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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/12/22 through 09/15/22. The survey team returned to the facility on 09/20/22 to validate the facility's immediate jeopary removal plan. Therefore, the exit date was chnaged to 09/20/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# U6EV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/12//22 through 09/15/22. The survey team returned to the facility 09/20/22 to validate the facility's immediate jeopardy removal plan. Therefore, the exit date was changed to 09/20/22. There were thirteen (13) complaint allegations investigated and one (1) was substantiated. Event ID# NC00192940, NC00192581, NC00192500, NC00190395, NC00189327, NC00189134, NC00184472, and NC00183596. Event ID# NC00190395 resulted in immediate jeopardy. Past non-compliance was identified at: CFR 483.12 at tag F 600 at a scope and severity of (J). Immediate Jeopardy was identified at: CFR 483.12 at tag F 607 at a scope and severity of (J). The tags F 600 and F 607 constituted Substandard Quality of Care.	F 000		

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

Electronically Signed | 10/14/2022

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F 000	Continued From page 1 Immediate Jeopardy began on 06/13/22 and was removed on 09/18/22. An extended survey was conducted.	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; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect a resident from verbal and physical abuse when Nurse Aide (NA) #2 proceeded to provide care to a resident (Resident #257) while he was agitated and combative. NA #2 taunted, aggressively pushed, aggressively turned, slapped the resident on the hip, and grabbed his arms and held them on his neck resulting in the resident asking, "are you trying to choke me," and leaving a bruise on his right hand and redness to his chest for 1 of 3 residents reviewed for abuse (Resident #257). The findings included:	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

Resident #257 was admitted to the facility on 4/13/22 with diagnoses which included progressive neurological progression, dementia, and muscle weakness

Review of the quarterly Minimum Data Set (MDS) dated 6/7/22 revealed Resident #257 moderately cognitively impaired and required extensive assistance for majority of activities of daily living (ADL). The MDS further revealed Resident #257 was not coded for behaviors.

Resident #257's care plan dated 4/25/22 revealed the resident was at risk for episodes of being upset and was cognitively impaired. The care plan's goal indicated Resident #257's mood and behaviors would be stable. Interventions included to administer medicines per medical director and monitor effectiveness and be alerted to changes in mood, sleep pattern, appetite, cognition, behaviors and keep MD informed.

Review of the facility initial allegation report dated 6/14/22 revealed on 6/13/22 at 10:30 PM an employee, NA #2, was changing the brief of a combative Resident #257, and slapped the resident on his hip and pressed the resident's arm to the resident's throat. The report further revealed NA #1 witnessed the incident and NA #2, was suspended pending investigation on 6/13/22. The facility substantiated abuse and NA #2 was terminated.

Review of the investigation completed by the Administrator on 6/13/22 related to Resident #257's incident revealed the following:

-Nurse Aide (NA) #1 statement dated 6/13/22 revealed NA #1 saw NA #2 hit Resident #257

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while they were changing him. NA #1 further revealed resident #257 was combative, but NA #2 rolled him and slapped him hard on the hip. The statement indicated NA #1 tried to calm the resident down and NA #2 rolled Resident #257 back and he began to hit at NA #2. NA #2 grabbed Resident #257 arms and held them on his neck, and he stated, "what, are you choking me?" NA #1 revealed care was completed on Resident #257 and NA #2 stated to NA #1 "what are you doing? You work to much". NA #1 indicated she cared too much for the residents and the incident was very upsetting.

A phone interview conducted with Nurse Aide (NA) #1 on 9/13/22 at 3:35 PM revealed she and NA #2 entered Resident #257's room on 6/13/22 after 7:00 PM to give care. NA #1 revealed NA #2 went to the right side of the bed and NA #1 went to the left side. NA #1 stated NA #2 started to pull down the sheet to give care and Resident #257 was grabbing at the sheet and appeared to be agitated muttering. NA #1 stated Resident #257 was commonly agitated when given care and his speech was unclear. NA #1 revealed NA #2 continued to give care by undoing the brief and Resident #257 tried to grab at NA #2. NA #2 then aggressively pushed Resident #257 on his left hip by placing one hand on his shoulder and the other on his hip. Resident #254 became more agitated and pushed against NA #2 and NA #2 took her right open hand and smacked the resident on the hip. NA #1 revealed it was a loud smack and she was in shock of what had happened. NA #2 stated, "You can't do anything? What you going to do?" taunting Resident #257. NA #1 revealed NA #2 observed to be frustrated and angry and laid the resident on his back aggressively. Resident #257 was muttering more

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words and was gritting his teeth and observed to be very angry. Resident #257 grabbed at NA #2 and NA #2 immediately grabbed the resident's wrist and placed them down on his chest under his neck in a forceful way. NA #1 indicated Resident #257 stated "what are you doing? Are you trying to chock me"? NA #1 revealed Resident #257 had quit being combative and observed eyes to be wide like he was scared. Resident #257 quit fighting the NAs and eyes appeared to be wide and in shock. NA #1 revealed NA #2 at this time let go of his wrist and completed care. NA #1 further revealed NA #2 wanted to move Resident #257 up in the bed. NA #1 stated she told NA #2 to stop and that they needed to go get help. NA #1 stated NA #2 threw the cover up on Resident #257 and stated, "you are awful mean for someone who pisses on themselves". NA #1 indicated they left the room and she reported to the charge nurse within 15 minutes.

A follow up phone interview conducted on 9/16/22 at 2:08 PM revealed NA #1 wanted to clarify her previous statement. NA #1 revealed she and NA #2 entered Resident #257's room and he began to grab at NA #2 when starting care. NA#1 indicated NA #2 rolled the resident on his left hip to give care and slapped the resident with her right open hand. NA #2 rolled the resident on his back and immediately grabbed both his hands and the resident stated, "what are you doing choking me?" NA #1 stated NA #2 wanted to pull him up in the bed and NA #1 said, "stop and let's get someone in here to help." NA #2 pulled the sheet over Resident #257 and left the room together. As they were walking out of the room NA #1 stated NA #2 made the comment "you sure are mean for someone who pisses himself." NA

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#1 and NA #2 stated they had walked out of the room at the same time and NA #1 reported the incident to the charge nurse. NA #1 was asked to clarify when she said "stop" to NA #2 during the incident. NA #1 was unable to be specific when she had told NA #2 to stop giving care to Resident #257. NA #1 continued to state the incident happened so quick that when NA #2 slapped the resident and grabbed the resident's wrist it appeared to be one motion.

