STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 1/31/23 through 2/17/23. Event ID# TBHM11 The following intakes were investigated: NC00197559, NC00197571, NC00196889, NC00196997, NC00197270 . 1 of 14 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.12 at tag F610 at a scope and severity (J) Both tags constituted substandard quality of care. A partial extended survey was conducted. Intake NC000197279 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 and F610 at a scope and severity J. Immediate jeopardy began on 01/7/23 and was removed on 1/16/23	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.	F 600		

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

Electronically Signed | 02/23/2023

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F 600	Continued From page 1 §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 interviews with staff and the Physician Assistant, the facility to protect Resident #1's right to be from a suspicious injury for 1 of 1 resident sampled for abuse (Resident #1). Resident #1 told staff he was hit in the eye and was later discovered with a bruise around the left eye. The findings included: Resident #1 was admitted to the facility on 5/7/20 with diagnoses which included dementia with behavioral disturbance and Alzheimer's disease. A review of a quarterly Minimum Data Set (MDS) dated 12/26/22 indicated Resident #1's cognition was severely impaired for daily decision making and required total assistance with activities of daily living. There were no behaviors documented on the behavior monitoring sheet on 1/7/23. An interview was conducted on 2/1/23 at 8:45 AM. The Transportation Staff stated Resident #1 returned from his appointment between 1:00 PM-1:30 PM on 1/7/23. Resident #1 was placed in bed after the completion of his lunch meal. Resident #1 did not exhibit any behaviors, nor did he have any injuries when he returned from his appointment.	F 600	Past noncompliance: no plan of correction required.	

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An interview was conducted on 1/31/23 at 3:17 PM, Nurse #3 stated she had worked the 3-11 PM shift on 1/7/23. She recalled she had observed Nurse Aide #4 using a lift with Resident #1. Nurse #3 did not state she observed Resident #1 combative in the lift when she walked by the room to go to her car. She said Resident #1 did not require transfer by a mechanical lift. The resident had already been placed in bed. She spoke with Nurse Aide #4 about not using the lift with Resident #1. Nurse #3 indicated she was notified by Nurse Aide #4 that Resident #1 was combative and fighting to get out of the lift. She checked on the resident between 6:00 PM-7:00 PM. She saw Resident #1's left eye was red and swollen at the bottom of the eye. She stated she asked the resident several questions about what happened. Initially, the resident did not respond. When asked if he was hit, he said, "Yes." He was asked if it was a female, he said, "Yes, she hit me in the eye." Nurse #3 stated she did not ask Resident #1 any other questions because she wanted to speak with the staff who worked with him on the previous shift (7AM-3PM). Nurse #3 did not state why Res #1 was agitated and wanted to be alone. Nurse #3 further stated she did not discuss the observation or incident with Nurse Aide #4 or the supervisor on duty. When asked was a head-to-toe assessment, incident report, nursing note about her observation or the statement made by the resident statement, the response was it was not done until 1/8/23.

There was no nursing documentation in the nursing notes or on any other form that Resident #1 had any concerns. There was no notation of observation of Resident #1's face on 1/7/23.

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The 24-hour shift report for 1/7/23 revealed there was no documentation of Resident #1's condition or behaviors on the 3-11 PM or 11-7AM shifts.

An interview was conducted on 1/31/23 at 1:22PM. Nurse Aide #3 stated she had worked with Resident #1 on first shift, Saturday, 1/7/23 and he did not have any injuries. When she arrived on Sunday morning 1/8/23 to provide care to the resident around 7:30 AM, she noticed the Resident #1 had a left black eye. Nurse Aide #3 stated Resident #1 told her he had been punched in the eye by staff. She stated she was unsure what happened, so she went to Nurse #3 and reported what she had found. Resident #1 had no injuries when he returned from his dialysis appointment on 1/7/23 around 1:00-1:30 PM and when she left her shift.

