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CARVER LIVING CENTER	**303 EAST CARVER STREET DURHAM, NC 27704**

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F 000	INITIAL COMMENTS A complaint survey was conducted from 4/30/23 through 5/4/23. The following intake was investigated: NC00201285 and resulted in immediate jeopardy. One (1) of the 1 complaint allegation resulted in deficiency. Immediate jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J). The tag F600 constituted Substandard Quality of Care. Immediate jeopardy began on 4/22/23 and was removed on 5/3/23. A partial 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:	F 600		5/4/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/23/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 Based on observations, record review and interviews with resident, family, staff, and Emergency Medical Services paramedic, Police Detective, Nurse Practitioner, psychiatry provider, and Medical Director, the facility failed to protect a resident's right to be free from physical abuse when a resident (Resident #1) assaulted another resident (Resident #2) for 1 of 3 residents reviewed for resident-to-resident abuse. On 4/22/23, Resident #1 approached his roommate (Resident #2) with a knife (described as a butter knife on a meal tray) to cut Resident #2's head. Resident #2 initially pushed Resident #1 away; however, Resident #1 returned to Resident #2's bedside multiple times and continued to cut his head with the knife. Resident #2 was a bedbound resident who was cognitively intact and, on an anticoagulant (apixaban). Resident #2 was unable to loudly shout out for help due to a history of a tracheostomy. While passing out lunch trays, a Nurse Aide (NA #1) observed Resident #1 standing beside Resident #2 and "carving" on his forehead. The attack ended and Emergency Medical Services (EMS) was called to transport Resident #2 to the hospital. Resident #2 sustained profuse bleeding with a 19-centimeter (cm) laceration on his forehead that exposed his skull, a 2-cm cut on the bridge of his nose, and multiple defensive wounds on his hands. He was taken to the hospital for treatment and required two units of fresh frozen plasm (used to help blood clot during active bleeding when a person is on a blood thinner), two units of packed red blood cells (used to replace blood when a person has had a large amount of bleeding with blood loss), sutures for the laceration, and pain management. Immediate Jeopardy began on 4/22/23 when	F 600	Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and The nursing staff notified Emergency services/ police on 4/22/23 regarding the resident-to-resident altercation at approximately 1:33pm. Emergency services/Police arrived at facility at approximately 1:49pm and assisted staff with Residents #1 and #2. Resident #2 was assessed and provided first aid by the licensed nurse on 4/22/23 at approximately 1:30pm and transferred to the hospital for evaluation and treatment of multiple lacerations of face and defensive wounds on both hands on 4/22/23 at 2:10pm. Resident #2 remains in the hospital in stable condition as of 4/27/23. Resident #1 was assessed by the licensed nurse on 4/22/23 at approximately 1:30pm and transferred to the hospital by the police for evaluation and treatment related to aggressive behavior at approximately 4:00pm. Staff remained 1:1 with Resident #1 in a safe area away from other residents until he was transferred out of the facility with police. An Immediate Discharge was provided to Resident #1 and his resident representative because the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. The Administrator contacted the Ombudsman on 4/22/23 and left a message regarding the immediate discharge. The facility was notified by the	

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Resident #1 assaulted Resident #2 with a knife. Immediate jeopardy was removed as of 5/3/23 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education and ensure monitoring systems put into place are effective.

The findings included:

A review of Resident #1's hospital record dated 3/6/23 revealed the resident was initially found sleeping on the floor in a gas station. When he was told to leave, he got up, wandered around and failed to respond to anyone. The police were contacted, then EMS was called. EMS transported Resident #1 to the hospital Emergency Department (ED). Resident #1 was unable to provide much of his medical history and provided incorrect information of his place of residence. It was determined he had lived in at least 3 different group homes since July 2022. Resident #1's Physical Examination in the ED Provider Notes was dated 3/6/23 at 12:37 AM. It reported the resident was "initially cataleptic [a condition that disrupts a person's awareness of the world and their ability to move and communicate], waxy flexibility [a relatively rare symptom typically seen in catatonia where a person's limbs respond like a warm candlestick being moved and positioned], staring, mute. Then spontaneously converted to normal pleasant interactive behavior." The trigger for the resident's catatonia was "unclear." A hospital ED Provider Note dated 3/7/23 at 8:40 AM read, "Reached out to case management ...case has

Police Detective on 4/24/23, that Resident #1 was cleared by the hospital medical team and was arrested at the hospital on 4/23/23.
The Nursing Supervisor notified the Director of Nursing on 4/22/23 at 1:50pm, once the residents were treated and safe.
The Administrator faxed the Initial Allegation Report to NCDHSR on 4/22/23 at 3:32pm.
The Administrator notified Adult Protective Services on 4/22/23 at 6:53pm.
The Director of Nursing, Administrator and Regional Director of Operations arrived at the facility on 4/22/23, to assist with investigation of incident.
The licensed nurse notified both residents representatives on 4/22/23.
The licensed nurse notified the medical provider on 4/22/23.
The nursing staff completed a room sweep on 4/22/23, of all current resident rooms to assure no potentially harmful items were in the rooms. There were no items found.
The licensed nurses completed Behavior assessments on 4/22/23, for current residents to identify residents with behaviors and assure appropriate interventions are in place for the safety of residents. Appropriate interventions were in place and monitored.
The licensed nurses completed trauma assessments on 4/23/23, for residents that were potentially affected by the incident that occurred on 4/22/23.
Chaplain services were contacted on 4/23/23, to provide counseling for staff and residents. They are scheduled to be

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been escalated to difficult placement." Another notation in the hospital record (dated 3/7/23 at 3:33 PM) reported the resident, "Had an episode of leaving ED room and being found outside, now stable and back in room safely. Has had previous similar presentations in past."

Resident #1 was discharged from the hospital and admitted to the locked Memory Care Unit (MCU) of the facility on 3/21/23. His cumulative diagnoses included dementia with other behavioral disturbance and schizophrenia.