-Nurse Aide (NA) #2 statement dated 6/14/22 revealed NA #2 and NA #1 entered Resident #257's room to change him. NA #2 further revealed the NAs moved resident #257 and he hit both NAs with his hands and feet. NA #2 noted she held Resident #257's arms under hers to keep him from hitting both NAs. Resident #257 stated "he couldn't breathe," and NA #2 removed her hands from the resident's arms. NA #2 noted Resident #257 hit her with his fist and NA #2 had a reflex and hit Resident #257's hip not meaning too. NA #2 indicated both NAs rolled Resident #257 and NA #1 put the residents brief on, lowered the bed, and left the room.

A phone interview with Nurse Aide (NA) #2 was unable to be completed after several attempts.

-Unit Charge Nurse statement dated 6/14/22 revealed NA #1 had come to her last night around 10:00 PM and stated that NA #1 and NA #2 were providing care to Resident #257 and he became combative and NA #2 hit the resident. The statement further revealed the Unit Charge Nurse went and assessed the resident immediately, called the Director of Nursing (DON), and was instructed to have NA #1 write a statement, and to send NA #2 immediately and that a staff

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member would be in contact with her the next day.

Review of the skin assessment completed by the Unit Charge Nurse dated 6/13/22 revealed redness noted on the resident's chest and a bruise forming on the right hand.

An interview conducted with the Unit Charge Nurse dated 9/14/22 at 3:24 PM revealed NA #1 had disclosed NA #2 hit Resident #257 on the hip at 10:30 PM on 6/13/22. The Nurse further revealed she contacted the DON immediately and was instructed to complete an assessment on Resident #257, and NA #1 write a statement on what had happened and send NA #2 home immediately. NA #2 was in the shower room cleaning and had not worked with any other residents. The Unit Charge Nurse's assessment revealed Resident #257 had a quarter size bruise forming on his right hand and did not show any kind of emotions of being sad, scared, or angry. The Nurse indicated Resident #257 was unable to recall the incident. She revealed both NAs had worked with Resident #257 numerous times and knew he could be combative sometimes. The Nurse also indicated the NAs had been educated that anytime Resident #257 or an aggressive resident became combative to either walk away, and wait till they are calm, to complete care.

An interview conducted with the Assistant Director of Nursing (ADON) on 9/14/22 at 5:09 PM revealed the Administrator and the DON joined her at the facility right after the incident occurred on 6/13/22. The ADON revealed she assisted the Administrator and DON with body checks and attempted to interview Resident #257, but the resident was not interviewable.

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An interview conducted with the Director of Nursing (DON) on 9/14/22 at 4:00 PM revealed she came to the facility when she was notified of the abuse by the Unit Charge Nurse and assessed Resident #257. The DON further revealed Resident #257 had a small bruise on his right hand and a small red mark on his chest from the pressure where NA #2 had held his arms down. The DON stated NA #2 admitted to slapping and holding down the resident and knew that it wasn't acceptable. NA #2 disclosed to the DON it was the reaction of Resident #257 being combative. The DON indicated Resident #257 was unable to recall the incident when interviewed. DON revealed both NAs had worked with Resident #257 numerous times and knew he could be combative sometimes. The DON also indicated the NAs had been educated that anytime Resident #257 or an aggressive resident became combative to either walk away, or wait until they calm, to complete care.

An interview conducted with the Administrator on 9/14/22 at 5:55 PM revealed she arrived at the facility on 6/13/22 and NA #2 had already been sent home. The Administrator revealed full body checks and resident interviews were completed that night. The Administrator indicated Resident #257 was unable to disclose information about the incident. The Administrator revealed she interviewed NA #1 and NA #2 the next day. It was further revealed NA #2 denied any incident at first the Administrator, but then admitted to the Administrator that she had smacked him but didn ' t ' t mean to and held his hands down but did not think it was hard. The Administrator interviewed NA#1 who revealed she and NA #2 were giving care to Resident #257 who became agitated and

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aggressive and NA #2 slapped Resident #257 on the hip and then proceeded to grab his wrist and hold his arms down on his chest. The Administrator indicated Resident #257 was the last resident to need care and NA #2 did not work with any other residents that shift. It was revealed both NAs had worked with Resident #257 numerous times and knew he could be combative sometimes. She reported the NAs had been educated that anytime Resident #257 or an aggressive resident became combative to either walk away, and wait till they are calm, to complete care.

The Administrator was notified of immediate jeopardy on 9/15/22 at 9:00 AM.

The corrective action plan for noncompliance dated 6/15/22 was as followed:

On 6/13/22, the Director of Nursing and Administrative Nurse initiated a skin sweep on 100% of all in house residents assessing for any signs of abuse, as all residents have the potential to be affected. This sweep was completed on 6/14/22, approximately at 3:00am. No additional concerns were identified. On 6/14/22, the Social Worker and Administrator interviewed all in-house alert and oriented residents with a BIMS of 10 or higher, to ensure no allegations of abuse were reported. No residents verbalized concerns. The Licensed Social Worker observed Resident #1 for any behaviors that would alert to any mental anguish, fear or pain from 6/14/22 to 6/16/22. Residents who are cognitively impaired and have combative behaviors during care are at higher risk to be affected by this deficient practice.

