against the resident Resident #2. Family Member #2 was detained by the law enforcement agent right after leaving the facility and arrested and jailed. Family Member #2 was contacted by the Administrator on 05/15/25 that a "no trespassing" order was issued to him by the facility. The "no trespassing" order was posted at the nurses station, in the resident chart and the front desk. Resident was evaluated by the Psyciatric Nurse Practitioner on	

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F 600	Continued From page 2 enforcement was notified, and Family Member #2 was picked up by the law enforcement agent after leaving the facility. Resident #2 was evaluated by the psychiatric Nurse Practitioner (NP) who was in the facility for anxiety related to the incident. Resident #2 stated: "He can't help it. He has dementia". The incident report indicated Resident #2 had bruises on her right shoulder and right antecubital areas after the incident. A review of the facility submitted 24-hour initial report dated 05/15/25 at 3:48 PM indicated an allegation of abuse for Resident #2 was reported to the DON and the Administrator on 05/15/25 at 3:15 PM. The report revealed Family Member #2 was seen by several staff hitting, pinching, and shoving Resident #2 when she was sitting in the wheelchair. Family Member #2 was separated from Resident #2 and asked to leave the facility immediately. Local law enforcement was notified on 05/15/25 at 3:15 PM as there was a reasonable suspicion of crime against Resident #2. Family Member #2 was detained by the law enforcement agent right after leaving the facility. Resident #2 was evaluated by the psychiatric NP who was in the facility for bruises and anxiety related to the incident. Family Member #2 was contacted by the Administrator on 05/15/25 that a "no trespassing" order was issued to him by the facility. The 5-working-day investigation report dated 05/19/25 revealed Resident #2 suffered bruises and redness to her right antecubital areas but not mental anguish that lasted 5 days or more. The facility concluded the investigation on 05/19/25 but did not determine whether the allegation was substantiated. The incident was reported to the County Department of Social Services and APS	F 600	5/16/25 and the resident received an order to take 1 tablet of hydroxyzine 25 milligrams (mg) once every 6 hours as needed for anxiety for 14 days. Resident #2 remains in the facility and Resident #2's family member has not been back to the facility due to a no-trespassig order. Staff reported the incident to the Director of Nursing and Administrator immediately. Staff were educated concerning compliance with reporting allegations of abuse/neglect on 5/15/25 and again on 5/29/25 through SNF Clinic, the facility on-line staff training portal and will be educated annually and the Abuse/Neglect Policy is included in the family admission packet. No other residents were involved in the allegation. The MDS Coordinator audited all other residents MDS for history of abuse on 5/29/25 and did not find any residents who stated they had issues with past abuse. The facility will continue utilizing a base line careplan upon admission, which ask if the resident has had any history of traumatic stress (PTSD), abuse, other and None. Staff were educated concerning compliance with reporting allegations of abuse/neglect on 3/13/25, 5/15/25 and again on 5/29/25 the Abuse/Neglect Policy is included in the family admission packet. The facility will continue utilizing a base line careplan upon admission, which ask if the resident has had any history of	