The resident's admission orders included the following psychotropic medications: 20 mg citalopram (an antidepressant) to be given as one tablet by mouth one time a day; 1 mg lorazepam (an antianxiety medication) to be given as one tablet by mouth every 8 hours as needed for anxiety/agitation for 14 days; 80 mg lurasidone (an antipsychotic medication) to be given as one tablet by mouth one time a day for schizophrenia; and 10 mg asenapine (an antipsychotic medication) to be given as one sublingual tablet placed under the tongue each night at bedtime.

Additional admission orders included the following:
-- Monitor behaviors of anxiety/agitation.
--Routine resident checks to help maintain resident safety and well-being at least every 2 hours, document exceptions in nurses notes every shift (documented by a check mark on the resident's monthly MAR with a Start Date of 3/21/23).

Resident #1's individualized care plan included the following areas of focus, in part:
--"[Resident's name] is not an elopement

F 600

in the facility to provide the services as needed. They were at the facility on 4/25/23 and 4/26/23 and stated they will be available for continued visits as needed.
The Administrator, Director of Nursing, Nurse management team completed a thorough investigation and did not identify any indication that Resident #1 was exhibiting any aggressive behaviors prior to and after admission to the facility.
Resident #1s medication regimen was effective and consistently maintained while a resident at the facility.

IDENTIFICATION OF OTHER RESIDENTS:
All residents are at risk for resident-to-resident abuse.
The licensed nurses completed Behavior assessments on 4/22/23, for current residents to identify residents with mental health illnesses (specifically those that can cause delusions/hallucinations/psychosis) to identify historical issues with delusions/hallucinations/psychosis, signs of present delusions/hallucinations/psychosis and to ensure psych services are involved (if consented to) and assure appropriate interventions are in place for the safety of residents. Appropriate interventions were in place to assure the safety of themselves and others.
Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the

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risk/wanderer r/t [related to] Dementia, Psychotic Disturbance and Mood Disorder." Date Initiated: 3/22/23; Revision on 3/28/23.
--"[Resident's name] has potential to have behaviors r/t Dementia, Mental / Emotional illness." Date Initiated: 3/28/23; Revision on: 3/28/23.
--"[Resident's name] uses psychotropic medications r/t Behavior management (Dx [Diagnosis] of schizophrenia)." Date Initiated: 3/27/23; Revision on: 4/4/23.

The resident's admission Minimum Data Set (MDS) assessment dated 3/30/23 indicated Resident #1 had severely impaired cognition. He was reported as having no behaviors nor rejection of care during the 7-day look back period. The resident required supervision for walking in the corridor, locomotion on the unit and for eating; limited assistance for walking in his room and personal hygiene; and extensive assistance from staff for bed mobility, transfers, dressing and toileting.

Resident #1 was seen for a Psychiatry Initial Consult by a Psychiatric Mental Health Nurse Practitioner (PMHNP) on 4/3/23. The consultation progress note included an Assessment and Plan as follows:
1. Dementia: Provide supportive care. He takes citalopram for depression associated with dementia. Continue med.
2. Schizophrenia: Continue lurasidone as prescribed. Please report any change in behavior or mood. No changes at this time.
3. Insomnia: Continue melatonin (a nutritional supplement). Supportive care.
Orders: Orders for this visit: None

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action will be complete.

MEASURES FOR SYSTEMIC CHANGE:
The Director of Nursing, Assistant Director of Nursing, and unit managers completed education on 5/2/2023, for current facility and agency or contracted staff related to Abuse, Neglect and Behavior Management to include definitions of abuse and neglect, identification of behavior and/or behavior changes to include delusions/hallucinations/psychosis and, process for responding to behaviors and implementation of appropriate interventions to control, prevent and monitor behaviors. Behavior monitoring to include delusions/hallucination and psychosis are documented every shift in the resident□s electronic medical record. Staff that were not available for education will be educated upon return to work prior to accepting assignment, including agency staff. The Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, and Managers on Duty will be responsible for the completion of all education for both current staff and agency/contracted staff.
The Region Clinical Director provided education on 4/23/23, for the Admission Director, Director of Nursing, Assistant Director of Nursing and Unit Managers, regarding the revised admission process for residents with mental illness with or without documented behaviors. The admission process starts when a referral is received. The Admission Director will use the Admission Capability form to

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A review of Resident #1's April Medication Administration Record (MAR) revealed the resident was documented as having anxiety/agitation one time in April (on 4/3/23 during the 7:00 PM to 7:00 AM shift). He was administered one dose of lorazepam on 4/4/23 with the medication reported as having been effective. No other documentation of anxiety/agitation, side effects of the psychotropic medications, nor exceptions related to the routine resident checks were identified.

An Interdisciplinary Team (IDT) Progress Note dated 4/14/23 at 5:52 PM was authored by the facility's Social Worker (SW). This note documented Resident #1 was moved from his room in the locked MCU to a room on the 200 Hall outside of the Unit as he no longer met the criteria to be in the MCU. The notation read, "Appropriate staff will continue to monitor roommate compatibility."

Accompanied by the facility's Administrator, Resident #1's new room was observed on 4/30/23 at 11:45 AM. Resident #1 was assigned to Bed A (the bed closest to the door) while his new roommate (Resident #2) remained in Bed B (the bed next to the window). The room was observed to be located just before the entrance to the MCU and at the farthest end of the hallway from the Nursing Station. On 5/2/23 at 9:27 AM, the facility's Maintenance Director reported the distance from Resident #1 and Resident #2's door to the Nursing Station was 126 feet.

Resident #2 was initially admitted to the facility on 11/5/14 with re-entry to the facility on 12/14/22 after a hospital stay. His cumulative diagnoses included glaucoma, atrial fibrillation (a type of

F 600

determine who will need to review the referral for admission. The Admission Capability form includes that resident with diagnosis of mental illness and/or behavior must be reviewed by the clinical team that includes the Director of Nursing, Assistant Director of Nursing, Unit Manager and the medical director, as needed, to assure the facility can meet the needs of the resident, to maintain safety of the resident and current residents. If the resident has resided at another facility, the admission team will obtain information from the previous facility to determine the resident□s care needs and treatment. The Admission Director will also obtain historical information from the family and/or resident representative to share with the clinical team to assist in making the decision if the resident will be admitted to the facility. Residents that are admitted to the facility with a mental illness and/or behaviors will be assessed by the medical team to include the psychiatric consultant.