Education on the abuse policy, preventing,

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protecting, and reporting, and caring for residents with aggressive behavior in long term care continued 6/13/22 through 6/15/22 for 100% staff and therapy contract staff by the Director of Nursing, Nurse Supervisors and Administrative Departmental Managers. Any staff member who did not receive an education by 6-15-22 was not allowed to work until this education was provided. The abuse policy, prevention, protecting, and reporting will continue to be provided during new hire orientation. Education on caring for residents with aggressive behaviors was added to the new hire orientation education on 6-15-22 and will be completed by the Director of Nursing or a member of the Nursing Administration team. The Director of Nursing and the members of the Nursing Administration team was notified on 6-14-22 by the Administrator of the new process.

Education on the abuse policy, preventing, protecting, and reporting, and caring for residents with aggressive behaviors in long term care will be provided in the monthly All-Staff meeting by the Administrator or Director of Nursing to staff x 6 months. The next staff meeting was held on July 13 th, 2022 and is ongoing monthly.

The Director of Nursing and Nursing Administration team conduct random observations of staff while providing care and interacting with residents with a cognitive impairment and combative behaviors. These routine audits have been on-going prior to the 6/13/22 allegation and will continue. The Director of Nursing and Nursing Administration team were educated by the Administrator on 6/14/22 to continue and begin documenting their observations of staff while providing care and interacting with residents with a cognitive

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F 600	Continued From page 10 impairment and combative behaviors. Documentation of the observations will continue until a pattern of compliance is sustained. To ensure continued compliance, The Director of Nursing will be responsible for bringing the special focus audits and observations on care provided to residents with a cognitive impairment and combative behavior to the Quality Assurance team for further review and to make any needed changes to our audit process for three consecutive months or until a pattern of compliance is sustained. Date of Immediate Jeopardy Removal: 6-15-22 On 9/20/22, the facility's credible allegation for immediate jeopardy removal effective 6/15/22 was validated by the following: Staff interviews revealed they had received education on resident abuse and how to care for aggressive and combative residents. Skin assessments were conducted on all residents and identified, and alert and oriented residents were interviewed with no concerns identified. The facility's action plan was validated to be completed as of 6/15/22.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		9/20/22

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F 607	Continued From page 11 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to intervene to stop verbal and physical abuse and/or failed to immediately call for assistance from administrative staff or licensed staff to stop the abuse. The facility policies and procedures failed to include reporting abuse to the state survey agency, APS and local law enforcement. The facility failed to report the abuse to APS and to the state survey agency, and local law enforcement within the required timeframes for 1 of 3 residents reviewed for staff to resident abuse (Resident # 257). Immediate Jeopardy began on 6/13/22 when the facility witnessed verbal and physical abuse and did not intervene to stop it, or immediately call for licensed staff or administrative staff to stop it. Immediate Jeopardy was removed on 9/18/22 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential of minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place effective. Findings Included: A review of the facility policy and procedure titled "Reporting Abuse to Facility Management", with a revised date of April 2010, read in part "it is the responsibility of our employees, facility	F 607	F000 Disclaimer Clause Preparation and or execution of this plan does not constitute admission or agreement by the Provider of Truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. F607 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) The facility failed to intervene to stop verbal and physical abuse and/or failed to immediately call for assistance from administrative staff or licensed staff to stop the abuse. The facility policies and procedures failed to include reporting abuse to the state survey agency, APS and local law enforcement. The facility failed to report the abuse to APS and to the state survey agency, and local law enforcement within the required timeframes for Resident #257. Resident #257 was assessed for injury and left in bed with call light in reach. Nurse Aide#2 was immediately sent	

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F 607	Continued From page 12 consultants, attending physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management." The "Policy Interpretation and Implementation" section specified in part: 2a. 4. Employee's facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Director of Nursing Services. In the absence of the Director of Nursing Services such reports may be made to the Nurse Supervisor on duty. "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish."9. When an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to the facility management regardless of the time lapse since the incident occurred. Reporting procedures should be followed as outlined in this policy. The policy did not indicate time frames of reporting to outside agencies. Resident #257 was admitted to the facility on 4/13/22 with diagnoses which included progressive neurological progression, dementia, muscle weakness, and hypertension. Review of the quarterly Minimum Data Set (MDS) dated 6/7/22 revealed Resident #257 was moderately cognitively impaired and required extensive assistance for majority of activities of daily living (ADL). Review of the facility initial allegation report dated 6/14/22 revealed on 6/13/22 at 10:30 PM an	F 607	home. Nurse #1 began abuse in-servicing to Nurse Aide #1 immediately after notifying the Director of Nursing and Administrator of the alleged event with Nurse Aide #2 to reeducate on the abuse policy, prevention, protecting and reporting, and dealing with residents with aggressive behaviors in long term care. Nurse Aide#2 was terminated on 6/14/22. On 6/13/22, the Director of Nursing and Administrative nursing team initiated a skin sweep on 100% of all in-house residents assessing for any signs of abuse, as all residents have the potential to be affected. This sweep was completed on 6/14/22. No additional concerns were identified. On 6/14/22, the Social Worker and Administrator interviewed all in-house alert and oriented residents with a BIMS of 10 or higher, to ensure no allegations of abuse were reported. No residents verbalized concerns. Nurse #1 then in-serviced all other staff in the facility on the abuse policy, prevention, protecting and reporting, and providing care for residents with aggressive behaviors in long term care. This education included what to do if witness to abuse and when to report. All staff were trained in empathy, prevention, and de-escalation. The Director of Nursing and the Administrator arrived at the facility at approximately 11pm to continue with the investigation of abuse. Education on the abuse policy, prevention, protecting and reporting, and dealing with residents with aggressive	