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F 600	Continued From page 3 on 05/15/25, within 2 hours of the facility notification. Local law enforcement filed charges against Family Member #2 for domestic violence crime and assault on a female. The MDS Coordinator and Nurse Aide (NA) #1 were listed as two of the witnesses to the incident. During an interview conducted on 05/28/25 at 9:22 AM, NA #1 recalled she was helping the Activity Director set up games and temporary tattoos in the main dining room on 05/15/25 at around 3:00 PM. She was aware of Resident #2 and Family Member #2 were in the smoking courtyard but did not pay attention to them as she was assisting in the activity. She saw Resident #2 returning to the main dining room from the smoking courtyard in her wheelchair with Family Member #2 pushing the wheelchair. They did not stop for the activity, and she noticed Family Member #2 pushed the wheelchair through the main dining room toward the hallway. After they left the main dining room, she saw Resident #2 trying to stop the wheelchair by grabbing the handrail in the hallway right outside the doorway of the main dining room. Family Member #2 reacted by shoving the wheelchair roughly first, then he hit Resident #2 with his hand at her right shoulder. She did not observe Family Member #2 pinching Resident #2 as the incident happened so quickly. Several staff members rushed over to separate Resident #2 from Family Member #2 immediately. At that point, Resident #2 stated Family Member #2 had pinched and hit her, and shoved her wheelchair. The staff escorted Family Member #2 out of the building immediately. An interview was conducted on 05/28/25 at 11:19 AM with the Activity Assistant. She recalled it was around 3:00 PM on 05/15/25 and she was in the	F 600	traumatic stress (PTSD), abuse, other and None. If a resident has been identified as having been abused prior to admission, the facility will investigate further to determine if the alleged abuser has access to the resident and if so, the Omsbudsman and APS and law enforcement would be notifed of residents alleged abuse prior to entering the facility for further guidance. Staff reported the incident to the Director of Nursing and Administrator immediately. Staff were educated concerning compliance with reporting allegations of abuse/neglect on 3/13/25, 5/15/25 and again on 5/29/25 through SNF Clinic, the facility on-line staff training portal and will be educated annually and the Abuse/Neglect Policy is included in the family admission packet. The facility will continue to educate staff annually and upon hire for abuse prevention and compliance with reporting allegations of abuse/neglect and explotation utilizing the on-line staff training portal annually and upon hire. All allegations of abuse will be taken to the monthly QAPI Meeting for review. The Abuse/Neglect Policy is included in the family admission packet.	

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main dining room conducting an activity with several residents. Suddenly, she heard a loud argument between Resident #2 and Family Member #2 outside of the building in the smoking courtyard. Family Member #2 was observed pushing the wheelchair with force to pass approximately 5 feet of gravel surface as he tried to take a short cut returning to the main dining room. She was concerned that Resident #2 might fall out of her wheelchair and was monitoring the scene closely with several other staff. After a few minutes, they made their way into the building and headed back towards Resident #2's room. She recalled she was standing around 10 feet from Resident #2 and saw her grabbing the handrail in the hallway right outside the doorway of the main dining room trying to stop the wheelchair. Family Member #2 continued to push the wheelchair roughly to the extent that Resident #2 almost had to stand up and grab the handrail to maintain balance. When she saw that, she started to run over to Resident #2 to intervene. Before she reached them, she saw Family Member #2 grabbing Resident #2's right shoulder, pinched and twisted the skin of her upper right shoulder area forcing her to remove her arm from the handrail. When Resident #2's hand let go, Family Member #2 tried to shove the wheelchair roughly but was stopped by the staff. She and four other staff separated Resident #2 from Family Member #2 immediately. One of the staff went to call the local law enforcement. She stated that when the altercation started and the staff began to intervene, her view was blocked by the staff who approached the scene. She did not see the hitting but confirmed Family Member #2 had pinched and twisted Resident #2's right shoulder during the incident.

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During an interview conducted on 05/28/25 at 1:01 PM, the MDS Coordinator recalled she was standing in the main dining room talking to NA #1 while assisting the activity. She saw Family Member #2 pushing Resident 2's wheelchair across the dining room and she was not facing them after they exited the main dining room. Suddenly, NA #1 said: "Oh my God, he just pinched her." She turned around and observed Family Member #2 trying to jerk the wheelchair vigorously with Resident #2 sitting in it and hitting her right arm and shoulder area. She ran toward the scene and separated them immediately. She added everything happened within a couple seconds and at least 5 staff members witnessed the incident. When she asked Resident #2 if she was okay, she started crying. Resident #2 was observed tearful and distressed after the event. She told Family Member #2 that he was not allowed to hit her, and he had to back off. She instructed another staff member to notify DON immediately and she stayed with Resident #2. A few minutes later, she saw Family Member #2 talking with DON at the nurse station. He was told to leave the facility immediately and escorted out of the building by DON.