A nursing note dated 1/08/2023 at 11:37 PM was reviewed. Nurse #3 documented Resident #1 was observed with a left black eye. Resident #1 told her he was hit in the eye. The Director of Nursing (DON) was made aware and 911 was called. Nurse #3 was in room when a police officer questioned the resident. Resident #1 had no complaint of pain or discomfort. Resident #1 was very agitated and wanted to be left alone.

The facility 24-hour shift report for 1/8/23 on the 7AM-3 PM shift indicated there was documentation Resident #1 had a left black eye. The body audit form dated 1/8/23, revealed discoloration of left eye. There was no timeframe for when the assessment was done or a description of the discoloration by Nurse #3.

An interview was conducted on 1/31/23 at 3:30 PM, Nurse #5 stated she received a call from

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Nurse #3 the morning of 1/8/23, she could not recall exact time. Nurse #3 stated that Resident #1 had a black eye and the resident had reported being hit in the face by staff on 1/7/23. Nurse #3 also reported Resident #1 had been combative during the evening shift per Nurse Aide #4. Nurse Aide #4 was using a mechanical lift alone on Resident #1 that should not have been used. Nurse #5 stated Nurse #3 stated Resident #1's eye was red and swollen during her observation on 1/7/23.

A telephone interview was conducted on 1/31/23 at 3:55 PM, Nurse #4 stated he was the supervisor on the 3-11 PM shift on 1/7/23 on a different floor. He was unaware Resident #1 reported he had been hit by staff and that Resident #1's eye had been injured. Nurse #3 did not inform him of the situation.

A telephone interview was conducted on 1/31/23 at 3:45 PM, the Nurse Aide #4 stated she received a call from Nurse #4 and Nurse #5 asking questions about Resident #1's black eye. Nurse Aide #4 stated when she left the shift, Resident #1 did not have any injuries. Nurse Aide #4 stated she was using the mechanical lift when the resident became combative as she was putting the resident to bed. Nurse Aide #4 stated Nurse #3 was informed of the behaviors and Nurse #3 proceeded to informed her that the lift should not have been used for this resident. Nurse Aide #4 stated there might have been a possibility the strap from the lift could have hit the resident in the face during his combativeness, but she was not certain this was the case. When she left her shift, the resident was asleep and there was nothing on the resident's face.

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F 600	Continued From page 5	F 600		

An interview was conducted on 1/31/23 at 4:42 PM. The Director of Nursing (DON) stated she had not received a call from the 3- 11 PM nursing staff on 1/7/23 when Nurse #3 observed the condition of Resident #1's eye. She further stated Nurse #3 spoke with her around 9:00 AM on 1/8/23 and informed her that Resident #1 reported he had been hit in the eye by staff on 1/7/23 and the left eye discoloration was red/dark and swollen.

An interview was conducted on 1/31/23 at 4:50 PM. The Administrator stated she was unaware the incident occurred on 1/7/23. She was informed on 1/8/23 that the resident reported being hit by staff resulting in a black eye.

An interview was conducted on 2/1/23 at 11:19 AM. The Physician Assistant (PA) stated she assessed Resident #1 on 1/9/23. Resident #1 was unable to state what happened. There was a circular bruise around the left eye, she was unable to determine if it was trauma related or abuse due to the lapse of time from the initial injury.

The Administrator was notified of the Immediate Jeopardy on 2/15/23 at 7:09 AM.

The facility provided the following corrective action plan with a completion date of 1/16/23.

Problem identified: On 1/7/23 Resident # 1 sustained an injury of unknown origin, a red and swollen left eye.

Immediate Action: Resident # 1 sustained an injury of unknown origin, a red and swollen left eye on 1/7/2023. The Certified Nursing Assistant

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assigned to Resident #1 was suspended on 1/8/2023 and terminated on 1/16/23, she did not work between 1/8/23 and 1/16/23. 2.Other residents with potential to be affected. All residents have the potential to be free from injures of unknown origin. On 1/8/23 the Unit Coordinator completed skin observations on four non-interviewable residents on the C.N.A assignment and did not identify any new skin impairments of the residents.