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F 607	Continued From page 13 employee, NA #2, was changing the brief of a combative Resident #257, and slapped the resident on his hip and pressed the resident's arm to the resident's throat. The report further revealed NA #1 witnessed the incident and NA #2, was suspended pending investigation on 6/13/22. The facility substantiated abuse and NA #2 was terminated. The report revealed law enforcement and adult protective services (APS) were not contacted. Review of the investigation completed by the Administrator 6/13/22 related to Resident #257's incident revealed the following: -Nurse Aide (NA) #1 statement dated 6/13/22 revealed NA #1 saw NA #2 hit Resident #257 while they were changing him. NA #1 further revealed Resident #257 was combative, but NA #2 rolled him and slapped him hard on the hip. The statement indicated NA #1 tried to calm the resident down and NA #2 rolled Resident #257 back and he began to hit at NA #2. NA #2 grabbed Resident #257 arms and held them on his neck, and he stated, "what, are you choking me?" NA #1 revealed care was completed on Resident #257 and NA #2 stated to NA #1 "what are you doing? You work to much". NA #1 indicated she cared too much for the residents and the incident was very upsetting. A phone interview conducted with Nurse Aide (NA) #1 on 9/13/22 at 3:35 PM revealed she and NA #2 entered Resident #257's room on 6/13/22 after 7:00 PM to give care. NA #1 revealed NA #2 went to the right side of the bed and NA #1 went to the left side. NA #1 stated NA #2 started to pull down the sheet to give care and Resident #257 was grabbing at the sheet and appeared to be	F 607	behaviors in long term care to all staff was completed on 6/15/22. Any staff not educated by 6/15/22 were not allowed to work until education is completed. The Regional Operations Manager educated the Administrator and the Director of Nursing on 6/21/22 on the abuse policy, prevention of abuse, protecting residents, staff & visitors, and reporting abuse to include reporting to The Healthcare Personnel Registry and Police Department within 2 hours of an abuse allegation. On 9/15/22, all facility staff were interviewed on the re-education that was provided on 6/13/22-6/15/22 by Administrator and/or designee validating what is abuse, who reports abuse, what to do if you witness an abuse, and when to report abuse. No issues were identified. On 9/17/22, the Department of Health and Human Services educated the Administrator on the requirement for reporting to APS. The Administrator educated the Director of Nursing on 9/17/22 regarding reporting to APS. Education on the abuse policy, preventing, protecting, and reporting, and caring for residents with aggressive behaviors in long term care will be provided in the monthly All-Staff meeting starting July 7/13/22 by the Administrator or Director of Nursing to staff for six months. As of 6/21/22, the Regional Operations Manager and/or the Regional Clinical Manager will review all reportable allegations to ensure timely reporting to the State Agency and other officials as	

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F 607	Continued From page 14 agitated muttering. NA #1 stated Resident #257 was commonly agitated when given care and his speech was unclear. NA #1 revealed NA #2 continued to give care by undoing the brief and Resident #257 tried to grab at NA #2. NA #2 then aggressively pushed Resident #257 on his left hip by placing one hand on his shoulder and the other on his hip. Resident #254 became more agitated and pushed against NA #2 and NA #2 took her right open hand and smacked the resident on the hip. NA #1 revealed it was a loud smack and she was in shock of what had happened. NA #2 stated" You can't do anything? What you going to do?" taunting Resident #257. NA #1 revealed NA #2 observed to be frustrated and angry and laid the resident on his back aggressively. Resident #257 was muttering more words and was gritting his teeth and observed to be very angry. Resident #257 grabbed at NA #2 and NA #2 immediately grabbed the resident's wrist and placed them down on his chest under his neck in a forceful way. NA #1 indicated Resident #257 stated "what are you doing? Are you trying to chock me"? NA #1 revealed Resident #257 had quit being combative and observed to be scared. Resident #257 quit fighting the NAs and eyes appeared to be wide and in shock. NA #1 revealed NA #2 at this time let go of his wrist and completed care. NA #1 further revealed NA #2 wanted to move Resident #257 up in the bed. NA #1 stated she told NA #2 to stop and that they needed to go get help. NA #1 stated NA #2 threw the cover up on Resident #257 and stated, "you are awful mean for someone who pisses on themselves". NA #1 indicated they left the room and she reported to the charge nurse within 15 minutes. NA #1 revealed she did not intervene during care because she was in shock and was scared of	F 607	required by the regulation, and to ensure that there is no failure for timely reporting of an allegation to a nurse, supervisor, or Administrator for three months. The Director of Nursing and Nursing Administration team conduct random observations of staff while providing care and interacting with residents with a cognitive impairment and combative residents. These routine audits have been on-going prior to the 6/13/22 allegation and will continue. The Director of Nursing and Nursing Administration team were educated by the Administrator on 6/14/22 to continue and begin documenting their observations of staff while providing care and interacting with residents with a cognitive impairment and combative behaviors. Documentation of the observations will continue until a pattern of compliance is sustained. Any issues identified during the monitoring process will be addressed promptly. To ensure Quality Assurance, all findings will be brought to the Quality Assurance Performance Improvement committee for further review and/or need for additional measures for four consecutive months. All corrective action will completed on September 20th, 2022.	

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retaliation from NA #2.

A follow up phone interview conducted on 9/16/22 at 2:08 PM revealed NA #1 wanted to clarify her previous statement. NA #1 revealed she and NA #2 entered Resident #257's room and he began to grab at NA #2 when starting care. NA#1 indicated NA #2 rolled the resident on his left hip to give care and slapped the resident with her right open hand. NA #2 rolled the resident on his back and immediately grabbed both his hands and the resident stated, "what are you doing choking me?" NA #1 stated NA #2 wanted to pull him up in the bed and NA #1 said, "stop and let's get someone in here to help." NA #2 pulled the sheet over Resident #257 and left the room together. As they were walking out of the room NA #1 stated NA #2 made the comment "you sure are mean for someone who pisses himself." NA #1 and NA #2 stated they had walked out of the room at the same time and NA #1 reported the incident to the charge nurse. NA #1 was asked to clarify when she said "stop" to NA #2 during the incident. NA #1 was unable to be specific when she had told NA #2 to stop giving care to Resident #257. NA #1 continued to state the incident happened so quick that it appeared to be one motion.

-Nurse Aide (NA) #2 statement dated 6/14/22 revealed NA #2 and NA #1 entered Resident #257's room to change him. NA #2 further revealed the NAs moved resident #257 and he hit both NAs with his hands and feet. NA #2 noted she held Resident #257's arms under hers to keep him from hitting both NAs. Resident #257 stated "he couldn't breathe," and NA #2 removed her hands from the resident's arms. NA #2 noted Resident #257 hit her with his fist and NA #2 had

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a reflex and hit Resident #257's hip not meaning too. NA #2 indicated both NAs rolled Resident #257 and NA #1 put the residents brief on, lowered the bed, and left the room.