An interview was conducted with Resident #2 on 05/28/25 at 1:22 PM. She stated Family Member #2 had visited her on 05/15/25 after lunch and after being in the room for a while, he felt sleepy. She told him to lie down in her bed. However, her roommate returned to the room and saw Family Member #2 lying in Resident #2's bed. Her roommate was upset and started to cry. Resident #2 urged Family Member #2 to get up from her bed. Family Member #2 got out of her bed and pushed her in her wheelchair into the hallway. While pushing her in the hallway, Family Member

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#2 became angry that he had to get up from her bed. He took her to the smoking courtyard and started arguing about why he had to get out of her bed. After that, they decided to return to the facility. He pushed her wheelchair vigorously trying to pass through a rough gravel surface in the smoking courtyard and she almost fell out of wheelchair. Family Member #2 took her back to the building through the dining room and he started to yell at everyone he encountered. He pushed her wheelchair to get away from the staff. Initially, she held on to the handrail in the hallway to stop him from pushing her wheelchair further. Then she tried to stop him from yelling by waving her right hand to signal him to stop. At that point, he started to hold her right shoulder and pinched and twisted her right shoulder. A few staff at the scene rushed over to separate her from him. Family Member #2 told the staff that she pinched him first, and he was just defending himself. Resident #2 clarified that she did not pinch Family Member #2 at all during the incident. Then, Family Member #2 was escorted out of the building. Resident #2 reported the incident resulted in pain, bruises, and soreness in her right shoulder and right forearm areas. The facility called the local law enforcement, and the law enforcement agent came to talk to her. She pleaded with the law enforcement agent not to arrest Family Member #2, but he was detained by the local law enforcement and spent four days in jail. She stated Family Member #2 did not mean to hurt her and explained he had dementia, did not know what he was doing and was driven by his anger at that time. Resident #2 stated they had been married for 28 years, and he had never been physically abusive. She indicated she felt safe in the facility even after the incident. Resident #2 explained she was upset with her

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husband at the time of the incident but not fearful of him. She added it made her feel better to talk about the incident. Resident #2 was not tearful during the interview, and she was free of bruises on her right shoulder area or other part of her extremities.

A review of physician's order written by the Psychiatric Nurse Practitioner dated 05/16/25 revealed Resident #2 had received an order to take 1 tablet of hydroxyzine (a prescription medication in the class of antihistamines used to treat anxiety) 25 milligrams (mg) once every 6 hours as needed for anxiety for 14 days.

During a phone interview conducted on 05/28/25 at 3:39 PM, the law enforcement agent who had investigated the incident confirmed Family Member #2 was charged with assault on a female and crime of domestic violence. He was scheduled to appear at the County Court House on 05/16/25 at 2:00 PM. The law enforcement agent could not provide any updates related to the court case.

The Surveyor was unable to conduct a phone interview with Family Member #2 as Resident #2 stated Family Member #2 did not have a phone.

During an interview conducted on 05/29/25 at 10:38 AM, the DON recalled when she was working in her office on 05/15/25 around 3:00 PM, she was notified by one of her staff that Family Member #2 had physically abused Resident #2 in the hallway. She rushed to the scene and found that a few staff had separated them. After listening to the statement reported by the staff, she decided to talk to Family Member #2 in the north side nurse's station. She told

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Family Member #2 that he was not allowed to physically abuse anyone in the facility including Resident #2. She ordered Family Member #2 to leave immediately and informed him that the facility would issue him a "No trespassing" order. She indicated the root cause of this incident was inadequate background screening of visiting family member. She stated the abuse incident was unusual as it involved visitors but not the staff. The facility had done a thorough investigation to identify the root cause to minimize risks of re-occurrence. She indicated during the admission process Resident #2 was asked to disclose history of trauma related to abuse from family members and she had checked "No". Otherwise, the facility might consider providing supervision during family visit. It was her expectation for all the residents to be free from abuse from staff, family, or visitors at all times.