HOW CORRECTIVE ACTION WILL BE MONITORED:
The Director of Nursing, Assistant Director of Nursing and unit managers will review progress note documentation, behavior documentation, behavior assessments and observation of residents daily 5 x for 4 weeks then 3x week for 2 months, to identify residents with behaviors or residents with mental illness that predispose a resident to delusions/hallucinations/and psychosis that may cause behaviors and validate

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irregular heartbeat), chronic obstructive pulmonary disease, muscle wasting / atrophy, and chronic pain syndrome.

The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 2/21/23. Resident #2 was assessed to have intact cognition. He was reported as having no behaviors nor rejection of care during the 7-day look back period. The resident was independent with eating, required supervision with dressing, extensive assistance for bed mobility and toileting, and he was totally dependent on staff for personal hygiene. Transfers, walking, and locomotion did not occur during the 7-day look back period.

Resident #2's Care Plan included the following areas of focus, in part:
--The resident has an Activities of Daily Living (ADL) self-care performance deficit and mobility deficit related to chronic health conditions. He needs staff assistance to complete daily ADL tasks (Date Initiated: 4/20/17; Revision on: 11/11/19).
--The resident is on anticoagulant therapy related to atrial fibrillation (Date Initiated: 4/20/17; Revision on: 8/15/17).
--The resident is at risk for pain ...he has chronic pain and consults a pain clinic for treatment (Date Initiated: 4/20/17; Revision on: 11/27/18).

A review of the resident's electronic medical record (EMR) indicated he was seen for a 60-day follow up visit on 4/17/23 from his Medical Doctor (MD) who also served as the facility's Medical Director. A progress note from this visit reported Resident #2 had no complaints of pain at that time. He described the resident's general

F 600

that interventions are in place to control, prevent and monitor behaviors.
The Administrator and/or Assistant Administrator will audit referral log weekly x 4 weeks then 2x month for 2 months, to validate that referrals with diagnosis of mental illness or behavioral concerns were reviewed by the clinical team, prior facility information was received if applicable and a historical review of behaviors with the resident representative was completed prior to offering a bed to ensure that the facility can safely meet the resident needs and maintain safety of the resident and current residents.
The Administrator, Director of Nursing and/or ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance.
The Administrator, Director of Nursing and/or Assistant Director of Nursing will review the plan during the monthly Quality Assurance and Process Improvement (QAPI) meeting and the audits will continue at the discretion of the QAPI committee.

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appearance as "comfortable, alert, no anxiety noted, no acute distress."

Resident #2's EMR also included a physician's progress note for a palliative care follow-up visit dated 4/18/23. The resident was being seen for help with advance care planning, symptom management, and ongoing psychosocial support. This note reported the resident had a history of prolonged respiratory failure resulting in a tracheostomy (which had since been removed). Resident #2's chronic pain was noted as "stable" and a report made to indicate he was "now off of opioid therapy altogether" and only taking gabapentin (a medication frequently used to treat nerve pain) and acetaminophen.

A review of Resident #2's current medication orders as of 4/22/23 included the following, in part:
--650 mg acetaminophen scheduled for administration by mouth every 6 hours for pain (Start Date 11/16/22).
--100 mg gabapentin to be given as two capsules by mouth at bedtime for neuropathy pain (Start Date 11/16/22);
--2.5 milligrams (mg) apixaban to be given as one tablet by mouth every 12 hours for clot prevention (Start date 11/16/22).

Resident #2's EMR included a Nursing Note dated 4/22/23 at 1:35 PM and authored by the facility's Weekend Supervisor (Nurse #1). This Nursing Note read: "I was alerted by the CNA [Certified Nurse Aide] to come to the resident's room. Upon entering the resident's room, resident [Resident #2] was noted with a large gash across his forehead, an injury to his right eye and injuries to the left side of his face.

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F 600	Continued From page 8 Copious amount of blood noted on the resident and the resident's bedding. Staff present was trying to control the bleeding. I immediately called 911. I walked into the hall so 911 could hear me. Resident's roommate [Resident #1] was noted in the tv room, down the hall, in the presence of staff. I explained to 911 the situation at hand and they stated ems was on the way. After speaking to 911, I went back into the room to assist staff in the care of the injured resident until EMS and police arrived. EMS took over the situation, controlled the bleeding and dressed the resident wounds. Resident was then transported to [name of hospital]. Resident's RP [name of Responsible Party] was made aware of the situation." An interview was conducted on 4/30/23 at 2:40 PM with Nurse Aide #2 (NA #2). NA #2 reported she was assigned to care for both Resident #1 and Resident #2 on the first shift of 4/22/23 from 7:00 AM to 7:00 PM. The NA reported this was the first time she had cared for Resident #1, but she was familiar with Resident #2. Upon inquiry, the NA reported everything seemed to be fine with these two roommates at the beginning of her shift. NA #2 stated she last went into their room before lunch around 12:00 to 12:15 PM as she was doing her rounds. At that time, Resident #2 was asleep lying on his back with his left leg hanging off the bed. She asked the resident if she could help him put his leg back up on the bed, but he declined saying he always laid like that. As she walked out of the room, NA #2 recalled seeing Resident #1 laying on his bed with his hands placed behind his head. Resident #1 gave her a "half-smile" as she left the room to go assist another resident next door since the lunch meal trays had not yet come out to the hall.	F 600		

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Approximately 10 minutes later, NA #2 reported, "I heard the screaming." The NA stated she initially thought this screaming was coming from the memory care unit but later thought it may have been Resident #2 calling for help. As she opened the door of the room she was in, she saw NA #1 going into Resident #1 and Resident #2's room. The NA heard NA #1 scream and run out of the room hollering, "He's trying to kill him, He's trying to kill him!" NA #2 reported she went right behind NA #1 to get help and to find the Weekend Supervisor (Nurse #1).