A phone interview with Nurse Aide (NA) #2 was unable to be completed after several attempts.

-Unit Charge Nurse statement dated 6/14/22 revealed NA #1 had come to her last night around 10:00 PM and stated that NA #1 and NA #2 were providing care to Resident #257 and he became combative and NA #2 hit the resident. The statement further revealed the Unit Charge Nurse went and assessed the resident immediately, called the Director of Nursing (DON), and was instructed to have NA #1 write a statement, and to send NA #2 immediately home and that a staff member would be in contact with her the next day.

- Review of skin assessment completed by the Unit Charge Nurse dated 6/13/22 revealed redness noted on the resident's chest and a bruise forming on the right hand.

An interview conducted with the Unit Charge Nurse dated 9/14/22 at 3:24 PM revealed NA #1 had disclosed NA #2 hit Resident #257 on the hip during 2nd shift on 6/13/22. The Nurse further revealed she contacted the DON immediately and was instructed to complete an assessment on Resident #257, NA #1 write a statement on what had happened, and send NA #2 home immediately. NA #2 was in the shower room cleaning and had not worked with any other residents. The assessment revealed Resident #257 had a quarter size bruise forming on his right hand and did not show any kind of emotions

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of being sad, scared, or angry. The Nurse indicated Resident #257 was unable to recall the incident. She revealed both NAs had worked with Resident #257 numerous times and knew he could be combative sometimes. The Nurse also indicated the NAs had been educated that anytime Resident #257 or an aggressive resident became combative to either walk away, wait till they are calm, or get another employee to complete care.

An interview conducted with the Director of Nursing (DON) on 9/14/22 at 4:00 PM revealed she believed NA #1 was upset and scared of NA #2 and is the reason NA #1 did not intervene to stop NA #2. The DON completed the initial investigation and did not complete a report to the state, adult protective services, or law enforcement within two hours. The DON stated she had spoken to law enforcement the next day, but a report was not made. The DON indicated a report was not made to APS. The DON indicated she was not aware that the initial intake report had to be sent in within two hours. The DON further revealed she believed to have 24 hours to report the incident. The DON revealed she expected for nursing staff to intervene and stop any abuse and to report immediately to upper management.

An interview conducted with the Administrator on 9/14/22 at 5:55 PM revealed she thought she had 24 hours to send the initial investigation report once the incident had happened. The Administrator further revealed the DON had contacted law enforcement the next day after speaking to their corporate, but an official police report was not made. The Administrator indicated a report was not made to APS because she was

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not aware the facility needed too. The Administrator expected for staff to intervene and stop any kind of abuse, but felt like NA #1 was upset and scared of retaliation from NA #2.

The Administrator was notified of immediate jeopardy on 9/15/22 at 9:00 AM. The facility provided the following credible allegation of immediate jeopardy removal.

The corrective action plan was as followed:

On 6/13/22, the Director of Nursing and Administrative Nurse initiated a skin sweep on 100% of all in house residents assessing for any signs of abuse, as all residents have the potential to be affected. This sweep was completed on 6/14/22, approximately at 3:00am. No additional concerns were identified.

On 6/14/22, the Social Worker and Administrator interviewed all in-house alert and oriented residents with a BIMS of 10 or higher, to ensure no allegations of abuse were reported. No residents verbalized concerns.

Nurse #1 began abuse in-servicing to Nurse Aide #1 immediately after notifying the Director of Nursing and Administrator of the alleged event with Nurse Aide #2 to reeducate on the abuse policy, prevention, protecting and reporting, and dealing with residents with aggressive behaviors in long term care. Nurse #1 then in-serviced all other staff in the facility on the abuse policy, prevention, protecting and reporting, and providing care for residents with aggressive behaviors in long term care. This education included what to do if witness to abuse and when to report. All staff were trained in empathy,

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prevention, and de-escalation. The Director of Nursing and the Administrator arrived at the facility at approximately 11pm to continue with the investigation of abuse. Education on the abuse policy, prevention, protecting and reporting, and dealing with residents with aggressive behaviors in long term care to all staff was completed on 6/15/22. Any staff not educated by 6/15/22 will not be allowed to work until education is completed. On 9-15-22, all facility staff were interviewed on the education provided on What is abuse, who reports abuse, what to do if you witness an abuse, and when to report abuse. No issues were identified.

The Regional Operations Manager educated the Administrator and the Director of Nursing on 6-21-22 on the abuse policy, prevention of abuse, protecting residents, staff & visitors, and reporting abuse to include reporting to The Healthcare Personnel Registry and Police Department within 2 hours of an abuse allegation.

As of 6-21-22, the Regional Operations Manager and/or the Regional Clinical Manager will review all reportable allegations to ensure timely reporting to the State Agency and other officials as required by the regulation, and to ensure that there is no failure for timely reporting an allegation to a nurse, supervisor, or Administrator. Any issues identified during this monitoring process will addressed promptly. On 9-17-22, Department of Health and Human Services educated the Administrator on the requirement for reporting to APS. The Administrator educated the Director of Nursing on 9-17-22 regarding reporting to APS.