An interview was conducted on 05/29/25 at 1:26 PM. The Administrator stated the facility had policies and procedures of abuse in place. She expected each abuse case to be handled according to the guidelines and investigated thoroughly to identify the root cause to minimize re-occurrence. She indicated this abuse incident was almost unpreventable as it involved visitor but not the staff, and the facility had limited authority to screen visitor. She stated the root cause of this incident was mainly due to inadequate background screening of visiting family member. It was her expectation for all the residents to be free from abuse from staff, family, or visitors at all times.

2. Resident #1 was admitted to the facility on 03/04/25 with diagnoses including osteoporosis and high blood pressure. She was discharged

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from the facility on 03/19/25.

The admission MDS assessment dated 03/10/25 coded Resident #1 with intact cognition. She had adequate hearing and vision with clear speech. She did not exhibit behavioral symptoms during the review period. Resident #1 had impaired range of motion on one side of her upper extremities and used a wheelchair or walker as the main mobility devices for locomotion.

The incident report dated 03/12/25 prepared by Nurse #2 revealed the incident occurred at 3:50 PM. Resident #1 stated that when Family Member #1 visited her in the courtyard, she became angry with her as she could not give her the passcode to the new phone immediately. Family Member #1 grabbed and pinched Resident #1's right arm and she was removed from the facility immediately. Resident #1 complaint of pain in her right arm and it was treated with a cold pack. The local law enforcement agent visited Resident #1 after the incident. A "no trespassing" order was issued to Family Member #1 by the facility on 03/13/25. The incident report described Resident #1 suffered a hematoma at her right arm near the inner elbow. Resident #1 was cognitively intact, and she did not wish to press charges against Family Member #1.

A review of the facility submitted 24-hour initial report dated 03/13/25 specified an allegation of abuse for Resident #1 was reported to the Director of Nursing (DON) and the Administrator on 03/12/25 at 4:30 PM. The report indicated that Family Member #1 visited the facility and yelled at Resident #1 about needing a passcode for her phone. Family Member #1 grabbed and pinched

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Resident #1's arm. It caused a circular bruise to the right antecubital area. The facility reported the incident to the local law enforcement on 03/13/25 at 10:00 AM as there was a reasonable suspicion of crime against Resident #1. The initial report indicated that the perpetrating Family Member #1 was contacted by the Administrator on 03/13/25 that a "no trespassing" order was issued to her by the facility.

The 5-working day investigation report dated 03/17/25 revealed Resident #1 suffered bruises to her right antecubital areas but not mental anguish that lasted 5 days or more. The allegation of abuse was substantiated. Nurse #1 was listed as the witness to the alleged abuse incident.

During an interview conducted on 05/28/25 at 8:57 AM, Nurse #1 stated that on 03/12/25 around 3:50 PM, when she was walking down to the 400 hall to provide wound treatment for another resident, she heard yelling from Resident #1's room. She stopped and entered the room and Resident #1 told her that she wanted Family Member #1 to leave. She observed Family Member #1 yelling at Resident #1 for issues related to a phone passcode. Since Resident #1 was cognitively intact and wanted Family Member #1 to leave, she asked Family Member #1 to leave. However, Family Member #1 did not leave immediately, and her voice got louder, saying something about Resident #1 giving her money away. She reminded Family Member #1 again that she needed to leave and she escorted her to the front door to ensure she left the facility. Then she reported the incident to DON and went back to check on Resident #1 and found that she had bruises in her right antecubital area. Resident #1

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(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
F 600	Continued From page 11	F 600		

told Nurse #1 that Family Member #1 pinched and twisted her right arm. She continued to check on Resident #1 the next couple days and the bruises faded away slowly. Nurse #1 reiterated that she did not witness Family Member #1 pinching or twisting Resident #1's arm. She did not recall any episodes of abuse of Resident #1 from Family Member #1 prior to this incident.

During a phone interview conducted on 05/28/25 at 3:39 PM, the local law enforcement agent who investigated the incident confirmed Resident #1's abuse incident was reported to the local law enforcement on 03/13/25 at 10:00 AM. He added he did not arrest Family Member #1 as Resident #1 insisted not to press charges.