A telephone interview was conducted with NA #1 on 5/1/23 at 12:37 PM. During the interview, the NA reported on 4/22/23 around 1:30 PM, she and several other NAs were passing out lunch trays for the residents on the hall. She pulled the lunch tray for Resident #2 from the meal cart. As she was walking into the room, she could see Resident #2's leg had blood on it. She reported, "I put the tray down and pulled the curtain back and saw [Resident #1] carving into [Resident #2's] skull. I yelled at [Resident #1], 'What are you doing?' and he moved away." When she asked Resident #1 what he was doing, the NA reported Resident #2 only said, "Help!" She stated Resident #1 stepped back from Resident #2 and started to walk in the direction of his own bed and the room's door. NA #1 continued by stating, "At that point, I ran out of the room. When I came back another [NA] had [Resident #1] in a wheelchair." The NA explained she had run out of the room to get help. Meanwhile, Nurse #1 and 3 other NAs ran into the room to provide assistance. Upon inquiry, NA #1 reported after everyone was in the room, Resident #2 said he had been calling for help for a while. However, the NA stated she had not heard him

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from out in the hallway because his voice was quite soft. When asked what kind of knife had been used to cut Resident #2's forehead, she reported it was a "butter knife, like off of the [meal] trays."

An interview was conducted on 5/2/23 at 11:40 AM with NA #3. NA #3 recalled seeing Resident #1 self-propelling his wheelchair as he came out of the MCU around 12:10 to 12:15 PM. She was passing meal trays on the 100 Hall at that time. A while later, she was helping to pass meal trays on the 200 Hall when she saw her coworker coming out of Resident #1 and Resident #2's room "saying something was done to the resident." NA #3 stated, "I went in [to the room] within seconds." When asked what she saw, the NA reported, "A lot of blood. [Resident #1] was going back to the bed ...he was heading to his bed. He was about at the curtain dividing the two beds with his back to [Resident #2]." NA #3 reported she knew her Unit Manager (Nurse #2) was in the MCU, so she went to the door of the unit (next to the residents' room) and screamed for Nurse #2 to come, then returned directly back to help care for Resident #2. NA #3 reported Nurse #2 and a couple of others came to help. Resident #1 was removed from the room by a co-worker while Nurse #2 instructed the NAs to put pressure on Resident #2's wounds. NA #3 stated she stayed with Resident #2 until EMS came. When asked, the NA reported Resident #2 was just crying out in pain. She did not recall hearing the resident say much else.

An interview was conducted on 5/1/23 at 11:14 AM with NA #4. NA #4 reported she had been sitting in the MCU hall monitoring when she heard a co-worker yell for help outside the Unit. She

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went into Resident #1 and Resident #2's room, looked to see how Resident #2 was, then put Resident #1 into a wheelchair and took him to the smoking area. The NA reported when she asked Resident #1 what had happened, he said he didn't know. She stated, "He just acted like he hadn't done anything." She reported she was familiar with Resident #1 from working in the MCU when he resided there. NA #4 reported she was not aware of Resident #1 having any issues with his roommate or other residents while he was in the Unit.

An interview was conducted on 4/30/23 at 2:15 PM with Nurse #2. Nurse #2 reported she worked as the Unit Manager over the 100 and 200 Halls, which included the MCU. The nurse recalled there were no behaviors or roommate issues for Resident #1 when he was initially admitted to the facility on the Unit. Nurse #2 stated that although she was not assigned to work on 4/22/23, she just came into the facility to check in and make sure everything was going smoothly. While she was there, she relieved the Hall monitor on the MCU so she could go to lunch. In a written statement provided by Nurse #2, the nurse reported being on the Unit around 1:20 PM on 4/22/23 when Resident #1 came into the Unit; she redirected him outside the Unit and back to his room (the first door to the right after exiting the MCU). During the interview, Nurse #2 stated that after just a few minutes she heard her name being screamed outside of the MCU. She jumped up, ran out of the Unit to see what was going on, then entered the residents' room. At that time, she saw Resident #1 lying on his bed "relaxing" with his legs crossed and hands placed behind his head. As she approached Resident #2, she saw the brown comforter on his bed had

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F 600	Continued From page 12 blood on it. She stated, "There was a lot of blood." He had a white blanket on his head but after seeing all the blood, she called for someone to get towels and sheets to help stop the bleeding. She reported, "Everyone was running and getting me stuff." The nurse stated she didn't realize how bad Resident #2's injuries were until they moved the blanket off his head, and she could see the forehead laceration was to the bone. She reported staff put wet towels on his wounds to try and stop the bleeding. Resident #2 was moving his hands and saying he couldn't see. Nurse #2 told him who she was and kept trying to reassure him she was there to help. She recalled Resident #2 was alert, he knew who she was, and he let her hold his hands. Meanwhile one of the NAs (NA #4) put Resident #1 into a wheelchair and took him out of the room. Three NAs (identified as NA #3, NA #5, and NA #6) assisted the nurse in getting linens and applying pressure to the wounds. Nurse #2 reported she stayed with Resident #2 until EMS arrived on the scene. After EMS came for Resident #2, the nurse reported she went out to the resident smoking area where staff had brought Resident #1. She recalled when she asked Resident #1 what happened he stated, "I don't know." Afterwards, she accompanied a police officer back to the residents' room. She reported at that time she observed blood behind Resident #2's headboard, on pillows, his blanket, and comforter. She also observed a knife was on Resident #1's rolling bedside table. An interview was conducted on 4/30/23 at 2:56 PM with Nurse #3. Nurse #3 reported she was working on 4/22/23, the date of the incident involving Resident #1 and Resident #2. She recalled working in the front conference room on	F 600		

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another task when she received a phone call from Nurse #2 requesting 911 be called and that she come to Resident #1 and Resident #2's room for assistance. She reported being unable to get through to 911 (although another staff member did). When she reached Resident #1 and Resident #2's room, she noted there was a lot going on as she tried to assist in providing first aid to Resident #2. Resident #2 was trying to touch his head and staff were encouraging him not to do so as they provided reassurance to the resident that they were there to help him. She reported the resident was "low spoken ...he was mumbling." Shortly after Nurse #3 got to the room, EMS arrived.