On 9-15-22, all facility staff, to include those not in

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F 607	Continued From page 20 the facility on 9-15-22, were interviewed by the Director of Nursing and Nurse Administration on the re-education that was provided on 6/13/22-6/15/22 by Administrator or designee validating what is abuse, who reports abuse, what to do if you witness an abuse, and when to report abuse. No issues were identified. Education on the abuse policy, preventing, protecting, and reporting, and caring for residents with aggressive behaviors in long term care will be provided in the monthly All-Staff meeting starting July 7/13/22 by the Administrator or Director of Nursing to staff x 6 months. Date of Immediate Jeopardy Removal: 9-18-22 On 9/20/22, the facility's credible allegation for immediate jeopardy removal effective 9/18/22 was validated by the following: Staff interviews revealed they had received education on resident abuse and how to care for aggressive and combative residents. Skin assessments were conducted on all residents and identified, and alert and oriented residents were interviewed with no concerns identified. The regional operational manager educated the Administrator and DON on abuse policy, prevention of abuse, protecting residents, staff and visitors, and reporting abuse Education was received regarding reporting in a timely manner to agencies. All reportables would be reviewed to ensure that that they are reported timely.	F 607		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement-	F 640		9/20/22

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§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that

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F 640	Continued From page 22 does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment within 14 days of the discharge date for 1 of 1 sampled resident reviewed for discharge (Resident #35). Findings included: Resident #35 was admitted to the facility on 07/08/22. A Social Worker progress note dated 08/02/22 at 8:00 AM noted Resident #35 was sent out to the hospital on 07/31/22 and was admitted. Review of Resident #35's medical record revealed the last completed MDS assessment was a quarterly dated 07/26/22. There was no discharge assessment completed or transmitted. During an interview on 09/14/22 at 10:54 AM, the MDS Coordinator explained typically MDS assessments showed up on their computer dashboard to indicate when an MDS assessment was due and/or had not been transmitted but for some reason Resident #35's discharge MDS assessment wasn't. The MDS Coordinator stated it was an oversight and should have been completed within the regulatory time frame.	F 640	F640 Encoding/Transmitting Resident Assessments CFR(s):483.20(f)(1)-(4) The facility failed to complete a discharge Minimum Data Set assessment within 14 days of the discharge date for Resident #53. On September 13th, 2022, the discharge assessment for Resident #53 was completed by the MDS Coordinator. On September 16th, 2022, the Administrator and two MDS Coordinators audited all assessments to ensure that all assessments completed were electronically submitted within 14 days. The two MDS Coordinators were re-educated by the Administrator on September 16th, 2022, that within 14 days after a completed resident assessment, the facility must electronically transmit encoded, accurate, and complete MDS data to the CMS system. To ensure Quality Assurance, the Administrator and MDS Coordinators will audit 10 resident assessments weekly for	

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F 640	Continued From page 23 During an interview on 09/15/22 at 7:36 PM, the Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes.	F 640	4 weeks, then 5 resident assessments per week for 4 weeks, then 1 resident assessment per week for 4 weeks for appropriate coding and timeliness for transmitting. Findings from this audit will be presented in the Quality Assurance meeting for a minimum of four consecutive months. All corrective action will be completed on September 20th, 2022.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Prospective Payment System (PPS) and Minimum Data Set (MDS) assessments in the areas of dialysis, hospice, Preadmission Screening and Resident Review (PASRR), and activities of daily living for 6 of 30 sampled residents (Residents #79, #309, #45 #44, #153, and #65) reviewed for MDS accuracy. Findings included: 1. Resident #79 was admitted to the facility on 01/12/22. His diagnoses included diabetes, chronic kidney disease, and dependence on renal dialysis. A staff progress note dated 07/09/22 written by the Social Worker revealed Resident #79 was	F 641	F641-483.20(g) Accuracy of Assessments The facility failed to accurately code the Prospective Payment System and Minimum Data Set assessments in the areas of dialysis, hospice, Preadmission Screening and Resident Review, and activities of daily living for Residents #79, #309, #45, #153 and #65. On September 16th, 2022, the MDS Coordinators corrected the Minimum Data Set for Residents #79, #309, #45, #153 and #65 to accurately code in the areas of dialysis, hospice, Preadmission Screening and Resident Review, and activities of daily living.	9/20/22

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F 641	Continued From page 24 scheduled to go to dialysis on Tuesday, Thursday, and Saturdays. Review of Resident #79's comprehensive care plans, last reviewed/revised 07/18/22, revealed he had the potential for complications related to hemodialysis. Interventions included hemodialysis three times a week as ordered on Tuesday, Thursday, and Saturday. The 5-day PPS assessment dated 08/26/22 revealed Resident #79 was not coded as having received dialysis services. During an interview on 09/14/22 at 10:32 AM, the MDS Coordinator confirmed Resident #79 received dialysis and stated it was a coding error that dialysis was not indicated as received on the 5-day PPS assessment dated 08/26/22. During an interview on 07/01/22 at 7:40 PM, the Administrator stated she would expect for PPS assessments to be coded appropriately and accurately reflect a resident's status at the time of the assessment. 2. Resident #309 was admitted to the facility 08/05/21. His diagnoses included dementia, heart failure, and diabetes. The Hospice Recertification for the period 06/06/22 through 07/30/22 revealed Resident #309 was admitted under hospice care on 12/03/21 related to a primary diagnosis of Alzheimer's disease, had a limited life expectancy of 6 months or less, and was certified as eligible for hospice care. The annual MDS assessment dated 07/12/22	F 641	On September 16th, 2022, the Administrator, Social Worker, Director of Nursing, Assistant Director of Nursing and MDS Coordinators audited all Minimum Data Sets to ensure that they were accurately coded for activities of daily living (ADL), Preadmission Screening and Resident Review (PASRR), hospice and dialysis. Any noted areas of deficiency were corrected at the time of identification. The Administrator in-serviced the Social Worker and two MDS Coordinators on recognizing and accurately coding residents who are receiving dialysis and/or hospice services and correct PASRR coding while completing a Minimum Data Set on September 16th, 2022. The MDS Coordinators were in-serviced on verifying the Nurse Aides documentation regarding activities of daily living to ensure the Minimum Data Set was accurate by the Administrator on September 16th, 2022. To ensure Quality Assurance, the Administrator and/or designee will review 5 Minimum Data Sets per week for eight weeks, then 2 Minimum Data Sets per week for four weeks. Findings from this audit will be presented in the Quality Assurance meeting for three consecutive months to three months to ensure continued compliance. All corrective action will be completed on September 20th, 2022.	

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revealed Resident #309 was not coded as having a prognosis that might result in a life expectancy of less than 6 months and receiving hospice care.