On 1/8/23 Nineteen Residents assigned to the Certified Nursing Assistant (C.N.A) were interviewed by the Unit Coordinator on 1/8/2023 regarding abuse, the questions asked of the resident included "Do you feel safe, have you ever been abuse, have you seen anyone else be abused, and do you have any concerns. Eighteen of the residents stated they had no concerns, and one resident stated the alleged C.N.A was rough during care. The week of 1/8/2023 the Director of Nursing and/or the Licensed Nurses completed skin observation on all residents residing in the facility with no other injury of unknown origins noted.

Systemic Changes: On 1/8/23 the Director of Health Services and/or Nurse Managers began education to all staff on Prevention of Abuse and Neglect with focus on no tolerance for injuries of unknown origin. This education has been added (enhanced) in the general orientation of all staff newly hired. Employees not educated by 1/16/23 will be educated prior to their next scheduled shift.
All newly hired employees continue to be educated in general orientation by the Director of Nursing / Clinical Competency Coordinator or Human Resource Director regarding all residents

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have the right to be free of injuries of unknown origin and the facility has a zero tolerance for abuse. Beginning 1/8/23 this education is now completed quarterly versus annually within the facility for all staff members.

The Director of Nursing reviews of the Skin Observations will be completed weekly for four weeks them monthly thereafter until three months of sustained compliance is maintained, then quarterly thereafter.
On 1/8/23 the Director of Nursing and /or Nurse Managers notified the Licensed Nurses that as they complete the weekly skin observation and a new skin impairment is identified (injury of unknown origin), the Director of Health Services is notified at the time of identification. The Director of Nursing is reviewing the skin observations for completion weekly to ensure all resident's skin observation has been completed.
The Director of Nursing reviews of the Skin Observations will be completed weekly for four weeks them monthly thereafter until three months of sustained compliance is maintained, then quarterly thereafter.

Quality Assurance

The Director of Nursing presented an analysis of the Resident Abuse questionnaire to the Quality Assurance and Performance Improvement Committee on 1/25/23 and monthly thereafter until three months of sustained compliance then quarterly thereafter.
The Director of Health Services presented an analysis of the skin observation review to the Quality Assurance and Performance Improvement Committee on 1/25/23 and monthly thereafter until three months of sustained

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F 600	Continued From page 8	F 600		

compliance then quarterly thereafter.
The Clinical Competency Coordinator will present the analysis of the prevention of injuries of unknown education / employee to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance then quarterly thereafter.
The Administrator decided to address the F 600 citation in the Ad Hoc Quality Assurance and Performance Improvement was made on 1/16/23 after the investigation related to the event was completed.
Completion dated 1/16/23.

The Credible Allegation was validated on 2/17/23 when staff interviews, revealed that they had received recent education on the Abuse policy and procedures, resident rights to be free from injuries of unknown origin. The education included documentation and reporting to management immediately when they become aware of reported, suspected abuse and/or injury. Staff were also educated on the assessment and daily checks of resident skin impairments during personal care, using the body audit form. The body audit form would provide the location of the skin impairment with staff circling the area on the diagram. The body audits for include measurements and description of the noted area. Nurse Aide must submit the report daily to the Nurse/Unit Manager immediately. The Nurse would review the body audit daily to be placed in the physician and wound care notebook for further evaluation. The Unit Manager would review the body audit forms weekly to ensure all skin impairments and/or injuries were reviewed by the physician and/or wound care nurse. The report would be submitted to the Director of Nursing and the Administrator. Facility

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F 600	Continued From page 9 documentation revealed staff were trained on the following topics: Abuse policy and procedures, resident right education and interviewing for abuse, nurse notification and assessment, body audit forms and physician notification of injury unknown origin.. Attestations were signed by trained staff for the verbal education that was provided. Staff indicated they were trained prior to working in the facility for their next shifts. Newly hired staff received an in-service packet prior to working and this was verified by the facility trainers and orientation form. The facility deficiency was corrected on 1/16/23.	F 600		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff	F 610	Past noncompliance: no plan of	

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F 610	Continued From page 10	F 610		

and the Physician Assistant (PA), the facility failed to report an allegation of abuse to the administrator immediately per policy, assess Resident #1 when the left eye was observed to be red and swollen, assess other residents who were under the care of Nurse Aide #4, and protect all residents from physical abuse by allowing Nurse Aide #4 to continue working the entire shift. This deficient practice was discovered for one of one resident sampled for abuse, however the deficient practice had the high likelihood to impact multiple residents.