A phone interview was conducted on 05/28/25 at 4:11 PM with Resident #1. She indicated that Family Member #1 yelled at her for a phone passcode during the visit on 03/12/25. When she could not provide the number immediately, Family Member #1 grabbed and pinched her right arm so hard that it caused a lot of pain and circular bruises to her right antecubital area. She added Nurse #1 witnessed the incident and notified the DON immediately. The facility filed a report with the local law enforcement. The law enforcement agent did not arrest Family Member #1 as she (Resident #1) insisted she did not want to press charges. She stated the abuse incident from Family Member #1 was the first time this ever happened. Resident #1 indicated she felt safe while staying in the facility. She denied she was fearful at the time of the incident but was upset at Family Member #1. She added that she was not fearful of Family Member #1, she simply did not have Family Member #1's current phone number.

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	345102	A. BUILDING _____ B. WING _____	C 05/29/2025

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The Surveyor was unable to conduct a phone interview with Family Member #1 as the facility and Resident #1 did not have Family Member #1's current phone number.

During an interview conducted on 05/29/25 at 10:38 AM, the DON stated she was not in the facility when the abuse incident occurred, but she was notified of the incident within one hour. She instructed the Social Services Director to report the abuse allegations to the state agency, Adult Protective Services, and law enforcement. She issued a "no trespassing" order to Family Member #1 the next morning on 03/13/25. The DON indicated the root cause of this incident was inadequate background screening of visiting family member. She stated the abuse incident was unusual as it involved visitors but not the staff. The facility had done a thorough investigation to identify the root cause to minimize risks of re-occurrence. She indicated during the admission process Resident #1 was asked to disclose history of trauma related to abuse from family members and she had checked "No". Otherwise, the facility might consider providing supervision during family visit. It was her expectation for all the residents to be free from abuse from staff, family, or visitors at all times.

An interview was conducted on 05/29/25 at 1:26 PM. The Administrator stated the facility had policies and procedures of abuse in place. She expected each abuse case to be handled according to the guidelines and investigated thoroughly to identify the root cause to minimize re-occurrence. She pointed out that this abuse incident was almost unpreventable as it involved visitor but not the staff, and the facility had limited authority to screen visitor. She stated the root

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F 600	Continued From page 13 cause of this incident was mainly due to inadequate background screening of visiting family member. It was her expectation for all the residents to be free from abuse from staff, family, or visitors at all times.	F 600		
F 609 SS=D	Reporting of Alleged Violations 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:	F 609		5/30/25

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F 609	Continued From page 14 Based on record review and interviews with staff, the facility failed to ensure staff implemented their abuse policy and procedure in the area of reporting when the facility failed to report an abuse allegation to the State Agency within the specified timeframes and failed to notify the Adult Protection Services (APS). This affected 1 of 3 residents reviewed for abuse (Resident #1). The findings included: The facility policy titled, "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation", revised 10/01/23 revealed in part; all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2 hours if the events that cause the allegation involve abuse or result in serious injury, or no later than 24 hours if the events that cause the allegations do not involve abuse or result in serious injury to the Administrator, North Carolina Division of Health Service Regulation (DHSR). This included an allegation regarding any individual against whom an allegation was made. The Administrator or designee will ensure that a completed Initial Allegation Report is submitted to DHSR in the required timeframe. The Administrator or designee will ensure that a report of the investigation is submitted within 5 working days of the allegation using the DHSR Investigation Report. Resident #1 was admitted to the facility on 03/04/25 with diagnoses including osteoporosis and high blood pressure. She was discharged from the facility on 03/19/25. The admission Minimum Data Set (MDS)	F 609	The Administrator/DON has educated the social services director on 5/29/25 concerning Compliance with Reporting Allegations of Abuse/Neglect/Exploitation including reporting to DSHR and APS within two hours. The Social Services Director contacted APS on 5/29/25 and spoke to them about the incident on 3/13/25. The Incident on 5/15/25 was reported to APS on 5/16/25. The Compliance with Reporting Allegations of Abuse/Neglect/Exploitation Policy was updated to reflect the regulation that Abuse allegations which includes reporting abuse would be reported within two hours to DSHR and APS. The Social Services Director failed to report the Incident to APS and reported the incident to the State Agency on 3/14/25. Staff reported the incident to the Director of Nursing and Administrator immediately. No other reporting issues have been identified having the potential to affect other residents. All other reports of allegations of abuse and neglect have been audited by the Administrator on 5/29/25 and found to have been reported in the appropriate time frame and to the appropriate agencies. To ensure any allegations of abuse are reported within the correct time frame, the Social Services Director will no longer be responsible for reporting abuse allegations. The DON was notified on 5/29/25 by the Administrator that she will be responsible for reporting all allegations to the appropriate agencies.	