During an interview on 09/14/22 at 10:32 AM, the MDS Coordinator confirmed Resident #309 received hospice services. The MDS Coordinator revealed she did not code hospice services or prognosis of life expectancy of less than 6 months on the MDS assessment because he was currently listed as private pay. She explained Resident #309 admitted to the facility with a Medicare replacement as his payor source then went to private pay due to having to spend down before he qualified for Medicaid. She added, once he became eligible for Medicaid hospice would become the payor source.

During an interview on 07/01/22 at 7:40 PM, the Administrator stated she would expect for MDS assessments to be coded appropriately and accurately reflect a resident's status at the time of the assessment.

3. Resident #45 was admitted to the facility on 03/22/22 with multiple diagnoses that included anxiety, depression, unspecified mood disorder, and dementia with behavioral disturbance.

A Preadmission Screening and Resident Review (PASRR) Level II Determination Letter dated 05/23/19 indicated Resident #45 had a Level II PASSR that ended in a "C" with no expiration date.

Review of the North Carolina Skilled Nursing Facility PASRR authorization codes document revealed a PASRR ending in "C" indicated "Level II: no end date, no limitation unless change in

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condition, specialized services required."

The annual MDS dated 04/18/22 revealed Resident #45 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability.

During interviews on 09/14/22 at 10:32 AM and 11:57 AM, the MDS Coordinator explained when they reviewed Resident #45's PASRR information via the North Carolina Medicaid Uniform Screening Tool (NC MUST) website, it was noted as "no" under the column "sent to Level II." The MDS Coordinator stated based on what she was instructed, Resident #45's PASRR did not meet the criteria and did not need to be coded as a Level II PASRR on the MDS assessment dated 04/18/22.

During an interview on 07/01/22 at 7:40 PM, the Administrator stated she would expect for MDS assessments to be coded appropriately and accurately reflect a resident's status at the time of the assessment.

4. Resident #44 was admitted on 07/29/22 with diagnoses which included osteomyelitis (infection of the bone), muscle wasting and atrophy and muscle weakness.

The resident was confined to his wheelchair due to paraplegia.

The admission Minimum Data Set (MDS) assessment dated 08/05/22 indicated Resident #44 had walked in his room once with minimal assistance from staff.

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An interview with the MDS Coordinator on 09/15/22 at 2:38 PM revealed Resident #44 was paraplegic and was not able to walk on his own or with assistance and this had been an error in coding the MDS. She explained some of the information on the assessment automatically populated from documentation by the Nurse Aides (NAs) but said the MDS nurses should have caught the error. The MDS Coordinator stated the assessment would be modified and corrected.

An interview with the Director of Nursing (DON) on 09/15/22 at 6:29 PM revealed the information on the Activities of Daily Living on the MDS assessment automatically populated from documentation of the NAs but said the MDS nurses should verify the information as correct prior to signing off on the assessment.

An interview with the Administrator on 09/15/22 at 7:40 PM revealed some of the information on the MDS assessment automatically populated from the NAs documentation. She stated they were no longer going to auto-populate that section from documentation but rather were going to code it according to the resident at the time of the assessment to ensure the MDS was accurate.

5. Resident #153 was admitted on 09/01/22 with diagnoses which included osteomyelitis of right ankle, arterial ulcers, diabetes mellitus and diabetic foot ulcer on the left foot.

Review of Resident #153 ' s physician orders dated 09/01/22 revealed he was non-weight bearing to bilateral lower extremities.

The admission Minimum Data Set (MDS)

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assessment dated 09/08/22 indicated Resident #153 had walked in his room independently and had walked in the corridor at least once with minimal assistance from staff. The MDS further indicated Resident #153 had impairment on both sides of his lower extremities.

An interview with the MDS Coordinator on 09/15/22 at 2:38 PM revealed Resident #153 was non-weight bearing and was not able to walk on his own or with assistance and this had been an error in coding the MDS. She explained some of the information on the assessment automatically populated from documentation by the Nurse Aides (NAs) but said the MDS nurses should have caught the error. The MDS Coordinator stated the assessment would be modified and corrected.

An interview with the Director of Nursing (DON) on 09/15/22 at 6:29 PM revealed the information on the Activities of Daily Living on the MDS assessment automatically populated from documentation of the NAs but said the MDS nurses should verify the information as correct prior to signing off on the assessment.

An interview with the Administrator on 09/15/22 at 7:40 PM revealed some of the information on the MDS assessment automatically populated from the NAs documentation. She stated they were no longer going to auto-populate that section from documentation but rather were going to code it according to the resident at the time of the assessment to ensure the MDS was accurate.

6. Resident #65 was admitted on 08/17/22 with diagnoses which included displaced fracture of the humerus and ulnar with routine healing and

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displaced fracture of right femur with routine healing.

The resident was able to feed herself with set up of her meals.

The admission Minimum Data Set (MDS) assessment dated 08/24/22 indicated Resident #65 required supervision from 2 or more staff physical assistance with eating.

An interview with the MDS Coordinator on 09/15/22 at 2:38 PM revealed Resident #65 was independent with eating after being set up and this had been an error in coding the MDS. She explained some of the information on the assessment automatically populated from documentation by the Nurse Aides (NAs) but said the MDS nurses should have caught the error. The MDS Coordinator stated the assessment would be modified and corrected.

An interview with the Director of Nursing (DON) on 09/15/22 at 6:29 PM revealed the information on the Activities of Daily Living on the MDS assessment automatically populated from documentation of the NAs but said the MDS nurses should verify the information as correct prior to signing off on the assessment.

An interview with the Administrator on 09/15/22 at 7:40 PM revealed some of the information on the MDS assessment automatically populated from the NAs documentation. She stated they were no longer going to auto-populate that section from documentation but rather were going to code it according to the resident at the time of the assessment to ensure the MDS was accurate.