An interview was conducted on 5/2/23 at 11:20 AM with Nurse #4. Nurse #4 identified herself as Resident #1 and Resident #2's usual hall nurse on first shift. The nurse reported she was working on the hall the day of the incident involving these two residents (4/22/23) and recalled she had last seen them around 11:30 AM on that day without any concerns noted. During the interview, the nurse reported on 4/22/23 she was in another room on the hall feeding a resident when she heard someone call out for 911 to be called because Resident #2 was stabbed. Nurse #4 reported she was able to get through to 911 on the second attempt. Nurse #4 then went to the room. She stated, "All I could see was a towel on his head .... I stepped out of the room." She noted other staff members were in the room helping the resident. After stepping out of the room, she reported seeing Resident #1 on the patio. The nurse went to the nursing station to get Resident #2's paperwork together and ready for EMS to transfer him to the hospital. When asked if she was aware of any

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disagreements between the two residents since they became roommates, she stated she was not. The nurse added that she was certain Resident #2 would have told her if there was a problem with his roommate because they were close. But she stated, "He never said a word to me."

An interview was conducted on 4/30/23 at 3:09 PM with Nurse #1. Nurse #1 identified himself as the Weekend Supervisor assigned to work on 4/22/23 at the time of the incident. The nurse reported he was sitting outside in the smoking area when NA #1 banged on the glass yelling, "He's trying to kill him." Nurse #1 went to Resident #1 and Resident #2's room and reported he saw "blood all over the bed." Resident #2 had a "huge" wound on his forehead and a "bloodied" area on the right side of his face around his right ear and eye. However, the nurse reported it was hard to know the extent of the injuries due to all of the blood. He stated, "It was shocking what I saw." Staff were already providing first aid while he stepped out of the room to focus on calling 911. He reported there was blood everywhere and he wanted to get help as quickly as possible. After he got through to 911, he went back into the room to assist with what was happening but there were already several staff members in there to help the resident. Nurse #1 stated that meanwhile, Resident #1 was being contained in the TV room.

An interview was conducted on 5/1/23 at 1:00 PM with NA #8. NA #8 reported he was in another resident's room when he heard someone yelling his name. He went into Resident #1 and Resident #2's room. At that time, he observed Resident #1 in his bed. When he went to

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Resident #2's side of the room, he saw the resident was injured. He retrieved some towels for him while another staff member took Resident #1 outside. He saw Resident #1 run back inside (from the smoking area) so he re-directed him to the TV room, and he stayed with the resident. When asked if the resident said anything to him, he stated, "No." However, when the police came to talk to him, they told him if he didn't stay still, he would be put in handcuffs. Resident #1 didn't want that. When the police asked him if he was hurt, he said only his mind was.

A Police Report dated 4/22/23 at 1:35 PM included the following narrative, in part: " ...Upon arriving, I spoke with the nurse, [name of NA #1], who stated that she walked into Resident #1 and Resident #2's room and saw the suspect, [Resident #1] sitting on top of [Resident #2] in his bed "carving into his head with a butter knife." She said that she yelled "what are you doing" but [Resident #1] did not say anything back. The nurse took [Resident #1] out of the room while the medic unit came into the room. [Resident #1] and [Resident #2] have been roommates in the living center for a week. [Resident #1] was transferred from [name of hospital] Psychiatric Ward a month ago. [Resident #1] has Schizophrenia and dementia. When I asked [Resident #1] what happened he stated that he does not remember. I asked him if they were in an argument, and he said no. [Resident #1] looks to be spaced out. And continued to try and walk away. [EMS] arrived on scene and transferred [Resident #2] to [name of hospital] with semi life threatening injuries. [Resident #2] has a large gash on his forehead from one temple to the other. He has severe face and head injuries and his ear was cut off ... [Resident #1] was

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F 600	Continued From page 16 transported to [name of hospital] for emergency commitment." A telephone interview was conducted on 5/1/23 at 1:21 PM with the Police Detective who was the lead investigator on the case involving Resident #1 and Resident #2 on 4/22/23. The Detective reported when he arrived at the facility on 4/22/23, the attacker was already in the police car. Resident #1 had told the patrol officer he was "Woodrow Wilson." The Detective requested Resident #1 be brought to the hospital where he spent one day being evaluated before being arrested. During the telephone interview conducted on 5/1/23 at 1:21 PM, the Detective stated he has talked with the victim 3 times since the incident occurred. Resident #2 reported to the Detective that he and his roommate had "on-going conversations" regarding Resident #2's television. Resident #2 told the Detective Resident #1 tried several times to cut him, "perhaps as many as 5-6 times." Resident #1 tried to cut him, then left (not sure where he went), and then returned to cut him again. Resident #2 reported this occurred over a period of up to 20 minutes (reported on the 2nd interview), but this estimation of time was changed on the 3rd interview to the assault lasting 5-minutes. Resident #2 said he was yelling for help and thought his yelling would have been heard outside of the room. However, the Detective reported the resident was soft-spoken and may not have been heard. Upon inquiry, the Detective reported he has looked into the statement written in the initial police report which indicated Resident #1's ear had been severed. He stated he was not finding anything from the hospital to support that	F 600		

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statement and it was likely that due to the massive amount of bleeding, the actual injuries could not be accurately determined. The Detective reported as of 5/1/23, Resident #1 was incarcerated at the County Jail. There were four felony charges against him:
--Assault inflicting serious bodily injury;
--Assault with a deadly weapon inflicting serious bodily injury;
--Felony assault on an individual with a disability;
--Maming without malice.
A follow-up telephone interview was conducted on 5/2/23 at 8:50 AM with the Police Detective. At that time, the Detective was asked about the possibility of interviewing Resident #1 about the incident. The Detective returned the call on 5/2/23 at 8:58 AM after talking with his supervisor. The Detective reported the resident may have been transferred out of the County Jail, so he was not sure of his location at that time. Regardless, he stated it was a "bad idea" to try to interview Resident #1.

A review of the EMS Report revealed a 911 call was received from the facility on 4/22/23 at 1:36 PM. EMS arrived at the scene at 1:39 PM. The EMS Report indicated the resident had a deep laceration across his forehead ear to ear with active bleeding and defensive abrasions on both hands. The resident's level of distress was reported to have been "moderate." The EMS report read, in part: "EMS immediately placed hemostatic dressing [a dressing with an adhesive-like action that seals the wound and controls the bleeding] on the pts [patient's] wounds and wrapped the wound to control bleeding. EMS then transitioned the pt onto the stretcher and rapidly transported pt to [name of hospital]/Trauma alert was made to [hospital]."