The findings included:

Review of the abuse policy dated 9/2022 revealed, in part, under procedure, anyone witnessing, suspecting, or hearing an allegation of mental, physical, verbal, or sexual abuse, neglect or exploitation of any resident will immediately report this to the Administrator whether the Administrator is on the premises or not. The Administrator will immediately begin an investigation and implement measures necessary to assure the safety and protection of the resident from the actual or alleged perpetrator. Under procedure: 8. If the alleged perpetrator(s) is a staff member of the home, the Administrator will place them on administrative leave until a determination of the allegation is made. Confirmed allegation shall result in termination with notification to appropriate boards, registries and agencies and the police as appropriate.

Resident #1 was admitted to the facility on 5/7/20 with diagnoses which included dementia with behavioral disturbance and Alzheimer's disease.

A quarterly Minimum Data Set dated 12/26/22

correction required.

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F 610	Continued From page 11	F 610		

indicated Resident #1's cognition was severely impaired for daily decision making and required total assistance with activities of daily living. There were no behaviors documented on the behavior monitoring sheet on 1/7/23.
There was no documentation on the facility's 24-hour shift report dated 1/7/23 that Resident #1 reported an allegation that he had been hit in the face by staff on the 3-11 PM or 11-7 AM shifts to Nurse #3.

The nursing notes dated 1/7/23 did not included documentation, that Resident #1 reported to Nurse #3 he was hit in the face or a description of the condition of Resident #1's eye. There was no documentation of the time Resident #1 reported the allegation to Nurse #3. There was no documentation in the nursing noted that Nurse #3 reported the allegation to the shift supervisor or contact the Director of Nursing and Administrator.

The 24-hour report to the State Agency dated 1/8/23 documented under allegation description, Resident #1 had discoloration to the eye and stated nurse aide from previous day hit him. The report was submitted as an injury of unknown origin. The 5-day report was submitted for an injury of unknown on 1/13/23, not for an abuse allegation.

An interview was conducted on 1/31/23 at 3:17 PM. Nurse #3 stated she had worked the 3-11 PM shift on 1/7/23. She recalled she had observed Nurse Aide #4 using a lift with Resident #1. Nurse #3 had not observed Resident #1 combative in the lift when she walked by the room to go to her car. She said Resident #1 did not require transfer by a mechanical lift. The resident had already been placed in bed. She spoke with

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F 610	Continued From page 12	F 610		

Nurse Aide #4 about not using the lift with Resident #1. Nurse Aide #4 notified Nurse #3 that Resident #1 was combative and fighting to get out of the lift. She checked on the resident between 6:00 PM-7:00 PM. She saw Resident #1's left eye was red and swollen at the bottom of the eye. She asked the resident several questions about what happened. Initially, the resident did not respond. When asked if he was hit, he said, "Yes." He was asked if it was a female. He said, "Yes, she hit me in the eye." Nurse #3 stated she did not ask Resident #1 any other questions because she wanted to speak with the staff who worked with him on the previous shift (7AM-3PM). Nurse #3 did not state why Resident #1 was agitated and wanted to be alone. Nurse #3 did not discuss the observation or incident with Nurse Aide #4 or the supervisor on duty. When asked was a head-to-toe assessment, incident report, nursing note about her observation or a statement made by the resident, the response was, it was not done until 1/8/23. When asked why she had not notified the Supervisor-on-Duty, contacted the Director of Nursing or the Administrator, Nurse #3 stated she did not want to put herself or the resident in danger.