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F 609	Continued From page 15 assessment dated 03/10/25 coded Resident #1 with intact cognition. She had adequate hearing and vision with clear speech. A review of the facility submitted 24-hour initial report dated 03/13/25 completed by the Director of Nursing (DON) specified an allegation of abuse for Resident #1 was reported to the DON and Administrator on 03/12/25 at 4:30 PM. The report indicated that Family Member #1 visited the facility and yelled at Resident #1 about needing a passcode for her phone. Family Member #1 grabbed and twisted Resident #1's arm, causing pain and circular bruises to the right antecubital (on the front of the elbow) area. The facility reported the incident to the local law enforcement on 03/13/25 at 10:00 AM as there was a reasonable suspicion of crime against Resident #1. The facility submitted the initial report to DHSR on 03/13/25 at 12:36 PM. DHSR was notified 20 hours and 6 minutes after the DON and Administrator were made aware of the incident. A review of Resident #1's medical record revealed the facility did not have any documentation to support the abuse allegation that occurred on 03/12/25 had been reported to APS. During an interview conducted on 05/28/25 at 3:45 PM, the Social Service Director (SSD) recalled she reported this incident to APS staff over the phone within 2 hours after the incident on 03/12/25, but she did not complete the reporting due to distractions during the call. She could not explain why she did not follow up with APS later. She acknowledged that the DON had instructed her to report this abuse allegation to	F 609	Staff reported the incident to the Director of Nursing and Administrator immediately. Staff were educated concerning compliance with reporting allegations of abuse/neglect on 3/13/25, 5/15/25 and again on 5/29/25 through SNF Clinic, the facility on-line staff training portal. Staff will continue to recieve abuse/reporting education anually and upon hire. The Administrator will ensure compliance with the Compliance with Reporting Allegations of Abuse/Neglect/Exploitation Policy by reviewing all abuse allegations with the DON within the same two hour period. All Abuse Investigations will be taken to QAPI for review each month.	

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DHSR as well. She did not do it within 2 hours after the facility was made aware of the incident as she thought she had 24 hours to meet the requirements. She stated it was her oversight.

An interview was conducted with the DON on 05/29/25 at 10:38 AM. She stated that she was aware of the 2-hour reporting requirement for any abuse incident or incident involving serious bodily injury. She was not in the facility when Resident #1's abuse allegation occurred on 03/12/25. However, she was notified of this abuse allegation within one hour after it had happened and she assigned the reporting tasks of this allegation to the SSD. When she returned to the facility the next morning, she found that DSHR and APS were not reported to within 2 hours after the facility was made aware of the incident. The SSD told the DON that she thought she had 24 hours to report the abuse allegation to DHSR. The DON indicated she went ahead and filled out and submitted the initial report to DHSR but could not explain why she did not complete the report to APS.

An interview was conducted on 05/29/25 at 1:26 PM. The Administrator stated the facility had policies and procedures for abuse in place. She expected each abuse allegation to be handled according to the guidelines and investigated thoroughly to identify the root cause to minimize future re-occurrence. It was her expectation for the staff to report all the abuse allegations to the State Agency and other specified agencies as required within 2 hours as outlined in the abuse policies and procedure.