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A telephone interview was conducted on 5/4/23 at 12:05 PM with the Emergency Medical Technician-Paramedic (EMT-P) who was the first responder to the facility on 4/22/23. The EMT-P recalled when she arrived at the scene, 4-5 staff members were in the room with Resident #2 as he was lying on the bed. He was actively bleeding from a very deep laceration extending from ear to ear and from what she could recall, she thought one ear may have been severed because there was so much blood. Bloody wet towels were wrapped around the resident's head; no other residents were in the room. A knife was observed to be sitting on a rolling table in the room. She reported the EMTs' main focus during the call was to stop the bleeding. The resident was on a blood thinner and had already lost a lot of blood. She described the resident as very alert but noted that while he could tell the EMT-P his name, he seemed disoriented. The EMT-P reported she thought the incident had gone on for several minutes, based on the amount of damage done to Resident #2 before someone noticed and called 911.

The hospital ED Provider Notes dated 4/22/23 at 2:20 PM reported Resident #2 presented to the ED as an assault victim with a stab wound to his head. The note read, "Per EMS, pt was reportedly stabbed across forehead using butter knife." The resident's physical examination documented he had a complex, irregular border, deep laceration extending across his forehead. Upon examination, he complained of right eye pain with extra-ocular eye movements intact (testing that examines the function of the eye muscles). The resident was reported to have bilateral eyelid bruising and mild swelling.

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Another laceration was noted over his nose and there were scattered lacerations (defensive wounds) over both of his hands. No trauma was reported to the resident's ears. Resident #2 was noted to be hypotensive (have low blood pressure) and treated with two units of fresh frozen plasm (used to help blood clot during active bleeding when a person is on a blood thinner) and two units of packed red blood cells (used to replace blood when a person has had a large amount of bleeding with blood loss).

Resident #2's records reported the hospital's Ear, Nose and Throat (ENT) service was consulted for the large scalp laceration "down to bone." An ENT consultation note dated 4/22/23 at 6:32 PM reported Resident #2 was status post right eye corneal transplant with baseline left eye blindness. The resident was "moaning in pain" when seen by ENT and stated the pain was along his forehead but particularly in the right eye. Resident #2 reported his vision in the right eye was not at baseline and he was very sensitive to moving his right eye laterally (to the side). The ENT service closed the 19-centimeter forehead laceration (described as "down to bone") with sutures and two Penrose drains sutured on either side of the head. A Penrose drain is a soft, flexible latex drain that allows blood and other fluids to move out of an area to prevent fluid from collecting and causing an infection. The 2-centimeter laceration over the resident's right nasal bridge and extending toward the medial canthus (the corner of the eye where the upper and lower lids meet) was also closed.

Resident #2's hospital records revealed he received multiple medications in the ED, including 50 micrograms (mcg) fentanyl injection (an opioid

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pain medication) given intravenously on 4/22/23 at 2:18 PM and 0.5 milligrams (mg) hydromorphone (an opioid pain medication) administered intravenously on 4/22/23 at 4:39 PM. Additional pain medications administered to the resident during his hospital stay included the following:
--On 4/22/23 at 10:25 PM, one dose of 4 mg of morphine (an opioid pain medication) was administered intravenously;
--On 4/23/23, one dose of 25 mcg of fentanyl was administered intravenously;
--One dose of 10 mg oxycodone (an opioid pain medication) was administered as one tablet by mouth on 4/23/23 at 8:34 AM, 4/23/23 at 9:41 PM and 4/24/23 at 6:00 AM;
--One dose of 5 mg oxycodone was administered as one tablet by mouth on 4/26/23 at 12:04 AM, 4/26/23 at 8:38 AM, 4/26/23 at 4:18 PM, and 4/27/23 at 11:55 AM, and 4/29/23 at 5:09 PM.
--One dose of 2.5 mg oxycodone was administered as one tablet by mouth on 4/27/23 at 11:55 AM.
Resident #2 also received 325 mg acetaminophen given as three tablets by mouth (total dose 975 mg) three times daily (beginning on 4/23/23 at 9:04 AM and continuing until his discharge back to the facility on 5/1/23).

An interview was conducted on 5/1/23 at 10:15 AM with Resident #2's family member. During the interview, the family member confirmed Resident #2 had a tracheostomy many years ago. She stated the tracheostomy damaged his vocal cords, making him unable to talk loudly.

Resident #2 was discharged from the hospital back to the facility on 5/1/23. He was admitted to a private room on the 400 Hall.

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A review of Resident #2's re-admission medication orders included the following, in part:
--325 mg acetaminophen to be given as 3 tablets (total dose of 975 mg) by mouth scheduled 3 times a day for pain for 10 days (Start Date 5/1/23);
--100 mg gabapentin (a medication frequently used to treat nerve pain) to be given as two capsules by mouth at bedtime for neuropathy pain (Start Date 5/2/23);
--2.5 milligrams (mg) apixaban to be given as one tablet by mouth every 12 hours for clot prevention (Start date 5/1/23);
--500 mg cephalexin (an antibiotic) to be given as one capsule by mouth every 6 hours for forehead laceration for 4 days (Start Date 5/1/23).

An observation and interview were conducted on 5/2/23 at 10:00 AM with Resident #2. The resident was observed to have a very large (approximately 8-inch) sutured area on his forehead from the left to the right side of his temple with a downward turn on the right side of his forehead with a yellow-green bruise slightly below the cut and just above his cheek bone. He also had a small cut on his right eye lid and a slightly larger cut on the right side of the bridge of his nose. The resident's right hand had two visible cuts on it and his left hand had 6 cuts. No cuts or bruising were observed on or around either of the resident's ears.