A nursing note written by Nurse #3 and dated 1/08/2023 at 11:37 PM revealed Nurse #3 observed Resident #1 with a left black eye. Resident #1 told Nurse #3 that he was hit in the eye. The Director of Nursing (DON) was made aware and 911 was called. Nurse #3 was in the room when the police officer questioned the resident. Resident #1 had no complaint of pain or discomfort. Resident #1 was very agitated and wanted to be left alone.

An interview was conducted on 1/31/23 at 3:30 PM. Nurse #5 stated she received a written

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PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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statement from Nurse #3 on 1/8/23 stating Resident #1's left eye was red, and the resident was hit by staff. Nurse #3 did not say anything to Nurse Aide #4. She did not want to put herself and resident in danger. Nurse #3 spoke with Nurse Aide #3 at 7:40 AM who worked with Resident #1 on previous shift and stated Resident #1 did not have any injury when he returned from his appointment. Nurse #3 proceeded to call the Director of Nursing, 911 and the Responsible Person. Nurse #5 stated she had contacted Nurse #4 the shift supervisor who worked on 1/7/23. He was asked if he was aware of Resident #1's black eye. Nurse #5 and Nurse #4 obtained a telephone interview on 1/8/23 from Nurse Aide #4. Nurse Aide #4 reported Resident #1 was fighting/combative and she was not sure Resident #1 was scratched. This was the first time she had used the lift on the resident and did not know the lift should not have been used. Nurse Aide #4 further stated the lift strap may have hit the resident in the face as he pulled it toward himself.

A telephone interview was conducted on 1/31/23 at 3:45 PM. Nurse Aide #4 stated she received a call on 2/1/23, no time was reported. Nurse #4 and Nurse #5 asked questions about Resident #1's black eye. Nurse Aide #4 stated when she left the shift Resident #1 did not have any injuries. Nurse Aide #4 stated she was using the mechanical lift when the resident became combative as she was putting the resident to bed. Nurse Aide #4 stated Nurse #3 was informed of the behaviors and Nurse #3 proceeded to inform her that the lift should not have been used for this resident. Nurse Aide #4 stated there might have been a possibility the strap from the lift could have hit the resident in the face during his

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combativeness, but she was not certain this was the case. When she left her shift the resident was asleep and there were no marks on the resident's face.

A telephone interview was conducted on 1/31/23 at 3:55 PM, Nurse #4 stated he was the Supervisor on the 3-11PM shift on 1/7/23 on a different floor. He was unaware Resident #1 reported he had been hit by staff and that Resident #1's eye had been injured. Nurse #3 did not inform him of the situation. Nurse #4 stated he assisted Nurse #5 with obtaining statements.

An interview was conducted on 1/31/23 at 4:42 PM. The Director of Nursing (DON) was asked why Nurse #3 had not let the shift supervisor know about the resident's eye, the allegation, or called the Director of Nursing and the Administrator during the shift. Nurse #3 stated she wanted to verify with first shift staff that the resident did not have any injuries or reported being hit by staff. The DON stated Nurse #3 should have called the Administrator and Director of Nursing immediately per policy on 1/7/23. Nurse #3 should have done a head-to-toe assessment, documented her observations on 1/7/23 in the nursing notes, performed a skin assessment form and completed an assessment form. The physician and responsible person should also have been called on 1/7/23. The alleged perpetrator should have been sent home until the investigation was completed.

An interview was conducted on 1/31/23 at 4: 50 PM. The Administrator stated she was unaware the incident occurred on 1/7/23. She was informed on 1/8/23 that the resident reported being hit by staff resulting in a black eye. Nurse

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#3 should have performed a head-to-toe assessment on 1/7/23, documented her observation and spoken with the shift supervisor. The nursing staff were trained how to conduct abuse investigations, report allegations of abuse and injuries of unknown origin. Staff were also trained how to contact the Administrator and Director of Nursing when there was an allegation of abuse and injury of unknown origin per policy. The Administrator stated the alleged staff should have been sent home to protect Resident #1 and any other resident who had been under Nurse Aide #4's care.