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F 761	Continued From page 30	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard an expired medication available for use in 1 of 5 medication carts (F hall medication cart). The findings included: An observation of the F hall medication cart on 9/14/22 at 6:38 AM with Medication Aide (MA) #1	F 761	F761 Label/Store Drugs and Biologicals CFR(s):483.45(g)(h)(1)(2) On September 14th, 2022, the facility failed to discard an expired bottle of Thera-tabs off the F hall medication cart. On September 14th, 2022, the facility discarded the expired bottle of Thera-tabs	9/20/22

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F 761	Continued From page 31 revealed a large, opened bottle of Thera-tabs which was about ¾ full of oblong-shaped reddish-brown tablets. (Thera-tabs is a multivitamin and iron product used to treat or prevent vitamin deficiency.) The bottle was marked with a best by date of 11/21. (Best by date is the date at which the manufacturer can still guarantee the full potency and safety of the drug.) An interview with MA #1 on 9/14/22 at 6:40 AM revealed she was not sure if any of the residents on her hall took Thera-tabs, but she didn't give it to any of her residents on her shift. MA #1 stated the staff just used the bottle of Thera-tabs to prop up the narcotic cards in the narcotic drawer. MA #1 also stated that the bottle did not need to be left inside the medication cart and that it needed to be disposed of. An interview with the Director of Nursing (DON) on 9/15/22 at 6:51 PM revealed she had just been made aware of an expired bottle of Thera-tabs being used to hold up the narcotic cards in the F hall medication cart. The DON stated all nurses and medication aides who worked on the medication carts were responsible for checking the dates on the medications and discarding any that were expired. She also stated that the expired bottle of Thera-tabs should not be stored in the medication cart and should have been discarded when it went out of date.	F 761	from the medication cart. On September 14th, 2022, the Director of Nursing and Assistant Director of Nursing checked all five medication carts to ensure that all carts were free from expired medications. The Director of Nursing and Assistant Director of Nursing was in-serviced by the Administrator on ensuring that all medication carts are free from expired medications on September 14th, 2022. All nurses and medication aides were re-educated by the Director of Nursing and/or designee by September 15th, 2022, that all medication carts must be free from expired medications and that they must check the medication carts each shift. To ensure Quality Assurance, all medication carts will be audited 5 times per week four four weeks to ensure all medication carts are free from expired medications by the Director of Nursing and/or designee, thereafter 3 medication carts per week for four weeks, and then 1 medication cart per week for four weeks. The Administrator will audit 2 medication carts per week for four weeks, thereafter 1 medication cart per week for eight weeks. Findings from this audit will be presented to the Quality Assurance meeting for four consecutive months. All corrective action will be completed on September 20th, 2022.	

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F 867	Continued From page 32	F 867		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place on after COVID-19 Focused Infection Control and complaint investigation survey completed on 11/19/2020 and the recertification survey completed on 5/20/21. This was for two repeated deficiencies in the areas of labeling and storage of drugs and biologicals and freedom from abuse and neglect. These areas were cited again on the current recertification survey with an exit date of 09/20/2022. The continued failure of the facility during the three federal surveys shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag was cross referenced to: F-761: Based on observation and staff interviews, the facility failed to discard an expired medication available for use in 1 of 5 medication carts (F hall medication cart).	F 867	F867 QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) The facility Quality Assurance Committee failed to mention implemented procedures and monitor the interventions the facility put into place following the COVID-19 Focused Infection Control and complaint investigation survey on 11/19/20 and recertification survey completed on 5/20/21 in the areas of labeling and storage of drugs and biologicals and freedom from abuse and neglect. A plan of correction for F600 cited during the COVID-19 Focused Infection Control Survey and complaint investigation on 11/19/20 and for F761 cited during the recertification survey on 5/20/21 were submitted to CMS and accepted with follow up and return to compliance visits. Plans of correction were put into place at the time of each deficiency cited. Each plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined amount of time. Monitoring of each plan of	9/21/22

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F 867	Continued From page 33 During the recertification survey of 5/20/2021 the facility failed to discard an undated opened multi-dose vial of influenza vaccine in 1 of 1 medication room, discard an opened single-dose vial of an injectable medication, undated and opened insulin pens, and loose pills in 5 of 5 medication carts (A hall, B hall, C hall, D hall and F hall). They also failed to store undated and unopened vials of insulin per manufacturer instructions and failed to secure a narcotics drawer in 1 of 5 medication carts. F- 600: Based on record review and staff interviews the facility failed to protect a resident from verbal and physical abuse when Nurse Aide (NA) #2 proceeded to provide care to a resident (Resident #257) while he was agitated and combative. NA #2 taunted, aggressively pushed, aggressively turned, slapped the resident on the hip, and grabbed his arms and held them on his neck resulting in the resident asking, "are you trying to choke me," and leaving a bruise on his right hand and redness to his chest for 1 of 3 residents reviewed for abuse (Resident #257). During the COVID-19 Focused Infection Control Survey and complaint investigation survey completed on 11/19/2020, the facility failed to transfer a resident with the required level of staff assistance. As a result, the resident was unable to support her weight during the transfer and fell. The fall was not reported to the assigned nurse, the next shift nurse or administration; the resident was not thoroughly assessed after the fall and the fall was not documented in the medical record. A day after the fall the resident complained of pain and an x-ray revealed a fracture of the outer layer of the femur just above the knee joint on the right leg. This was for 1 of 3 sampled residents for	F 867	correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued. The Administrator initiated an in-service to all administrative staff on September 21st, 2022, regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing, and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education. The QAPI Committee will review the compliance audits for F600 and F761 to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance.	

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F 867	Continued From page 34 provide supervision to prevent accidents. An interview was conducted on 09/15/22 at 7:35 PM with the Administrator who also headed the QAA committee. The Administrator stated the facility had completed medicine cart audits by the Administrator, nurses, and pharmacist after the last recertification, discussed medicine storage frequently at quarterly QAA meetings, and had staff complete in-service and education on medicine storage. The Administrator further revealed she could did not know why medicine storage had been an issue again but indicated one on one training would be completed with staff.	F 867	The Administrator will be responsible for the plan of correction. Date of compliance: September 21st, 2022	