During the interview conducted on 5/2/23 at 10:00 AM, Resident #2 was asked about the 4/22/23 incident. The resident stated, "I think it was about the TV" or else something was just wrong with him. He reported his TV was bigger than his roommate's television and Resident #1 always

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wanted to turn it off. Resident #2 stated immediately before he was attacked, he was lying on his bed resting with the curtain between his bed and the roommate's bed pulled closed. His roommate (Resident #1) came over to his bed with a knife and tried to cut him on his head. Resident #2 stated he was initially able to push Resident #1 away; however, Resident #1 returned to Resident #2's bedside and continued to cut his head with the knife. During the interview, the resident reported he began to call out for help when his roommate approached him the second time. Without prompting, the resident attempted to yell out "Help!" to demonstrate his calls for help. The resident couldn't be sure if his calls were heard outside the room, and he acknowledged the volume of his voice had been affected by having had a tracheostomy years ago. Resident #2 estimated the attack from his roommate lasted "maybe 10, 15 or 20 minutes" with Resident #1 returning to cut him approximately six to seven times. The resident reported each time his roommate came to cut him, "I would switch hands." At that time, he showed the defensive wounds on his hands. Resident #2 stated, "If I could have gotten up, I'd have clocked him." When asked where his call light was at the time of the incident, he stated he did not know. He added that he did not have any time or opportunity to use the call light because he was busy defending himself. He stated, "I had no time to use it."

As the interview conducted on 5/2/23 at 10:00 AM continued, Resident #2 was asked about his level of pain. The resident stated he always had some pain even before the attack and reported he took acetaminophen for it. Since the attack, both his eyes and forehead have hurt him. On a scale of

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1 to 10 (with 10 indicative of the worst pain imaginable), Resident #2 reported the pain was "a lot of 10's." He reported he received oxycodone for the pain while in the hospital and the medication was effective in helping to control the pain. He also stated that yesterday he saw ophthalmology and his vision was tested. He reported the vision in his right eye was exactly the same as his baseline tests had previously shown. A follow-up interview was conducted on 5/2/23 at 11:15 AM with Resident #2. During this interview, the resident was asked how he felt during and after the attack. He stated during the attack, there was "not too much time to think." Resident #2 added, "He could have killed me."

An interview was conducted on 5/1/23 at 10:44 AM with the Nurse Practitioner (NP) who cared for Resident #1 at the facility. The NP recalled Resident #1 and reported she had seen him 3-4 times since he came into the facility. During her visits, the resident was usually sitting in a wheelchair or was in his bed smiling. She confirmed the resident had a diagnosis of dementia and schizophrenia but seemed to be stable on his current medications. The NP reported each time she talked with the nursing staff about Resident #1, no behaviors were reported. Upon further inquiry, the NP stated she typically obtained information about a resident's behavior(s) via communication with the nursing staff and direct observations of the resident. The NP noted she could also refer to documentation in the Nursing Notes as well to learn about a resident's behaviors. She stated, "I was shocked" upon learning of the 4/22/23 incident. The NP reported that from her perspective, there was no indication of this happening. When asked if she had written the 3/21/23 order for "routine resident

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checks" to be conducted for Resident #1, she stated she did not and added, "I think that's the standard order" and more pertinent to the Memory Care Unit.

An interview was conducted on 5/1/23 at 9:07 AM with the facility's Medical Director. During the interview, the physician reported that when residents came from the outside, they typically came with extensive information. Resident #1's social disposition indicated he had a history of wandering, so he was initially put into the MCU. The physician reported the resident was on some very good medications for schizophrenia which seemed to be effective. He reported there was no known history or other indication of Resident #1 having behaviors or aggression. The physician stated he did not think the reason for the aggressive attack on Resident #2 could be determined.

A telephone interview was conducted on 5/1/23 at 12:25 PM with the psychiatry provider (a Board Certified Psychiatric-Mental Health Nurse Practitioner or PMHNP-BC) who had seen Resident #1 for an initial consultation after his admission to the facility. The NP recalled seeing Resident #1 for this initial consult when he was in the Memory Care Unit. She described the resident as being polite, not aggressive, and soft-spoken at the time of her visit. He had very good eye contact and answered basic questions appropriately (although he was forgetful). The resident denied any hallucinations, suicidal or homicidal ideations. The NP reported when she heard about the incident that occurred on 4/22/23, her first thought was that Resident #1 had a psychotic episode. Since she had only seen Resident #1 one time, she was unable to

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make a determination of how therapeutic his current medication regimen was compared to other meds he may or may not tried in the past. She reported if Resident #1 was prone to incidents such as the incident on 4/22/23, he should not be in a nursing home.

The Administrator was notified of Immediate Jeopardy on 5/2/23 at 2:45 PM in the presence of the Assistant Administrator, Director of Nursing, and Regional Director of Operations. The Administrative team verbalized a desire to submit a Corrective Action Plan for review to designate the citation at Past Non-Compliance.

An interview was conducted on 5/2/23 at 4:30 PM with NA #9. NA #9 reported she had worked as an Agency (temporary staff) NA up until the day she became an employee of the facility, effective Sunday, 4/30/23. The NA stated she had worked as an Agency NA on 3 days during the week of 4/23/23. She also worked on the Sunday (4/30/23) when she became an employee of the facility. The NA reported she received verbal in-service education on abuse, neglect, and behavior management when she worked on Sunday, 4/30/23. When asked again, NA #9 confirmed she did not receive this in-service education between 4/22/23 and 4/29/23 (inclusive).

An interview was conducted on 5/2/23 at 5:16 PM with NA #10. NA #10 was an Agency NA who reported this was her first day to work at the facility since the incident of 4/22/23. When asked, the NA reported she had not received in-service education on abuse, neglect, and behavior management before working her shift on this date (5/2/23). A follow-up interview was

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conducted with NA #10 on 5/2/23 at 6:15 PM. During the follow-up interview, the NA reported she received the abuse, neglect, and behavior management education approximately 10 minutes after she was initially asked about it on this date (5/2/23). NA #10 stated she signed the In-Service Signature Sheet after receiving the information on 5/2/23.

The facility provided an acceptable credible allegation on 5/3/23.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

The nursing staff notified Emergency services/ police on 4/22/23 regarding the resident-to-resident altercation at approximately 1:33pm. Emergency services/Police arrived at facility at approximately 1:49pm and assisted staff with Residents #1 and #2.