An interview was conducted on 2/1/23 at 11:19 AM. The Physician Assistant stated she was not informed Resident #1 had been hit by staff or the resident had been agitated over the weekend. She was told on 1/8/23 the resident had a black eye and needed to be assessed. The PA further stated staff should have notified the on-call physician of any injuries to any part of a resident's head so the physician could determine if the resident needed to be evaluated outside of the facility.

The Administrator was notified of the immediate jeopardy for F610 on February 15, 2023 at 7:09 AM.

The facility provided the following corrective action plan with a completion date of 1/16/23.

Problem identified: Nurse #3 failed to notify the Administrator of allegation of abuse per facility policy. Resident # 1 reported to Nurse #3 he was hit in the face by staff and Nurse #3 observed Resident #1's eye red and swollen on 1/7/23.

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Immediate Action: Nurse #3 did not report Resident #1 red and swollen left eye to the Director of Health Services and/or Administrator per policy on 1/7/23. Nurse #3 reported the discoloration of the left eye to the Director of Health Services on 1/8/23. The Director of Nursing / Administrator reported the injury of unknown origin to the Health Care Personnel Registry within a 2-hour time frame of their notification, with police and Adult protective services notification also. Nurse #3 interviewed Resident #1 on 1/7/2023 he stated, "she knocked the hell out of me". Nurse #3 did not remove the Certified Nursing Assistant assigned to Resident #1. The Administrator and Director of Nursing investigated the allegation when notified on 1/8/23 by Nurse #3. Certified Nursing Assistant was suspended on 1/8/2023 when the Administrator and Director of Nursing were notified on the event and terminated on 1/16/23, she did not work between 1/8/23 and 1/16/23. The Director of Health Services verbally counseled Nurse #3 on immediate reporting of alleged abuse including injuries of unknown origin, and immediate removal of the alleged abuser from the facility.
Identification of others potentially affected. Nineteen Residents assigned to the Certified Nursing Assistant (C.N.A) were interviewed by the Unit Coordinator on 1/8/2023 regarding abuse, the questions asked of the resident included "do you feel safe, have you ever been abuse, have you seen anyone else be abused, and do you have any concerns. Eighteen of the residents stated they had no concerns, and one resident stated the C.N.A was rough during care.

The Unit Coordinator completed skin observations on 1/8/2023 of the Four

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non-interviewable residents on the C.N.A assignment and did not identify any new skin impairments of the residents.

The week of 1/8/2023 the Director of Nursing and/or the Licensed Nurses completed skin observation on all residents residing in the facility with no other injury of unknown origins noted. When the Licensed Nurses complete the skin observation and a new skin impairment and/or injury of unknown origin is identified, the Director of Health Services is notified at the time of identification.
The facility Administrator and Department managers completed a sample of 20 residents interview throughout the facility from 1/8/23 through 1/27/23 for any indicators of abuse. 0 of 20 resident identified any issues of abuse during this time frame.

Systemic Changes:

On 1/8/23 the Director of Health Services and/or Nurse Managers provided re- education to all staff in all departments on Prevention and Protecting Residents from Abuse and Neglect, Reporting of Abuse, removal of any suspected / alleged abuser and immediate Notification and assessment of any allegation of abuse, neglect, and injuries of unknown origin to the Director of Health Services and/or Administrator. Facility staff members were educated prior to their next scheduled shift. Employees not educated by 1/16/23 will be removed from the schedule until education is completed.

The Clinical Competency Coordinator/Human Resources Director/ Director of Nursing continues to educated newly hired employees on

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Prevention and Protecting Residents from Abuse and Neglect, Reporting of Abuse, removal of any suspected / alleged abuser and immediate Notification and assessment of any allegation of abuse, neglect, and injuries of unknown origin to the License nurse / Supervisor for completion of assessment of area of unknown injury and notification to the Director of Health Services and/or Administrator during general orientation of newly hired employees, however on 1/8/2023 this education was given emphasis and newly hired employees are required to complete the education prior to working with Residents. The Clinical Competency Coordinator/ Director of Nursing is tracking the compliance of completion during general orientation of the Staff who have completed the education.