Resident #2 was assessed and provided first aid by the licensed nurse on 4/22/23 at approximately 1:30pm and transferred to the hospital for evaluation and treatment of multiple lacerations of face and defensive wounds on both hands on 4/22/23 at 2:10pm. Resident #2 remains in the hospital in stable condition as of 4/27/23.

Resident #1 was assessed by the licensed nurse on 4/22/23 at approximately 1:30pm and transferred to the hospital by the police for evaluation and treatment related to aggressive behavior at approximately 4:00pm. Staff remained 1:1 with Resident #1 in a safe area away from other residents until he was transferred out of the facility with police. An

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Immediate Discharge was provided to Resident #1 and his resident representative because the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. The Administrator contacted the Ombudsman on 4/22/23 and left a message regarding the immediate discharge. The facility was notified by the Police Detective on 4/24/23, that Resident #1 was cleared by the hospital medical team and was arrested at the hospital on 4/23/23.

The Nursing Supervisor notified the Director of Nursing on 4/22/23 at 1:50pm, once the residents were treated and safe.

The Administrator faxed the Initial Allegation Report to NCDHSR on 4/22/23 at 3:32pm.

The Administrator notified Adult Protective Services on 4/22/23 at 6:53pm.

The Director of Nursing, Administrator and Regional Director of Operations arrived at the facility on 4/22/23, to assist with investigation of incident.

The licensed nurse notified both residents representatives on 4/22/23.

The licensed nurse notified the medical provider on 4/22/23.

The nursing staff completed a room sweep on 4/22/23, of all current resident rooms to assure no potentially harmful items were in the rooms. There were no items found.

The licensed nurses completed Behavior

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assessments on 4/22/23, for current residents to identify residents with behaviors and assure appropriate interventions are in place for the safety of residents. Appropriate interventions were in place and monitored.

The licensed nurses completed trauma assessments on 4/23/23, for residents that were potentially affected by the incident that occurred on 4/22/23.

Chaplain services were contacted on 4/23/23, to provide counseling for staff and residents. They are scheduled to be in the facility to provide the services as needed. They were at the facility on 4/25/23 and 4/26/23 and stated they will be available for continued visits as needed.

The Administrator, Director of Nursing, Nurse management team completed a thorough investigation and did not identify any indication that Resident #1 was exhibiting any aggressive behaviors prior to and after admission to the facility. Resident #1's medication regimen was effective and consistently maintained while a resident at the facility.

IDENTIFICATION OF OTHER RESIDENTS:

All residents are at risk for resident-to-resident abuse.

The licensed nurses completed Behavior assessments on 4/22/23, for current residents to identify residents with mental health illnesses (specifically those that can cause delusions/hallucinations/psychosis) to identify historical issues with delusions/hallucinations/psychosis, signs of

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present delusions/hallucinations/psychosis and to ensure psych services are involved (if consented to) and assure appropriate interventions are in place for the safety of residents. Appropriate interventions were in place to assure the safety of themselves and others.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

MEASURES FOR SYSTEMIC CHANGE:

The Director of Nursing, Assistant Director of Nursing, and unit managers completed education on 5/2/2023, for current facility and agency or contracted staff related to Abuse, Neglect and Behavior Management to include definitions of abuse and neglect, identification of behavior and/or behavior changes to include delusions/hallucinations/psychosis and, process for responding to behaviors and implementation of appropriate interventions to control, prevent and monitor behaviors. Behavior monitoring to include delusions/hallucination and psychosis are documented every shift in the resident's electronic medical record. Staff that were not available for education will be educated upon return to work prior to accepting assignment, including agency staff. The Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, and Managers on Duty will be responsible for the completion of all education for both current staff and agency/contracted staff.

The Region Clinical Director provided education on 4/23/23, for the Admission Director, Director of Nursing, Assistant Director of Nursing and Unit

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Managers, regarding the revised admission process for residents with mental illness with or without documented behaviors. The admission process starts when a referral is received. The Admission Director will use the Admission Capability form to determine who will need to review the referral for admission. The Admission Capability form includes that resident with diagnosis of mental illness and/or behavior must be reviewed by the clinical team that includes the Director of Nursing, Assistant Director of Nursing, Unit Manager and the medical director, as needed, to assure the facility can meet the needs of the resident, to maintain safety of the resident and current residents. If the resident has resided at another facility, the admission team will obtain information from the previous facility to determine the resident's care needs and treatment. The Admission Director will also obtain historical information from the family and/or resident representative to share with the clinical team to assist in making the decision if the resident will be admitted to the facility. Residents that are admitted to the facility with a mental illness and/or behaviors will be assessed by the medical team to include the psychiatric consultant.

Date of IJ removal-5/3/23.
The facility's credible allegation of Immediate Jeopardy removal was validated on 5/4/23. Staff from different departments were interviewed and verified they had received training on Abuse, Neglect and Behavior Management. The education included definitions of abuse, neglect and identification of behavior, process for responding to behaviors and implementation of appropriate interventions to control, prevent and monitor behaviors, and the documentation of behavior monitoring in the resident's medical

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F 600	Continued From page 31 records each shift. A review was completed of the audit logs that included the educational information provided to staff during the in-service and a review of the in-service sign in logs. The in-service logs were reviewed, staff names were randomly selected and verified through interviews to have received training. The audit sheets of resident behavior assessments were reviewed, and resident medical records randomly selected from the list were reviewed and verified to have had a behavior assessment, interventions listed on their care plan, and physician orders in place to monitor residents' behavior. The facility implemented a revision to the admission process for residents with mental illnesses with or without documented behaviors. Staff interviewed reported they had received the training and a sample resident was reviewed during the validation. A review of the monitoring tool revealed staff had completed daily monitoring of resident behaviors. The QAPI plans to include this monitoring in their next meeting. Based on staff interviews with NA #9 and NA #10 staff education was not completed prior to the survey start date of 4/26/23 and the facility's assertion for past non-compliance was not accepted. The immediate jeopardy removal date was validated as 5/3/23.	F 600		