Beginning on 1/8/2023 the Administrator / Director of Health Services and/or Department Managers are interviewing 20 alert and oriented residents monthly to identify if 1. Have you ever been physically, verbally, sexually, mentally abused or exploited; and 2. Have you ever witnessed any abuse. The Administrator / Director of Health Services and/or Department Managers Resident will continue the monthly Resident interviews for six months then quarterly thereafter.

Beginning on 1/8/2023 the Director of Nursing and/or the Licensed Nurses will complete skin observation on all residents residing in the facility weekly and ongoing weekly. When the Licensed Nurses complete the skin observation, and a new skin impairment (injury of unknown origin) is identified the Director of Health Services is notified at the time of identification. When any staff member identifies an injury of unknown

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origin at any time, the staff member immediately notifies the License nurse / Supervisor for completion of assessment of area of unknown injury and the Director of Health Services and/or facility Administrator, for reporting to the Health Care Personnel Registry.

Beginning on 1/8/2023 the Facility Administrator and/or Director of Health Services will notify the Area Vice President and/or the Senior Nurse Consultant for Pruitt Health - Durham of all allegations of abuse including injuries of unknown origin. The Area Vice President and/or Senior Nurse Consultant will review the allegation of abuse including injuries of unknown origin to validate a thorough investigation was completed, including assessing the resident injuries, protecting the resident from abuse, and reporting resident alleged abuse was completed timely. This process of notification will be ongoing.

Monitoring:
The Director of Nursing presented an analysis of the Resident Abuse questionnaire to the Quality Assurance and Performance Improvement Committee on 1/25/23 and monthly thereafter until three months of sustained compliance then quarterly thereafter.
The Director of Health Services presented an analysis of the skin observation review to the Quality Assurance and Performance Improvement Committee on 1/25/23 and monthly thereafter until three months of sustained compliance then quarterly thereafter.
The Administrator decided to address the F 610 citation in the Ad Hoc Quality Assurance and Performance Improvement was made on 1/16/23 after the investigation related to the event was completed.

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The credible allegation was validated on 2/17/23 when staff interviews, revealed that they had received recent education on the Abuse policy and procedures, and resident rights to be free from injuries of unknown origin. The education included documentation and reporting to management immediately when they become aware of reported or suspected injury. The Administrator and the Director of Nursing were the designated staff to complete the state agency required reports within 24-hour and 5 days. Newly hired staff were required to complete the computer-based training on abuse before the start of the shift. New hire orientation packets for the past two months were reviewed to ensure abuse policy and procedures were reviewed.

The Unit Manager would submit the completed the weekly skin observations and monthly audit of the resident skin assessments to the Director of Nursing and the Administrator. The Unit Managers completed the abuse questionnaire with residents and documented any concerns the resident reported.

Attestations were signed by trained staff for the verbal education that was provided. Staff indicated they were trained prior to working in the facility for their next shifts.

An interview was conducted on 2/17/23 at 3:30 PM, the Administrator stated that the Facility Administrator and/or Director of Health Services will notify the Area Vice President and/or the Senior Nurse Consultant for Pruitt Health - Durham of all allegations of abuse including injuries of unknown origin. The Area Vice President and/or Senior Nurse Consultant

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F 610	Continued From page 21 reviewed the allegation of abuse including injuries of unknown origin to validate a thorough investigation was completed, including assessing the resident injuries, protecting the resident from abuse, and reporting resident alleged abuse was completed timely. This process of notification will be ongoing. The Administrator reviewed all the audit and monitoring tools and assessment for all residents and address areas of concern monthly. The facility deficiency was corrected on 1/16/23.	F 610		